

REGIONAL REPORT

ASSESSMENT OF ADOLESCENTS AND YOUTH-FRIENDLY HEALTH SERVICE DELIVERY EAST AND SOUTHERN AFRICA REGION



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ACRONYMS

ANC	Antenatal Care
ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immunodeficiency Syndrome
ARO	Africa Regional Office
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AYFHS	Adolescent and Youth-Friendly Health Services
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CBO	Community-Based Organisation
CD4	Cluster of Differentiation 4
COMESA	Common Market for Eastern and Southern Africa
CPD	Continuous Professional Development
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
DANIDA	Danish International Development Agency
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
EAC	East African Community
ESA	East and Southern Africa
ESARO	East and Southern Africa Regional Office
EU	European Union
FBO	Faith-Based Organisation
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
GBV	Gender-Based Violence
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH
HCIH	Health Centre III
HCIV	Health Centre IV
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus

HMIS	Health Management Information System
ICPD	International Conference on Population Development
IDI	In-depth Interview
IEC	Information Education Communication
IGAD	Intergovernmental Authority on Development
INGO	International Non-Governmental Organisation
IPPF	International Planned Parenthood Federation
IUD	Intra-Uterine Device
KIT	Royal Tropical Institute
LGBT	Lesbian, Gay, Bisexual, Transgender
MA	Member Association
M&E	Monitoring & Evaluation
MOH	Ministry of Health
NAFCI	National Adolescent Friendly Clinic Initiative
NGO	Non-Governmental Organisation
NUEYS	National Union of Eritrean Youth and Students
ODK	Open Data Kit
PEP	Post-Exposure Prophylaxis
PEER	Participatory Ethnographic Evaluation Research
PGB	Geração Biz Programme
PMTCT	Prevention of Mother to Child Treatment
PNSA	Programme National de Santé de l'Adolescent
PSI	Population Services International
PTA	Parent-Teacher Association
RTI	Reproductive Tract Infection
SADC	Southern African Development Community
SDC	Swiss Development Cooperation
SDG	Sustainable Development Goal
SDP	Service Delivery Point
SGBV	Sexual and Gender-Based Violence
Sida	Swedish International Development Cooperation Agency
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub Saharan Africa

STI	Sexually Transmitted Infection
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YFHS	Youth-Friendly Health Services
YHC	Youth Health Centre
YPLHIV	Young People Living with HIV
YSO	Youth Serving Organisation

GLOSSARY OF TERMSⁱ

Adolescents: UNFPA/WHO/UNICEF's standard definition of adolescents is people between the ages of 10 and 19 years.

Adolescents and Youth-Friendly Health Services: Adolescents and youth-friendly services are those that are based on a comprehensive understanding of, and respect for, young people's rights and realities of their diverse sexual and reproductive lives. These are services that young people trust and feel are there for them. To be considered adolescent-friendly, health services should be:

- Accessible: Adolescents and young people *are able* to obtain the health services that are available.
- Acceptable: Adolescents and young people feel health services are suitable for them and *are willing* to obtain services that are available.
- Equitable: *All adolescents and young people*, not just selected groups, are able to obtain the health services that are available. Serving a selected group could mean that some barriers including stigma, or services not being available in some areas, are preventing the others from accessing the services. It is because of discrimination which is intentional or by failing to do something about the barriers.
- Appropriate: The *right health services* (i.e., the ones they need) are provided to them.
- Effective: The *right health services are provided in the right way*, and make a positive contribution to their health.

Attitude: A person's views about a thing, process or person, which influence their behaviour.

Community Health Worker: Any health worker who performs functions related to healthcare delivery in the community. Community health workers have received training on the interventions and activities they are involved in, but have not received formal professional, paraprofessional or tertiary education. They are normally members of the communities where they work, selected by the communities, answerable to the communities for their activities and should be supported by the health system.

Competency: Sufficient knowledge and communication and decision-making skills and the attitudes to enable the performance of actions and specific tasks to a defined level of proficiency.

Confidentiality: The right of an individual to privacy of personal information, including healthcare records. This means that access to personal data and information is restricted to individuals who have a reason and permission for such access. The requirement to maintain confidentiality governs not only how data and information are collected (e.g., a private space in which to conduct a consultation), but also how the data are stored (e.g., without names and other identifiers) and how, if at all, the data are shared. 'Privacy' and 'confidentiality' are distinct and complementary concepts. Privacy is 'the right and power to control the information (about oneself) that others possess'. Confidentiality is 'the duty of those who receive private information not to disclose it without the patient's consent'. Thus, confidentiality ensures privacy.

Evolving Capacity: Evolving capacity is about individual development and autonomy – it refers to the way that each young person gradually develops the ability to take full responsibility for his/her own actions and decisions. This happens at a different pace for each individual. At any given age, some young people will be more mature and experienced than others; context and personal circumstances will almost certainly influence each individual's development and level of capacity to act independently on his/her issues.

ⁱ Definitions have been taken or adapted from WHO, UNFPA and IPPF publications.

Health Literacy: The cognitive and social skills that determine the motivation and ability of an adolescent or young person to gain access to, understand and use, information in ways that promote and maintain good health.

Informed Choice: A choice made by an adolescent or young person regarding elements of their care (e.g., treatment options, follow-up options, refusal of service for care) as a result of adequate, appropriate and clear information in order to understand the nature, risks, alternatives of a medical procedure or treatment and their implications for health and other aspects of the adolescent or young person's life. If there is more than one possible course of action for a health condition, or if the outcome of a treatment is uncertain, the advantages of all possible options must be weighed against all possible risks and side effects. Also, the views of the adolescent or young person must be given due weight based on their age and level of maturity (see also Evolving Capacity).

Informed Consent: A documented (usually written) agreement or permission accompanied by full and clear information on the nature, risks and alternatives of a medical procedure or treatment and their implications before the physician or other healthcare professional begins the procedure or treatment. After receiving this information, the adolescent or young person (or the third party authorised to give the informed consent) either consents to or refuses the procedure or treatment. The procedures and treatments requiring informed consent are stipulated in country laws and regulations. Many procedures and treatments do not require informed consent; however, they all require that the adolescent or young person is supported to make an informed choice and give assent if so desired.

Key Populations: Men who have sex with men, people who inject drugs, sex workers, transgender people and people in prisons. While this is the definition used by UNAIDS and its co-sponsors to identify people whose behaviours are criminalised, therefore, putting them at increased risk of HIV because stigma and discrimination prevents them from accessing life-saving services. Some countries include other categories of people (e.g., young people with disabilities) in the definition of key populations.

Outreach (healthcare delivery): Any health-related activity coordinated by a health system or a non-governmental organisation (NGO) that takes place outside the health facility premises, but is linked to a health facility. Outreach activities can be performed by healthcare providers (for example, primary care nurses that perform classroom health education or doctors that perform medical check-ups in schools), or by outreach workers. The purpose of outreach activities in adolescent healthcare is to reach adolescents or young people by bringing services close to where they are such as schools, universities, clubs, churches, workplaces, street settings, shelters or wherever young people gather. Examples of outreach activities include, health education and distribution of commodities such as condoms.

Outreach Worker: Any person who performs functions related to outreach healthcare delivery on behalf of the health system. Outreach workers are not healthcare professionals, but receive special training to perform their functions. An example of an outreach worker is a peer educator.

Peer Education: The process whereby specially trained adolescents or young people undertake informal or organised educational activities with their peers (those similar to themselves in age, background or interests). These activities, occurring over an extended period of time, are aimed at developing adolescents' and young people's knowledge, attitudes, beliefs and skills, and at enabling them to be responsible for, and to, protect their own health. Examples of activities that peer educators carry out include: co-teaching or guest lecturing during a health education session in school; leading a group discussion in the waiting room of a health facility; doing educational outreach and referrals with 'street adolescents' in urban areas; providing contraception information and distributing condoms to key populations of adolescents and young people; presenting a theatre piece or role play at a community health fair or other event; providing house calls to

reach other young people with information and services; and referring young people to relevant health facilities where they can access additional care.

Peer Educator: An adolescent or young person who has been trained to provide information and services to their age mates.

Quality of Care: WHO has defined quality dimensions for adolescent healthcare as being available, accessible, acceptable, appropriate, equitable and effective. Ensuring privacy and confidentiality is also critical to quality services.

Standard: A statement of a defined level of quality in the delivery of services that is required to meet the needs of intended beneficiaries. A standard defines the performance expectations, structures, or processes needed for an organisation to provide safe, equitable, acceptable, accessible, effective, and appropriate services.

Young People: UNFPA/WHO/UNICEF's standard definition for young people is people between the ages of 10 and 24 years.

Youth: UNFPA/WHO/UNICEF's standard definition for youth is people between the ages of 15 and 24 years. The African Youth Charter and some governments define youth as people between the ages of 15 and 35 years. In this Assessment, youth is referring to those between the ages of 15-24 years.

EXECUTIVE SUMMARY

The Assessment of Adolescent and Youth-Friendly Health Services in the East and Southern Africa Region (2015-2017) was undertaken with the purpose of: conducting a review of existing adolescent and youth-friendly health services (AYFHS) guidelines, protocols and standards, and assessing how they are implemented in 23 countries of the East and Southern Africa (ESA) region. The specific objectives were to:

- Review AYFHS guidelines and standards in 23 ESA countries against World Health Organization's (WHO), International Planned Parenthood Federation's (IPPF) and other international standards developed and used in the public health, private and non-for-profit health systems.
- Assess the status of AYFHS implementation in the ESA region, how guidelines and standards are being applied to improve quality and coverage of services, and both negative and positive factors affecting provision of services.
- Identify and document promising practices for the implementation of the AYFHS guidelines and standards in selected countries.
- Based on the findings above, provide recommendations for improving and scaling up AYFHS in the ESA region.

The assessment used a mixed methodology with a literature review of published, academic and grey literature on AYFHS; stakeholder meetings with key informants from ministries of health, non-governmental organisations, civil society organisations, youth serving organisations, IPPF Member Associations, and the United Nations Population Fund (UNFPA) country offices; quantitative interviews with health service providers in selected health facilities, and client exit interviews with adolescents and young people aged 15-24 years at the selected health facilities; qualitative focus group discussions (FGDs) with young potential male and female service users (15-24 years) from the catchment areas of the selected health facilities, young peer educators, and adult outreach workers; and observations of operations and set up of selected health facilities. The Assessment covered 23 countries in the ESA region: Angola, Botswana, Burundi, Comoros, Democratic Republic of Congo (DRC), Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. In-country studies were conducted in 12 of these countries from November 2015 to January 2016 (i.e., Burundi, Comoros, DRC, Ethiopia, Kenya, Lesotho, Madagascar, Mozambique, Swaziland, Uganda, Zambia, and Zimbabwe). The total health facility observations, including interviews with managers, were 146. The total number of health service providers interviewed were 146. The total number of young exit clients interviewed were 969.

Key findings are:

The national policies, standards and guidelines on AYFHS of 23 countries were compared with the WHO Global Standards for quality healthcare services for adolescents (2015). The key findings on the policy and legislative framework were that almost all the countries have specific policies or strategies on adolescent and/or youth health, especially sexual and reproductive health (SRH). The policies, strategies or guidelines of at least 14 countries adopt a rights-based framework or refer to young people's rights. Guidelines and/or standards for AYFHS delivery were found in 19 of the 23 countries studied: all 19 countries had a standard on

providers' competencies; 17 countries had a standard on the appropriate package of services; 16 countries had standards on adolescent's health literacy, community support, facility characteristics, and data and quality improvement; 15 countries had standards on adolescents' participation; and only 13 countries had standards on equity and non-discrimination.

Key findings per Standard are as follows:

Standard 1. Adolescents' health literacy: *The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services:* Despite the availability of educational materials in a large number of the health facilities visited, the young clients were mainly talking to other waiting clients, or spending time on their phones, and/or doing nothing. For example, while 76% of the health facilities visited had educational materials on safer sex and condom use, only 42% of young clients interviewed said they had received information on safer sex during this or previous visits. Similarly, only 43% of young clients reported receiving information on contraception, even though 78% of health facilities visited had educational materials on contraception. Thus, reinforcing that having educational materials at the health facility may not be the most effective way to transmit knowledge to young clients.

Sixty five per cent of the health facilities visited were observed to have peer educators or other providers distributing informational publications to adolescents and young people, and 74% of all health service providers reported that peer educators are involved in outreach programmes. However, most of the young clients interviewed did not quote the peer educators or the outreach workers as their source of information about the health facility. Peer educators and community workers alike reported lack of basic or refresher training, which resulted in a lack of confidence in discussing SRHR issues with adolescents and young people.

In addition, there was confusion and lack of adequate information and trust among potential clients about the health facilities. While 92% of all young exit clients said they would recommend the health facility to family and friends, those young people who had not used the services, but were within the catchment area of the services, revealed that they either did not know that the services were for them, or did not trust that the services would provide them with privacy, confidentiality, respect, or quality services.

Standard 2. Community support: *The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents:* While there appears to be an understanding about the need for community engagement and outreach, and plans for this tend to be in place (available in 71% of all the health facilities visited), inadequate funding and training results in the plans not being fully implemented (records of accomplished outreach activities for community in 59% of all health facilities visited, and for parent-teacher meetings in schools only in 41% of all health facilities visited), or a lack of ability to deal with difficult opinion leaders in the community (as stated by the adult outreach workers and peer educators).

It is interesting to note that while 60% of all the health service providers interviewed felt that parents and community members supported AYFHS, 80% of all the clients interviewed felt that their family members supported their accessing AYFHS. This, of course, contrasts with the opinions expressed by the young people not accessing the services, who did not think that the community was supportive. Most young clients first

heard of the health facility from family and friends, thus this needs to be capitalised on. It also indicates that there needs to be a prioritisation of communities and households that do not already access the services vis-à-vis those who do, to ensure equity of access.

Standard 3. *Appropriate package of services:* The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfil the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach: The most provided service to young people was reported by health service providers as family planning counselling (96%), and other than general health services, this was also the most sought service by young exit clients. This was followed by condoms (94%), oral contraception (86%), injectables (82%), pregnancy tests (82%), HIV services (76%), sexuality counselling (76%), STI services (74%), implants (71%) and emergency contraception (71%). It is pertinent to note that more young exit clients were seeking injectables than other contraceptive methods. ANC and HIV counselling and testing were also frequently sought by young clients.

The services least provided and, in turn, among the least sought by young exit clients were post-exposure prophylaxis (PEP), drug and alcohol use, medical male circumcision, pap smear / other cervical cancer screening, mental health, and induced medical and surgical abortion. The referral systems for legal, psycho-social and rehabilitative services were seen to be in even fewer health facilities. Considering the situation of adolescent SRHR in the ESA region, it is possible that those young people in need of these services are not presenting at the health facilities visited, since they do not provide services responding to their needs and realities. There is data to show that SGBV is high in all these countries, but the service packages are not adequately addressing this issue. Similarly, (unsafe) abortion is a high contributor to maternal mortality, but few health facilities are providing post-abortion care services. Since the service package in more than half the health facilities is decided without consultation with adolescents and young people, community members or needs assessments, it may be pertinent to re-orient the package to reflect needs and realities on the ground.

Standard 4. *Providers' competencies:* Healthcare providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect: While one in two of health facilities visited had the national AYFHS policies / standards / guidelines available, the knowledge of these documents among health service providers was low. This indicates that further efforts to strengthen dissemination of, and training on, the national standards / guidelines is necessary at the health facility level. All countries have policies or strategies on AYFHS, but only 45% of the health service providers are aware of these and their implications on their delivery of health services.

Training specifically on AYFHS has not been rolled out comprehensively in all the countries, despite most of them having national guidelines or training manuals on AYFHS – 64% of the health service providers indicated ever being trained in AYFHS – of these, 26% had received training for 7 days, while 13% had been trained for only one day and only 13% had been trained for two weeks or more. 52% said that this training had been conducted in 2015. In contrast, the high levels of satisfaction with the health services availed, reported by the young clients (92%) during their exit interviews, imply that despite inadequate training on AYFHS, health service providers appear to be doing well when providing services.

However, when it comes to adolescents and young people who are not accessing the services, there are several gaps including the lack of positive attitudes towards adolescent sexuality, respect for adolescents and young people among the health service providers, and a lack of trust in health service providers for maintaining clients' privacy and confidentiality.

The lack of training registers at the health facilities visited (only 39% of facilities had them) is symptomatic of the lack of systems at district or national level to track training and to provide supportive supervision and/or mentorship. It could be that the training registers exist at the district or other level, but having them at the health facility level is just as important.

With AYFHS integrated into other health facilities, there is also the possibility that a staff member who has not received AYFHS training is enlisted to provide services to adolescents and young people, as observed by some of the Assessment teams in the larger hospitals visited in different countries. Hence, ensuring that AYFHS is integrated into pre-service training curricula would help all health service providers be prepared to deal competently with adolescent sexuality, followed by continued education for in-service providers and outreach workers.

Standard 5. Facility characteristics: *The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents:* Despite the fact that only 62% of health facilities had policies or standard operation procedures (SoPs) in place to ensure clean and welcoming environments, minimal waiting time, and convenient operating hours, among others, a majority of the young exit clients were satisfied with these aspects of the health facilities. However, when speaking to young people who are not yet accessing the health services (i.e., potential clients), it was clear that the inconvenient operating hours and waiting times constituted barriers to their access. In addition, while basic amenities seem provided for, infrastructural issues of privacy and confidentiality are not as well catered to, including, for example, anonymous registration. Even though this does not appear to affect the level of satisfaction expressed by young clients, it remains a barrier for those adolescents and young people who are not accessing the services. Adolescents' and young people's low knowledge of their rights as clients may explain the fact that they are not demanding better services and better health facilities, including enhanced privacy and confidentiality.

Although 92% of the health service providers reported using educational materials / giving practical demonstrations while providing services to young people, some of them across many of the countries cited lack of adequate medicines, supplies, equipment or specialists as barriers to providing services to adolescents and young people. The issue of inadequate resources was also raised by key informants. Condoms, contraceptive pills, paracetamol and injectable contraceptives were available in most of the health facilities; items available in the least number of health facilities included PEP and anti-retrovirals (ARVs) which were available in only half of all health facilities visited.

Sixty-eight per cent of young clients needed less than 30 minutes to reach the clinic, and this in itself might be a bias with regard to the young clients accessing health services. However, this also contradicts what some potential young clients have said about wanting to go further to access services rather than using the neighbourhood clinic due to concerns around privacy. This indicates that the profile of the young clients accessing the services is different from that of those who are not (i.e., those accessing have support from

family and community to access services). It seems this support is more important than the actual distance from services to facilitate adolescents' and young people's access to services.

Similarly, 90% of the young clients found the opening hours of the health facilities convenient, even though less than half of the health facilities had specific hours for adolescents and young people, and just over half were open after school hours or on weekends. Since most of the health facilities visited were integrated rather than stand-alone health facilities for adolescents and young people, it may imply that separate or special opening hours for adolescents and young people may not be necessary. However, what is convenient for these young people who are accessing the services may not be convenient for the adolescents and young people who are not accessing them. This could be due to their being unable to leave work, school or household chores to visit the health facility. Thus, the context of the health facility is an important deciding factor for such things as opening hours, location, etc. For example, when trying to provide health facilities to marginalised, excluded and vulnerable groups of adolescents and young people, there may be the need for a stand-alone health facility, separate timings or mobile outreach.

Standard 6. Equity and non-discrimination: *The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics:* Inequity of access is symptomatic of all the countries, not only in terms of where and how resources have been invested, but also in terms of who is (not) being reached by the health services. In addition, while many health service providers (79%) across the ESA region said they served YPLHIV, only half of all the health facilities visited had ARVs. There are certain groups in each country that are typically left out of service access: the common ones across the board being LGBT adolescents and young people, and young people who use drugs. Added to this is the lack of adequate policies and guidelines on issues of equity and non-discrimination – 65% of all health facilities visited had a policy on free or affordable service provision for adolescents; 56% had guidelines or SOPs on equitable service provision to all adolescents and young people regardless of their ability to pay, age, sex, marital status, or other characteristics; 49% had a policy on child protection or creating a safe environment for adolescents and young people. The claim of the health system, health facilities or health service providers being 'open to all' cannot be used to hide behind the fact that marginalised and excluded, and vulnerable, groups of young people are not being reached specifically.

The issue of rights is not being adequately dealt with – neither in the display and delivery of information to adolescents and young people on their rights (only 42% of young clients had seen a display mentioning that services would be provided to all adolescents and young people without discrimination), nor in the adoption or dissemination of policies that respect, protect and fulfil adolescents' and young people's rights. Most health service providers (94%) confirmed having the knowledge of clients' rights, and the analysis of the data on training they report having received reveals that 70% of all health service providers interviewed had been trained on, 'providing effective health services that respect, protect and fulfil adolescents' and 'youth rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect' and 55% of them had been trained on, 'human rights-based approach to adolescent and youth healthcare.' This was corroborated by the fact that 74% of the young clients indicated that they felt very comfortable and at ease at this health facility; 66% of the young clients felt that all staff understood young people's concerns on sexuality and sexual relationships. However, peer educators reported receiving negative feedback from young clients about support staff being rude and unwelcoming. In addition, half of the health service providers (51%) said that there were some services that could not be provided to young people due to their age, parental consent,

spouse / partner consent, and marital status. In most cases, these health service providers were referring to contraceptive services, especially long-acting methods and HIV testing, thus revealing a provider bias against providing long-acting contraceptive methods for adolescents and young people.

Thus, despite being a positive finding, the lack of focus on educating adolescents and young people about their rights results in them not being able to demand their rights to access health services in an equitable manner; and the lack of an equity lens results in health service providers not providing services that adolescents and young people need.

Standard 7. Data and quality improvement: *The health facility collects, analyses and uses data on service utilization and quality of care disaggregated by age and sex to support quality improvement. Health facility staff is supported to participate in continuous quality improvement:* Half of the health service providers reporting regular supportive supervision said this happens once a month. In addition, outreach or extension health workers and peer educators often do not have effective or standardised systems for quality assessment or M&E. This, combined with the low percentage of health facilities having guidelines and/or tools on self-monitoring quality of care to adolescents and young people (55%), means that M&E specific to AYFHS is weak across all countries. Supervisory visits in the last 3 to 6 months were seen in 71% of health facilities visited, but those focused on adolescent healthcare were only seen in 53% of health facilities. Despite this, 86% of the health service providers said that they had regular meetings with a supervisor. While it is difficult to determine one interval for supportive supervision visits across all countries, it is important to set and implement feasible national standards nevertheless.

Despite the recording of data (88% of health service providers said they recorded client data disaggregated by age, sex and type of service provided) and regular supervisory meetings to some extent, qualitative data from key informants has revealed that the disaggregated data collected is rarely used to inform decision-making at the national level.

Standard 8. Adolescents' participation: *Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision:* Adolescents' and young people's participation in governance, planning, decision-making and M&E remains low across all countries. It was mainly NGOs that were making the effort to meaningfully involve adolescents and young people, while the involvement seemed sporadic in government health facilities. The most common means of involving adolescents and young people is in relation to implementation (i.e., as peer educators, peer counsellors, community mobilisation, etc.). SOPs related to involvement of adolescent and young people and/or vulnerable groups of adolescents were found in about a third of the health facilities visited, and only 46% had adolescents and young people on facility advisory committees. Only 34% of the young clients indicated that they had been given opportunities to express their opinion regarding the services provided in that health facility.

Qualitative data from young peer educators revealed that there were very few opportunities for them to provide feedback to health facility management, other than routine reporting and they were not involved in planning or decision making. Typically, these adolescents and young people involved in health promotion and delivery are inadequately informed about government policies and guidelines, as well as about adolescents' and young people's rights.

Key recommendations are:

Standard 1. Adolescents' health literacy: Greater focus is required on making adolescents and young people aware of the existence of AYFHS. In addition, potential clients need to be assured about privacy and confidentiality, including through the adoption and display of policies on the same, and including this in awareness raising about AYFHS. Young people must be reached before they require services to enable not only awareness, but also trust-building. Involvement of adolescents and young people in the design of the outreach methods, materials and content would ensure that issues relevant to adolescents and young people are addressed and that they reach the intended audience. Using social media and smartphones to target adolescents and young people is a strategy that should be explored for different contexts. Continuous investment in the recruitment, training, mentorship, and supervision of both adult outreach workers and peer educators is necessary to ensure their confidence in addressing adolescent sexuality. Since many countries are moving towards an integrated approach to delivering AYFHS and the creation of adolescent responsive healthcare systems, more comprehensive educational materials need to be made available. Adolescent health literacy should also include policy literacy, so that adolescents and young people are aware of their rights and entitlements with respect to the public health system.

Standard 2. Community support: Community engagement mechanisms need to be strengthened to enable adolescents and young people who are not yet accessing the health services to reach them. In fact, the engagement needs to go beyond simply raising awareness to ensuring that adolescents and young people receive the support they require to access services. Referral and feedback mechanisms that are appropriate, and address the specific needs of young people in a particular catchment area need to be put in place. Outreach records should contain details of who was addressed during the outreach activity, for how long, and the topic of interaction, discussions conducted. Combining suggestion boxes with periodic meetings between young clients, parents and management, and discussing issues that adolescents and young people are facing with regard to access to services, would result in improved quality of care and access to services. The plans for outreach and community engagement in AYFHS require adequate funding, including for training.

Standard 3. Appropriate package of services: Several gaps in the availability of different types of services remain, and more efforts are therefore needed to ensure that the service packages specified in national policies and standards are rolled out. Fund allocations must be made to ensure that relevant equipment and supplies are available in health facilities; trained and competent health service providers are hired and retained; and adolescents and young people are informed about the health services available to them, the key importance of the services that are not currently in place, and the need for strengthened referral mechanisms including for counselling on mental health, drug and alcohol use and gender-based violence (GBV), as well as non-clinical services including schools, social protection and other support programmes, especially for key populations and marginalised groups.

Standard 4. Providers' competencies: Ensure that nationally adopted guidelines and materials for competency-based trainings are systematically implemented in accredited in-service training and continuous professional development programmes for all healthcare providers dealing with adolescents and young people. Adolescent health and principles of AYFHS should be integrated into pre-service training curricula to create a critical mass of health service providers that possess the necessary competencies and skills to deal with adolescent sexuality. Both pre-service and in-service training should focus on value clarification and building positive attitudes towards adolescent sexuality.

Standard 5. Facility characteristics: Resource allocation and implementation of the standards set on basic health facility characteristics is necessary not only for adolescents and young people, but in fact for all clients to be able to access health services. Therefore, adopting a health systems strengthening approach, and making the system more client-oriented would be a more effective utilisation of scarce resources. For example, investing in reducing waiting times would be a more effective investment of resources than on improving the waiting areas. The issues of long waiting hours, provider absenteeism, and lack of privacy when waiting for services, as expressed by adolescents and young people not using the services, need to be addressed. There is a range of context specific factors that contribute to client satisfaction, including appropriateness of opening hours, travel time, space for privacy, and models for service delivery, (i.e., integrated versus stand-alone health facilities for young people). Thus, an in-depth analysis of the context and the involvement of adolescents and young people in the design of health facilities is important. Additionally, innovative solutions for effective outreach (e.g., through mobile clinics) that can be implemented in resource-poor settings and among underserved populations are also needed to address the barriers and misconceptions among adolescents and young people who are not interested in using, or are unable to access, services.

Standard 6. Equity, non-discrimination: Policies and guidelines on issues of equity and non-discrimination are inadequate and need greater attention, especially for countries where AYFHS policies, guidelines and standards are due to / being revised. Additionally, strategies for inclusiveness of adolescents and young people need to be in place. Community, peers and parents support serve as protective factors and enablers for uptake of services, while those adolescents and young people not accessing the services cited lack of information on services, and lack of supportive family or community in accessing services. Effective and diverse approaches for outreach to adolescents and young people who have more 'risk factors' and less 'protective factors' are needed to increase the access to, and the uptake of, services among those who are not being served at health facilities. Efforts are needed to reach young key populations with comprehensive AYFHS and not only with HIV-related information and services.

Standard 7. Data and quality improvement: There is a need for standardised systems by country on the use of data recorded at health facility levels and an exploration of the use of new technologies. The national Health Management Information System needs to be disaggregated by age as per WHO guidelines where this is not so. Supportive supervision that enables health service providers, adult outreach workers and peer educators to strengthen their delivery of information and services is needed on a more systematic basis. At the same time, enabling health facilities to use tools on self-monitoring quality of care to adolescents and young people is likely to encourage health service providers to work on self-improvement. This, combined with the meaningful involvement of adolescents and young people in M&E and feedback on services, would enable much better access to services for adolescents and young people. Budget allocations are required for adequate and on-going training, user-friendly tool development and dissemination, regular supportive supervision visits, and actual utilisation of health facility level data to inform programming.

Standard 8. Meaningful participation of young people: Enhance young people's participation from only implementation (peer educators, community mobilisers, etc.) to all levels of AYFHS programming at the health facility level, including decision making. This is a process that involves capacity building and sensitisation for adults, adolescents and young people, to be able to work in partnership.

Standard 9. Policies, standards and institutional support: While the newer policies, strategies and standards in the ESA region are comprehensive and addressing young people's rights, their implementation must be strengthened by: building ownership among programme managers, health facility managers, health service providers and outreach workers; allocating adequate funding for the implementation of the specified package of services, competency requirements and M&E; and incorporating supportive and participatory supervision and monitoring methods in the health system. In addition, there needs to be a reduction in the legal and policy barriers to adolescents' and young people's access to services (e.g., requirements for parental or spousal consent, marital status, and age of consent for the uptake of services and to sexual activity). Policies and guidelines on issues of equity and non-discrimination are also needed.

I. INTRODUCTION

More than one-third of the population in East and Southern Africa (ESA) is aged 10 to 24 years. The 182 million population of 10-24 year olds is expected to rise to 341 million by 2050.ⁱ For most adolescents and young people, this period of their lives is a time of enormous vibrancy, discovery, innovation, and hope. Yet it is also the time when they face many sexual and reproductive health (SRH) challenges, including early and unintended pregnancy, HIV and sexually transmitted infections (STIs), gender-based violence (GBV) and child marriage – all of which can undermine education opportunities, especially for girls, and affect future health and opportunities. Investing in the education and health of adolescents and young people at the right time ensures that they transition into healthy adults who can contribute to the economy.²

A healthy transition into adulthood is directly related to achieving the Agenda 2030 and its Sustainable Development Goals (SDGs), the Global Strategy on Women's, Children's and Adolescent's Health (2016-2030), Africa's Agenda 2063 and the Eastern and Southern Africa Commitment on comprehensive sexuality education (CSE) and SRH health services (ESA Commitment), which was endorsed by ministers of health and education from 21 countries in 2013.ⁱⁱ The region is facing the opportunity of realizing the demographic dividend; the economic benefit that can arise when a population has a relatively large proportion of working-age people who are effectively invested in for their empowerment, education and employment, but only if the right investment is made. Adolescents and young people can be a great force for attaining social, economic and political change, but to do this the ESA region will need strong political leadership that upholds and expands the commitments made to increase the empowerment of girls and women, ensure universal and quality education that is tailored to new economic opportunities, and augment secure employment, as well as healthcare that enables fertility decline and promotes well-being of adolescents and young people.

The evidence presented by a 2013 regional diagnostic report on adolescent SRH, including CSE and youth-friendly service delivery, suggests that many of commitments made by governments remain partially or wholly unrealized, and in general coverage rates of SRH services for adolescents and young people are low in sub-Saharan Africa despite several efforts to make health services accessible, acceptable, equitable, appropriate, and effective for adolescents and young people. While the policy environment is positive in relation to adolescent and youth-friendly health services (AYFHS) in the ESA region, a number of existing legislative and policy frameworks in many ESA countries continue to be barriers for adolescents and young people to access SRH information and services due to a lack of harmonisation³ (e.g., of age of consent to sexual activity and access to contraception and HIV testing). Further, insufficient budget and poor institutional capacities of government agencies, inconsistent implementation of national guidelines, training manuals and other relevant tools, health service providers' capacities, and poor monitoring and evaluation (M&E) of AYFHS affects quality of services. Even in countries where significant progress has been made regarding policies and standards, a lot remains to be done to develop appropriate strategies and to integrate youth-friendly service concepts into pre-service and in-service providers' training modules, improve existing services and increase their scale to facilitate increased access to quality services for adolescents and young people.²

ⁱ Angola, Botswana, Burundi, Democratic Republic of Congo, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

It is against this background that the United Nations Population Fund's (UNFPA) East and Southern Regional Office (ESARO) and the International Planned Parenthood Federation Africa Regional Office (IPPF ARO), in partnership with other United Nations (UN) agencies such as the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), and the Joint United Nations Programme on HIV/AIDS (UNAIDS), civil society organisations (CSOs), the East African Community (EAC), the Intergovernmental Authority on Development (IGAD), and the Southern African Development Community (SADC), commissioned a review of existing AYFHS guidelines and standards and assessment of how they are being implemented in the ESA region. The findings from this Assessment will inform efforts to improve quality and coverage of AYFHS, capacity building and advocacy.

ⁱⁱⁱ Member states of EAC: Burundi, Kenya, Rwanda, Tanzania, Uganda

^{iv} Member States of IGAD: Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan, South Sudan and Uganda

^v Member states of SADC: Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia, Zimbabwe

2. OBJECTIVES AND EXPECTED OUTCOMES OF THE ASSESSMENT

Purpose of the Assessment:

To conduct a review of existing AYFHS guidelines, protocols and standards, and assess how they are implemented in 23 countries of the ESA region.

Specific Objectives of the Assessment are to:

- Review AYFHS guidelines and standards in 23 ESA countries against WHO's, IPPF's and other international standards developed and used in the public, private and non-for-profit health systems.
- Assess the status of AYFHS implementation in the ESA region, how guidelines and standards are being applied to improve quality and coverage of services, and both negative and positive factors affecting provision of services.
- Identify and document promising practices for AYFHS implementation of the guidelines and standards in selected countries.
- Based on the findings above, provide recommendations for improving and scaling up AYFHS in the ESA region.

Expected outcomes:

- A Regional Report and twelve national reports with recommendations for improving, scaling up and institutionalising AYFHS at national levels.

Scope of the Assessment:

The Assessment highlights what is happening on the ground, including adolescents' and young people's perspectives and realities with regard to AYFHS access, learn from what is available, and identify areas for improvement. More specifically, the Assessment is intended to bring out practical recommendations at three levels: (i) the service delivery point (SDP)/health facility level to enable the assessed SDP/facility to improve its adolescent and youth-friendly health services; (ii) the national level to provide an analysis of AYFHS implementation and status of standards, guidelines and policies; and (iii) the regional level to feed into regional level development of guidelines and share promising practices.

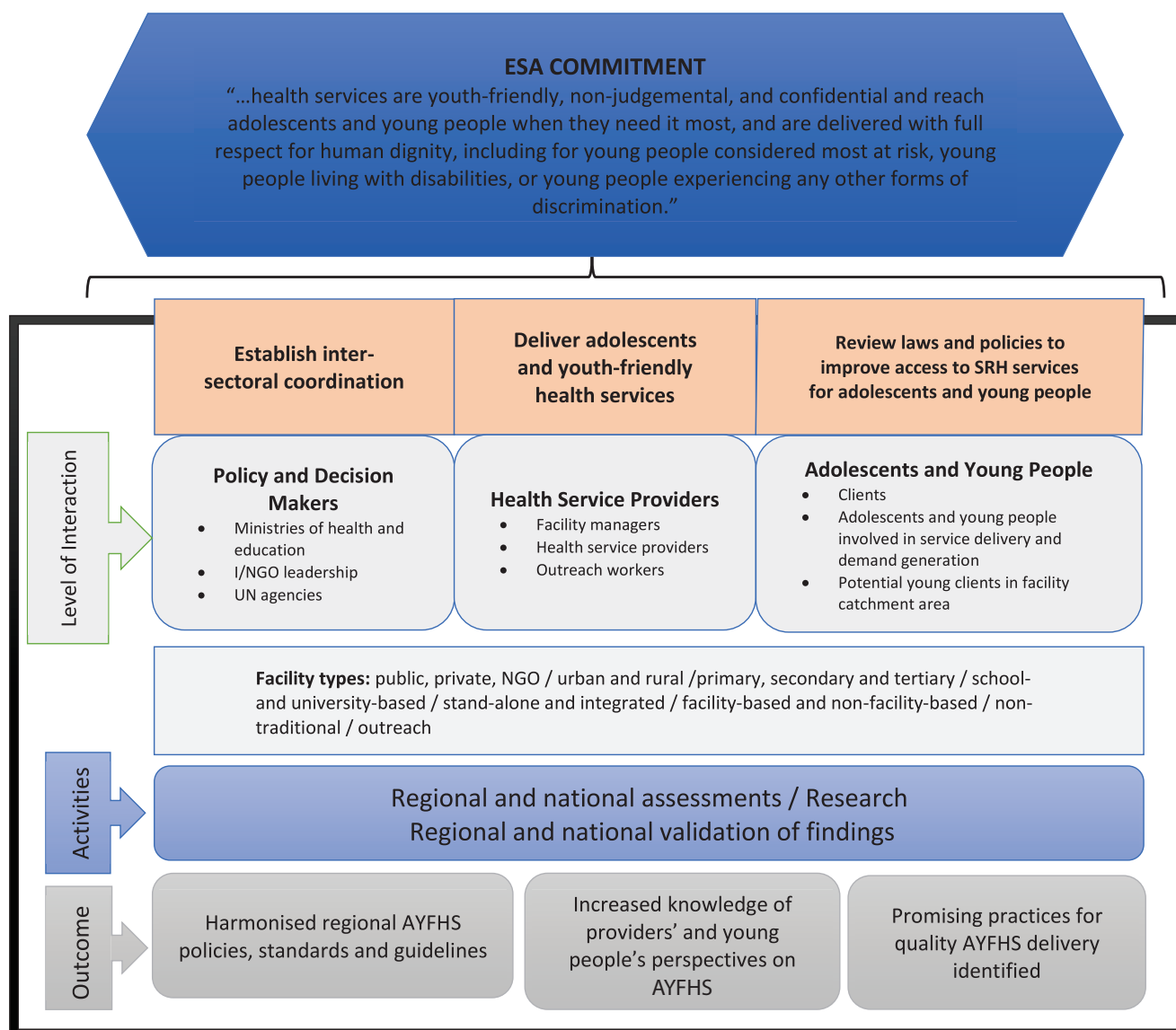
2.1 Conceptual Framework

The conceptual framework starts from the section of the ESA Commitment that this Assessment is aimed at, along with the three broad areas of intervention required from the governments that have signed on to the ESA Commitment to achieve their goals (see Figure 1).

The outcomes were defined as leading to the development of harmonized guidelines, standards and evidence-based comprehensive AYFHS programmes that: address the needs of AYFHS health service providers

for capacity building; address the need for services among adolescents and young people; and would ultimately lead to improved health outcomes. To achieve these outcomes and to cover the three broad areas of government intervention, this Assessment was undertaken as one of the activities, and the results were validated at regional and national levels. The level of interaction for this Assessment has been defined in Figure 1 under the policy and decision makers, health service providers, and adolescents and young people.

Figure 1: Conceptual Framework



2.2 Utilisation of Assessment Results

The findings of this Assessment will be used for several purposes including: a) provide guidance to national governments, implementing partners and donors on the successes, challenges and recommendations for scale up of quality, and rights-based AYFHS in countries; b) inform development of regional level guidance for scale up and institutionalisation of adolescent health and AYFHS programmes that are aligned to WHO guidelines and standards; c) contribute to the regional and national knowledge base on AYFHS; and d) strength competency-based training and education in adolescent health and AYFHS in pre-service and in-service training for healthcare providers.

3. Research Questions

The key research questions that this Assessment aimed to answer were:

- What are the existing AYFHS guidelines, standards and policies in countries?
 - How do they align to WHO's/international guidelines?
 - What are the gaps?
 - What improvements are possible?
- To what extent are existing AYFHS guidelines, standards and policies implemented in the country? How are the policies being used to systematically improve and scale up AYFHS? Are there national level earmarked resources allocated to this improvement and scale up? Is there clear national level ownership and commitment to scaling up AYFHS (e.g., dedicated staff, annual action plans including monitoring tools, annual reports or sections of reports dedicated to AYFHS)? Is there a clear handover of responsibility from departing AYFHS staff member to incoming staff? Has the government modified the Health Management Information System (HMIS) system to capture age and sex disaggregated data for adolescents and young people (10-14 years; 15-19 years; 20-24 years)? Health services reports include analysis of adolescents and youth service use from the HMIS? Are the AYFHS equitably distributed nationally (i.e., urban, rural or both, reaching marginalised and under-served young people)? At which level are the services available? What models are implemented? What is the age range reached by these services?
- What is the quality of AYFHS services as per the existing standards?
 - How are they assessed (methodology, by whom and how often; monitoring system available or not)?
 - To what extent are public, private and non-profit health SDPs/health facilities adolescent and youth-friendly?
 - What are the areas for improvement in each of the SDPs/health facilities assessed?
 - What are their operational realities?
 - What are health service providers' perspectives on AYFHS?
 - What are adolescents and young people's (clients and non-clients) perspectives on AYFHS?
 - What can be learnt from their operations to inform development or improvement of AYFHS guidelines, standards and policies in the country (and the ESA region)?
- What are the enabling factors or barriers for young people to access AYFHS?
 - What is motivating those young clients who access the services?
 - What are the barriers to access? Why are young people not accessing them?
- What are the promising practices?

These questions formed the basis for the development of the research tools and guides used for the in-country studies. While many of the research questions were addressed at the national level, it is important to note that consistent responses were not obtained to address all the above research questions from all countries. Therefore, the findings presented in this report do not address all of the above questions. Refer to section 4.9 below on Limitations for further clarification.

4. Methodology

4.1 Assessment Population

The Assessment covered 23 countries in the ESA region: *Angola, Botswana, Burundi, Comoros, Democratic Republic of Congo (DRC), Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe*. Only literature and desk reviews of policies and standards were conducted for the 11 countries in italics, while the remaining 12 countries conducted stakeholder meetings, and in-depth assessments of health facilities, health service providers, young exit clients, outreach workers, peer educators, and potential young clients.

These 12 countries were those where assessments on AYFHS had not been conducted in recent years (see Figure 2). Rwanda was also meant to have an in-country assessment, however, the Ministry of Health did not grant approval for the Assessment as a similar study was already being conducted in the country.

Figure 2: Countries where assessment was conducted



Countries covered: Burundi, Comoros, DRC, Ethiopia, Kenya, Lesotho, Madagascar, Mozambique, Swaziland, Uganda, Zambia, and Zimbabwe.

4.2 Assessment Design

The Assessment design was guided by the research questions and standards detailed below, and had a mixed methodology including:

- **Review of AYFHS related literature** involved reviewing both published and grey literature studies on AYFHS including national or regional reports, evaluations, assessments, guidelines and policies, reports of studies involving health service providers' perspectives/competences and attitudes and/or adolescents and young people's use of services, national Demographic and Health Survey (DHS), HIV reports both national and regional, global studies and reviews (International Conference on Population Development, SDGs, African Union documents and ESA Commitment). The results from this aspect of the Assessment informed both the methodology and tools, and the final recommendations at the regional and national levels.
- **Stakeholder meetings** with key informants from ministries of health, CSOs, non-governmental organisations (NGOs), youth-serving organisations (YSOs), IPPF Member Associations (MAs), and UNFPA country offices; AYFHS implementers to identify national level achievements in relation to improving and scaling up AYFHS, challenges, existing best practices and recommendations for achieving results for adolescents and young people.
- **Quantitative studies** involving: a) interviews with health service providers in selected health facilities; and b) interviews with adolescents and young people (15-24 years) who have recently used a health facility (exit interviews), ensuring a gender balance as far as possible based on client flow.
- **Qualitative study** involving focus group discussions (FGDs) with young potential male and female service users (15-24 years) drawn from the catchment areas of a health facility, young peer educators, and adult outreach workers.
- **Observations of operations** and set up of selected number of health facilities in each country.

4.3 Research Tools

4.3.1. Checklist for Review of National Policies, Standards and Guidelines

The national policies, standards and guidelines on AYFHS of the 23 countries were compared to the WHO Global Standards released in 2015, which identify 8 specific standards to judge the quality of adolescent healthcare services.

Standard 1. Adolescents' health literacy: The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.

Standard 2. Community support: The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.

Standard 3. Appropriate package of services: The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfil the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.

Standard 4. Providers' competencies: Healthcare providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.

Standard 5. Facility characteristics: The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.

Standard 6. Equity and non-discrimination: The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.

Standard 7. Data and quality improvement: The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.

Standard 8. Adolescents' participation: Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

Before the in-country Assessments started, the team was able to categorise most of the standards or characteristics of AYFHS from 11 countries whose standards and guidelines were accessible online (i.e., Botswana, DRC, Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Swaziland, Tanzania, Uganda, and Zambia) under the above eight standards, but some fell outside these 8. More specifically, while policies are cross-cutting in the WHO Standards, issues related to national level policy actions and institutional support to improve, supervise and continue to support individual health facilities, roll out the scale up of services nationally are not specified in the 8 Global Standards. Thus, the Assessment team agreed to include a ninth Standard, which would specifically address the issues of the existence of policies and procedures, institutional support for AYFHS, as well as young people's rights.

Standard 9. Policies, standards and institutional support: Appropriate national level policies, standards, and institutional support to improve and scale up quality adolescents and youth-friendly health services that protect adolescents' rights are in place and being implemented.

Under this standard, data from some of the other countries where policies enabling AYFHS were found, was also added (i.e., Burundi, Comoros, Lesotho, Namibia, South Africa and Zimbabwe).

4.3.2 Data Collection Tools

All data collection tools were consistent with the research questions and were adapted from those developed to assess national performance against the WHO Standards as reflected in the WHO *Global standards for quality healthcare services for adolescents: a guide to implement a standards-driven approach to improve the quality of healthcare services for adolescents*,⁴ as well as the IPPF's Provide tool. (See Table 1 for types of instruments used with different study populations).

Different data collection tools were developed for the different study methodologies and populations, and included structured questionnaires for interviews, FGD guides, qualitative interview guides for key informants, observation tools (health facility) and checklists for reviewing content of AYFHS guidelines and standards at the national level (refer to Annexure 1 for all tools and Annexure 2 for informed consent forms).

All tools were pre-tested by the Regional Coordination team through a pilot in a clinic located in a peri-urban area in Nairobi, Kenya. The findings from the pilot were used to revise and simplify the tools.

Table 1: Data Collection Tools

Data Sources, Data Collection Methods, and Number of Interviews / FGDs						
Stakeholder meeting / key informant interviews (IDI tool):	Health facility observation tool, including interview with health facility manager:	Client exit interviews:	Focus group discussion (FGD) with adolescents and young people:	Health service provider interviews:	Focus group discussion (FGD) with adult outreach workers:	Literature / content review
Stakeholder meeting for data collection, hosted by the inter-agency / youth task force and coordinated by National Consultant	Random cluster sampling based on the following criteria:	Clients aged 15-24 years random sampling: (e.g., select every other client) Aimed to ensure 15-25% interviews with males	Peer educators / peer service providers / outreach workers / other young people involved with or linked to the facility (6-8 respondents per group)	1 service provider at each facility or at school health programme	Outreach workers / community health workers / health extension workers (6-8 respondents per group)	Global literature on AYFHS
Qualitative key informant interviews: - Director of Health Services - Person responsible for youth / adolescent health at Health Ministry - Person responsible for supplies, commodities, infrastructure, budgeting / human resources,	- Location: urban / rural - Ownership: public, private, CSO / faith-based organisation (FBO) - Level: primary, secondary, tertiary - Type: standalone / integrated services, facility-based / non-facility-based, services	Client exit interviews per country: Cluster 1 = 100 Cluster 2 = 75 Cluster 3 = 50	Vulnerable / marginalised / under-served / hard-to-reach / key populations in the catchment area of the facility - random sampling; ensure diversity of representation across different FGDs	No data available	FGDs per country: Cluster 1 = 5 Cluster 2 = 4 Cluster 3 = 3	Regional literature reviews / assessments on AYFHS

Data Sources, Data Collection Methods, and Number of Interviews / FGDs

Stakeholder meeting / key informant interviews (IDI tool):	Health facility observation tool, including interview with health facility manager:	Client exit interviews:	Focus group discussion (FGD) with adolescents and young people:	Health service provider interviews:	Focus group discussion (FGD) with adult outreach workers:	Literature / content review
HMIS - National Youth Councils where applicable - Person responsible for health / school health programme at Ministry of Education 2-4 interviews per country	reaching marginalised or vulnerable populations, outreach or demand generation, school health programme, university-based	No data available	No data available	No data available	No data available	No data available

Data Sources, Data Collection Methods, and Number of Interviews / FGDs

Stakeholder meeting / key informant interviews (IDI tool):	Health facility observation tool, including interview with health facility manager:	Client exit interviews:	Focus group discussion (FGD) with adolescents and young people:	Health service provider interviews:	Focus group discussion (FGD) with adult outreach workers:	Literature / content review
Local / province / district level health department officials as nominated by Ministry officials 1-2 interviews per country	1 health facility manager / head / in-charge	No data available	FGDs per country: Cluster 1 = 10 Cluster 2 = 7 Cluster 3 = 6	No data available	No data available	Country level literature, assessments, standards / guidelines / policies
Youth focal person / programme manager of those NGOs whose health facilities have been chosen for Assessment	No data available	No data available	No data available	No data available	No data available	No data available
Youth focal person at UNFPA Country Office	No data available	No data available	No data available	No data available	No data available	No data available

4.4 Sampling

For the 12 countries where in-country reviews, including health facility Assessments, were conducted, the sampling methodology included:

- **Government agencies:** The government departments directly involved in the provision of AYFHS were selected purposively and key representatives engaged directly with AYFHS were selected in each country from the ministries of health, and where relevant, the ministries of education and youth.
- **CSO and youth-led organisations:** CSOs were purposively selected based on their work in the area of advocacy, services delivery and CSE for young people, including marginalised and under-served groups.
- **UN agencies and international non-governmental organisations (INGOs):** Representatives from the UN agencies and INGOs operating in the countries directly engaged with AYFHS were selected. These included UNFPA, UNESCO, UNICEF, WHO, Pathfinder International, Marie Stopes International, Population Services International (PSI), DKT International, Ipas, United States Agency for International Development (USAID), FHI360, among others.
- **SDPs/health facilities selection:** This was done taking into account their urban and rural distribution, ownership (public, private, CSO/FBO), level (primary, secondary and tertiary), and type (stand alone or integrated services, health facility-based or out-of-facility-based, services reaching marginalised or vulnerable populations, outreach or demand generation, school health programme or university-based. SDPs/health facilities did not need to be classified as 'youth-friendly' to be included in this Assessment, but had to either be serving adolescents/young people or be located in an area with a significant population of adolescents and young people (i.e., aged 10-24 years). SDPs/health facilities were categorised accordingly, and a sampling table was used to fill in all available health facilities and generate a random cluster-based sample of the health facilities to be assessed.
- **Young people:** As for the client exit interviews, young clients (aged 15-24 years) who utilised the services were randomly selected at the health facility being assessed. In some health facilities, low client flow meant that all the clients accessing services on the day of the Assessment were chosen, while in other health facilities with higher client flow, clients were chosen randomly with each Assessment team having their own formula. One group of FGD participants was selected from young people who were associated with the health facility already (e.g., peer educators, peer health service providers, community-based distributors, etc.) while another was selected randomly from among young people located in the catchment area of the chosen health facility, with the help of outreach and health facility staff. Care was taken to ensure a gender balance in the selection of young people for the client exit interviews and FGDs.

Countries were classified into 3 clusters based on population size, and the number of health facilities covered in each country was based on the cluster. Therefore, Cluster 1 countries which were those with population size of above 25 million were to cover 14 health facilities per country; Cluster 2 countries which were those with population size of 10 to 25 million were to cover 12 health facilities per country; and Cluster 3 countries which were those with population size of less than 10 million, were to cover 10 health facilities per country. At least 1 service provider and 1 health facility manager, who were directly involved in providing services to adolescents and young people, were interviewed per health facility and 5-10 young people were interviewed (client exit interview) per health facility. According to these assumptions a total of 146 SDPs/health facilities, including health facility managers, 146 health service providers, and at least 730 young clients were to be covered (to be refined based on country context and availability of services).

Based on ground realities and available AYFHS health facilities, the number of actual health facilities and client exit interviews conducted in each country are presented in Table 2.

Table 2: Sampling

Cluster 1 (countries with population above 25 million)	Cluster 2 (countries with population above 25 million)	Cluster 3 (countries with population above 25 million)
Minimum of 14 health facilities per country	Minimum of 12 health facilities per country	Minimum of 10 health facilities per country
DRC = 14 health facilities, 100 young client exit interviews Ethiopia = 14 health facilities, 122 young client exit interviews Kenya = 15 health facilities, 113 young client exit interviews Mozambique = 14 health facilities, 100 young client exit interviews Uganda = 14 health facilities, 71 young client exit interviews	Madagascar = 12 health facilities, 80 young client exit interviews Zambia = 14 health facilities, 112 young client exit interviews Zimbabwe = 12 health facilities, 75 young client exit interviews	Burundi = 10 health facilities, 52 young client exit interviews Comoros = 8 health facilities, 28 young client exit interviews Lesotho = 9 health facilities, 63 young client exit interviews Swaziland = 10 health facilities, 55 young client exit interviews
Total health facilities = 71 Total health service providers = 71 Total young client exit interviews = 506	Total health facilities = 38 Total health service providers = 38 Total young client exit interviews = 267	Total health facilities = 37 Total health service providers = 37 Total young client exit interviews = 198
Total health facility observations, including interviews with managers = 146 Total health service provider interviews = 146 Total young clients exit interviews = 969		

4.5 Data Collection and Management

A Regional Team supervised by IPPF ARO and supported by an expert Advisory Committee was responsible for the overall design of the research protocol and the conduct, quality control and completion of the Assessment. The data collection with regards to policies, standards and guidelines was ongoing from April 2015 to July 2017, while the in-country studies were conducted between November 2015 and January 2016.

4.5.1 Literature Review

For the literature review, documents were sourced through the internet, development partners, UNFPA and IPPF regional and country offices/affiliates, UN agencies and other sources. Key words used were: adolescent and youth-friendly health services, youth-friendly service standards, guidelines youth-friendly services, adolescent health policy, evaluation adolescent and youth-friendly services, etc. in conjunction with country names.

4.5.2 In-Country Studies

The in-country studies were led by trained National Consultants who trained and worked with a team of researchers consisting of adult researchers (including at least two ex-health service providers), as well as young people drawn from the IPPF MAs who had been involved in working with youth-friendly services and/or trained in qualitative research previously.

The training conducted by the National Consultants was adapted from the Regional Team. This covered understanding of what constitutes AYFHS, the standards being used, working with adolescents and young people as partners, understanding the research tools and ethical considerations. All members of the research team (adults and young people) were trained at the same time in the country (refer to training agenda in Annexure 3).

The national teams:

- Reviewed existing policies, standards and guidelines against the WHO standards checklist for AYFHS.⁴
- Conducted a high-level consensus meeting with key stakeholders, including government officials from ministries of health, education and youth affairs, UN officials from the country offices of UNFPA, UNESCO, UNAIDS and WHO, and heads or youth programme managers of INGOs and NGOs and/or Inter-Agency Taskforce for Youth for data collection. This meeting was led by the National Consultant, in collaboration with the IPPF MA and UNFPA Country Office. Where there was an Inter-Agency Youth Taskforce, the members were brought together at this meeting to discuss and provide input on the situation of AYFHS in the country (policy and implementation), including promising practices, enabling factors and barriers. It also aimed to build ownership among the stakeholders for the Assessment by introducing to them the objectives and methodology of the Assessment.
- Conducted qualitative stakeholder interviews with government officials at relevant ministries, UN agency officials directly involved in youth-friendly service delivery programmes, INGO and NGO staff directly involved in AYFHS and/or programmes. These in-depth interviews aimed to elicit information on the policy and legislative framework for AYFHS in the country, the status of integration or scale of AYFHS being implemented, the country's accountability framework for regional commitments on AYFHS, mechanisms for collecting disaggregated data on youth health and monitoring systems for AYFHS, as well as ideas for improvement and recommendations.
- Observed the chosen facilities and conducted interviews with health facility managers to complete the facility observation tool.
- Interviewed health service providers at the chosen health facilities.
- Conducted client exit interviews with young clients at chosen health facilities by the young researchers, ensuring privacy and confidentiality of the client. The research team requested a space that ensured audio-visual privacy to conduct these interviews.
- Conducted FGDs with adult outreach workers, community health workers, health extension workers, etc. who were engaged in promoting AYFHS and/or demand generation for the chosen health facility by the adult researchers.
- Conducted FGDs with young people associated with the health service facility (e.g., clients, peer educators, peer service providers, community-based distributors, etc.), as well as with other young people in the catchment area of the health facility who may not have accessed services, or are vulnerable, marginalised or hard-to-reach by the young researchers.

- Analysed and wrote the national reports with technical support from IPPF ARO and the Regional Consultant Team.

The research team spent one working day at each health facility, including the observation and interview with the health facility manager, one interview with a health service provider, five client exit interviews, and one to two FGDs.

4.6. Data Quality Assurance

To ensure that a high-quality standard was maintained, the following minimum measures were instituted:

- Automated data validation rules were created and activated in the data-entry frame.
- All completed questionnaires were checked in the field by the team leaders.
- Data generated by each interviewer was checked by team leaders to verify that the relevant information had been recorded and the right respondents had been contacted.
- The research team met at the end of each day to review progress, discuss problems and challenges, and explore ways to improve data collection activities.
- After data entry, data cleaning and validation was carried out by national consultants, with technical support from IPPF ARO, to identify errors and inconsistencies for correction.

4.7 Data Entry and Analysis

To ensure ease of data entry and analysis, all quantitative data collection tools were pre-coded by IPPF ARO. The research team either filled in the tools directly onto the Open Data Kit (ODK) Collect app on smartphones or filled in hard copies of the tools on-site, and then entered the data into ODK Collect when they could access a smartphone with internet. This data was instantly available to IPPF ARO and the Regional Consultant. The quantitative data was exported to SPSS version 16.0 format for further cleaning, editing and processing at the regional level through IPPF ARO. It was presented using descriptive statistics in the form of tables and graphs based on the agreed indicators and analytical framework.

Building on the scoring methodology used by WHO in *Global standards for quality healthcare services for adolescents: a guide to implement a standards-driven approach to improve the quality of healthcare services for adolescents, Volume 4: Scoring sheets for data analysis* (2015), scores were given to each question on the facility observation tool as following: 1 for 'Yes' answer and 0 for 'other answers'.

An eligibility condition to include a health facility to the scoring mechanism in compliance with the 8 standards was set and approved by the Regional Team. Referring to this decision, only the health facilities in which the observation tools for the 8 standards were fully completed were eligible for further scoring.

After the eligibility criteria was applied to the health facilities visited, the final lists of health facilities, grouped by country and standard, were converted into SPSS (.SAV) files from where the scoring methodology as explained above was applied within each standard by health facility. Furthermore, for the purpose of regional aggregation, country scores by standard were generated by calculating the average score of health facilities visited within that same country.

The questionnaires for health service providers and the young client exit interviews were coded with questions pertaining to each standard. The responses were then analysed alongside the information obtained from the facility observation tool and inferences drawn based on the findings from the three sources of information.

In-depth interviews (IDIs) and FGDs were audio-taped, transcribed and translated into English or French for analysis by the research team in-country. The qualitative data was analysed by using thematic analysis. Themes and sub-themes were generated based on the objectives of the Assessment, and guided the analysis and presentation of information. This initial analysis from each country was then reviewed and strengthened by the Regional Consultant to form the basis for this Regional Report.

After excluding incomplete questionnaires, data was analysed only from the following number of health facilities, health service provider interviews, and young client exit interviews (see Table 3).

Table 3: Data Analysis

Country	Health facilities observation tool	Health service provider interviews	Young client exit interviews
Burundi	10	10	52
Comoros	7	7	28
DRC	14	14	116
Ethiopia	14	14	113
Kenya	14	14	62
Lesotho	7	7	80
Madagascar	13	12	100
Mozambique	13	13	100
Swaziland	10	9	55
Uganda	14	14	70
Zambia	14	14	113
Zimbabwe	12	12	75
Total	142	140	964

Thus, one less health facility than those visited in Comoros, Kenya and Mozambique, and two less health facilities than those visited in Lesotho, have been analysed.

IPPF ARO oversaw the data entry, and the Regional Consultant, in collaboration with the National Consultants, conducted the analysis and drafted this Regional Report in collaboration with UNFPA staff for input and approval by the Advisory Committee.

4.8 Data Validation

Prior to the finalisation of the national reports, the results and findings were validated by national stakeholders during a one-day meeting in each country. The findings from the Regional Report were presented to national stakeholders and the Regional Advisory Committee at a two-day consultation in November 2016, and further validated by the Regional Advisory Committee before this report was finalised.

4.9 Ethical Considerations

This Assessment included no invasive or medical procedures of any kind. Consent from the relevant ministries, UN, international agencies and NGOs was obtained for their participation in the review. The objectives and nature of the Assessment were explained clearly to the respondents who were interviewed only after they agreed to participate in the Assessment by signing a consent form or giving a verbal consent. Participation in the Assessment was strictly voluntary. It was emphasized to the respondents that refusal to participate in the Assessment would not result in any loss of service. Participants were able to withdraw from the interviews and survey at any time and if they felt uncomfortable responding to certain questions, he/she could decline to do so. It was emphasized by the interviewer and in the consent form that the participants did not have to answer any questions they did not wish to. Except for refreshments for those participating in FGDs, participants received no direct financial or any other material benefits for participation. This was explained to them by the interviewer and in the informed consent form.

Measures were taken to assure the respect, dignity and freedom of each respondent. During the training of the research teams, the importance of obtaining informed consent (see informed consent forms in Annexure 2) and avoiding coercion of any kind was emphasised, as was the confidentiality of Assessment subjects. The young respondents ranged between 15-24 years of age. For those below the legal age of majority, consent was also sought from parents / guardians / accompanying persons, if any. In the case of young service users who had accessed the services without the need for parents / guardians consent, the respondent was considered capable of consent (based on the concept of evolving capacities). Introduction and consent forms for each of the Assessment respondents are provided (based on the WHO Global Standards for Quality Healthcare Services for Adolescents).

Confidentiality of respondents was safeguarded to ensure both respondents' safety and data quality. Names of respondents or their organisational affiliation did not appear in write-ups or reports in order to maintain the anonymity of the participants. Any statements by participants quoted in reports was attributed by their profession or role to the extent that confidentiality could be preserved. For FGDs, moderators were trained to state up-front to all participants that their discussions should be kept confidential within the community they are located in. Any client records accessed at the health facilities during health facility observation were used strictly to obtain data on service statistics and no client names, health conditions or other confidential information was taken. All Assessment data was kept under lock and key at the IPPF ARO offices, and was only

accessible to the Assessment staff. All audio tapes will be kept secure at all times for a period of 24 months after the completion of the Assessment and will be destroyed thereafter, with only Assessment staff having access to them. Ethical clearances for the Assessment were obtained for the in-country Assessments (details in Annexure 4) and the research teams carried a copy of the ethical clearance / exemption at all times during field work.

4.10 Assessment Limitations

This was an Assessment of a sub-sample of SDPs in 12 countries in the ESA region, and should therefore not be perceived as representative of the overall status of the countries' AYFHS programme, which would have required a larger assessment, with a bigger sample size, and more diverse range of respondents, than allowed by the financial resources and time available. The results will, however, give us an indication of the prevailing situation of AYFHS, as well as highlight successes, challenges and best practices that can be used to improve from the current situation of AYFHS implementation.

A limitation affecting the results was that the Assessment teams were not always able to reach the expected sample size for health facilities and young clients due to the client flow found on the day that the Assessment team visited a particular health facility. Thus, some health facilities may have more representation of young clients' views, while others may have much less.

In addition, some of the initially planned research questions pertaining to institutional set up with the Ministry of Health (MOH), allocation of government resources (budgets, human resources, etc.), utilisation rates, availability of national M&E and availability of gender and sex disaggregated data could not be addressed due to reticence by government officials and limited time availability.

Since the national Assessment teams could not collect consistent data on all the research questions from all their respondents and Assessment locations, this regional report only analyses and presents data that was consistently available across countries, respondents and Assessment locations. Hence, this report only answers some of the broad research questions that were initially defined (as laid out in Chapter 3).

5. Definition of Terms

5.1 Defining Adolescents and Young People

For the purpose of this Assessment, the definition of adolescents and young people or youth is taken to be those between 10 and 24 years of age. For the purpose of analysis, where possible, the age groups will be further disaggregated from 10-14 years, 15-19 years and 20-24 years.

Some of the guiding principles and values shared by IPPF and UNFPA are used as a critical lens to determine of the effectiveness of interventions for this Assessment, especially AYFHS and their responsiveness to adolescents and young people needs. These guiding principles and values are:

- Adolescence is a critical life stage for all young people to develop knowledge, skills and resilience for a healthy, productive and fulfilling life. Their right to a safe and successful passage from adolescence into adulthood can only be fulfilled when focused investments are made in young people's development, including their sexual and reproductive health and rights.

- It is important to focus on the positive aspects of adolescence and youth to counter the dominant discourse of them engaging in risky behaviours.
- Their evolving capacities must be acknowledged, seeing them as agents of change and rights holders, rather than merely as recipients of information, services and other interventions. Thus, policies and procedures, while recognising young people's vulnerability and need for protection, should ensure equity and non-discrimination, and support them to demand their rights and promote their meaningful participation at all levels.

5.2 Defining Adolescents and Youth-Friendly Health Service Delivery

According to WHO, adolescents and young people from different groups around the world identify two key characteristics for youth-friendly health services, which are that:

- They are treated with respect.
- Their confidentiality is protected.

WHO further specifies that to be considered adolescent-friendly, services should be:

- **EQUITABLE:** All adolescents and young people, not just certain groups, are able to obtain the health services they need.
- **ACCESSIBLE:** Adolescents and young people are able to obtain the services being provided.
- **ACCEPTABLE:** Health services are provided in ways that meet the expectations of adolescent clients.
- **APPROPRIATE:** The health services that adolescents and young people need are provided.
- **EFFECTIVE:** The right health services are provided in the right way and make a positive contribution to the health of adolescents and young people.

International NGOs like Pathfinder International and IPPF have defined AYFHS as being able to effectively attract adolescents and young people, responsively meet their varying needs, and succeed in retaining these young clients for continuing care. IPPF has also defined an integrated package of essential sexual and reproductive services for young people that should be provided through AYFHS. These definitions and characteristics highlight the importance of addressing all adolescents and young people, meeting their needs and expectations, and respecting, protecting and fulfilling their rights (refer to Annexure 5 for definition of standards and principles of AYFHS by WHO, IPPF, EngenderHealth and Pathfinder).

The Ministerial Commitment on CSE and SRH services for adolescents and young people (The ESA Commitment) which has been endorsed and agreed to by ministers of health and education from 21 ESA countries states that the ministers commit to ensuring that,

“...health services are youth-friendly, non-judgemental, and confidential and reach adolescents and young people when they need it most, and are delivered with full respect for human dignity, including for young people considered most at risk, young people living with disabilities, or young people experiencing any other forms of discrimination. Reliable, affordable commodities must be made available as part of service delivery through public, private and civil society channels.”

⁺⁺ According to Article 5 of the UN Convention on the Rights of the Child, “as young people grow and develop, their capacities to make decisions and act independently evolve. This will happen at different rates for different young people in different contexts.”

For the purpose of this Assessment, a working definition of AYFHS that draws upon the existing ones highlighted here is:

Adolescent and Youth Friendly Health Services are those that are based on a comprehensive understanding of, and respect for, young people's rights and the realities of their diverse sexual and reproductive lives. They are services which young people trust and feel are there for them. To be considered adolescent and youth friendly, health services should be accessible, acceptable, equitable, appropriate, and effective.

6. Guidelines and Standards for Adolescents and Youth-Friendly Health Services

According to a global literature review conducted by the Royal Tropical Institute (KIT) in Amsterdam,¹⁰ the types of service delivery models for AYFHS currently in use are:

1. Specialised adolescent health services offered in hospitals.
2. Community-based (youth-friendly) health centres / health facilities.
3. School or college-based health services / clinics.
4. Multi-purpose community-based youth centres that not only provide health services, but also SRH related information, recreational activities and computer training.
5. Pharmacies and shops selling health products.
6. Outreach information and services.
7. Service provision by static health services.

Recommended guidelines for AYFHS, as per a region-specific literature review from 2011 that was conducted by MiET Africa, specify that: staff training and their demonstration of respect for young clients, efforts for confidentiality and privacy that may mean adding partitions in a health service facility, among others, using a space for delivering AYFHS that is not too far for adolescents and young people, but also provides anonymity, having supportive policies and processes in place that recognise adolescents' and young people's rights, and garnering community support.¹¹ Some of these guidelines are supported by a more recent review of literature by Denno et al. (2015) on evidence for improving adolescent access to and use of SRH services.¹² Both these reviews highlight that the most effective interventions in increasing adolescents' and young people's access to services is to ensure that, other than quality clinical services, sexuality and life skills education, and linkages with educational and economic opportunities and supportive adults are in place. Similarly, a meta-review, by Nair et al. (2015),¹³ of systematic reviews conducted during the development of the WHO Global Standards for Quality Health Care Services for Adolescents affirmed that making services available at schools and communities was a main facilitator for improving access.

Denno et al. specifically mentioned that a one-off training for health workers is not enough to boost AYFHS.¹² Consistent training and support for health workers, combined with demand generation and outreach results in better uptake of AYFHS.

¹⁰ Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern African (ESA), 2013, Cape Town, South Africa. <http://www.unesco.org/fileadmin/MULTIMEDIA/HQ/HIV/AIDS/pdf/ESACCommitmentFINALAffirmedon7thDecember.pdf>

While health facility-based AYFHS seems to be effective, there is limited research available on the most effective way of providing AYFHS to vulnerable and marginalised adolescents and young people. Despite services being available, they are not always equitable (i.e., vulnerable and marginalised young people may still not be able to access them).¹² Therefore, it appears essential to look for examples of programmes and services that not only reach a large number of adolescents and young people, but also those successfully reaching vulnerable and marginalised young people in the ESA region.

The WHO Global Standards (2015) identify 8 specific Standards to assess the quality of adolescent healthcare services, as presented in Chapter 4. These, along with the ninth standard added by the Assessment team, are further explained below:

Standard 1. Adolescents' health literacy: The health facility implements systems to ensure that adolescents are knowledgeable about their own health and they know where and when to obtain health services. This includes having several educational materials and different information channels for adolescents and young people on health and rights, and ensuring that the SDP is well advertised, welcoming, branded for adolescents and young people, and conveniently located. These areas of assessment are also included in the client exit interviews and FGDs with young people, especially young peer educators associated with the SDP.

Standard 2. Community support: The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents. This is related to reaching out to the parents, guardians and other community members in the area to increase support for adolescents and young people's access to health services. It includes having an outreach plan in place, as well as referrals between community-based resources and the SDP.

Standard 3. Appropriate package of services: The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfil the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach. This refers to the information and services provided at the SDP, formal links to referral services within and outside the health sector (e.g., for legal or psycho-social services, or with schools in the area), and assessing whether the young clients in the area have information and service needs beyond what is offered at the SDP (through the client exit interviews and FGDs with young people).

Standard 4. Providers' competencies: Healthcare providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect. This includes ensuring that the SDP has the required number and level of staff in place with clear job descriptions and competencies, healthcare providers are given regular and relevant training, and receive supportive supervision. This is also assessed through the interview with the health service providers.

Standard 5. Facility characteristics: The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents. Other than operating hours and a welcoming environment, this refers to audio-visual privacy at different steps of the young client's experience at the SDP, including the

manner in which registration records are taken and maintained. There is also an observation of several essential clinical commodities and equipment, along with the supply chain systems in place (i.e., procurement and stock management, storage and inventory).

Standard 6. Equity and non-discrimination: The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics. This refers to the provision of free or affordable services to adolescents and young people, as well as putting in place measures to ensure a safe environment for adolescents and young people. It is also assessed through the interviews with health service providers, and young clients, as well as the FGDs with adult outreach workers and young people, where areas of possible discrimination are explored.

Standard 7. Data and quality improvement: The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement. This takes into account all the data collected at the SDP on clients (disaggregated by age and sex), its analysis and use for quality improvement, as well as self-assessments and supportive supervision. The interviews with the health service providers are also aimed at understanding the use of data and the monitoring systems in place.

Standard 8. Adolescents' participation: Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision. This assesses the level of young people's involvement in the SDP, from their ability to provide suggestions to their inclusion in advisory committees. This is also included in the FGDs with young people.

Standard 9. Policies, Procedures and Institutional Support: Appropriate national level policies, procedures, and institutional support to improve and scale up quality adolescents and youth-friendly health services that protect adolescents' rights are in place and being implemented. This refers to the existence, knowledge and implementation of appropriate policies, standards, and/or operating procedures at the SDP under each of the above standards. It is also assessed through the interview with the health service provider. In addition, the in-depth interview with key informants assesses the institutional support or scale of AYFHS, for example, funding allocations for AYFHS.

7. Adolescent Sexual and Reproductive Health in the East and Southern Africa Region

7.1 Demographic and Epidemiological Situation

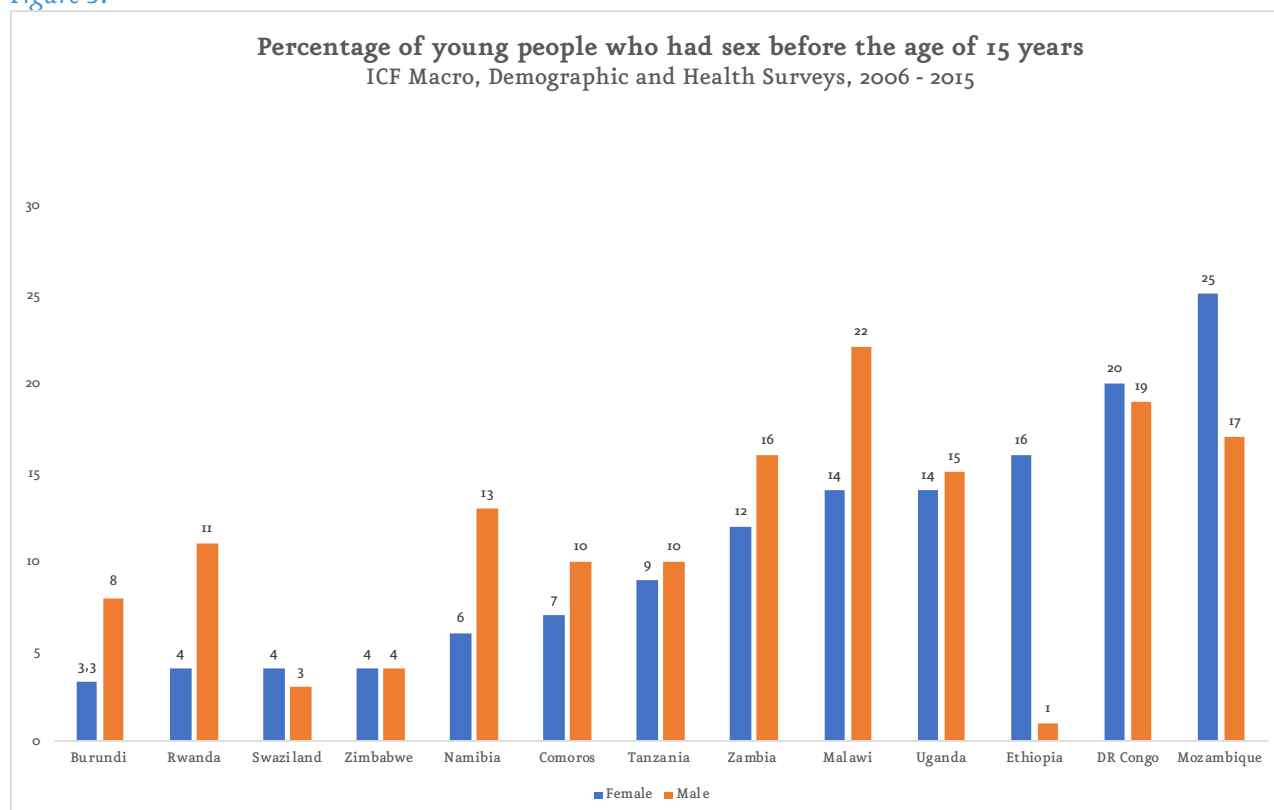
More than one-third of the population in ESA is aged 10 to 24 years. The 182 million population of 10-24 year olds in 2016 is expected to rise to 341 million by 2050.¹ Ushering them into healthy and productive adulthood is critical for Africa's development and achievement of the demographic dividend.

Since there is no universal definition of 'youth' across the region, comparison of data across countries is difficult.² However, throughout this report, adolescents and young people refer to those aged 10-24 years. Presented below are some key statistics around the sexual and reproductive health and rights (SRHR) of adolescents and young people in ESA. This data is intended to provide a context for policies and their implementation, which are described in the following sections.

One of the key issues that affect girls and young women is **child marriage**, with an estimated 37% of women aged 20-24 years being married by the age of 18 years in the ESA region. Despite progress on reducing child marriage, South Sudan (52%), Mozambique (48%), Malawi (46%), Madagascar (41%), Eritrea (41%), Ethiopia (41%), and Uganda (40%) remain in the list of 20 countries with the highest rates of child marriage globally. Child marriage is most prevalent among girls in rural areas and among under- and un-educated girls and families. Child brides end up having many children to care for while still young, with nine of ten pregnancies among adolescents taking place within a marriage or union. They are also less likely to receive medical care during pregnancy than women who married as adults.

The **median age of first sexual experience** in the ESA region is 16-18 years for young women and 17-20 years for young men. As can be seen in Figure 3, the percentage of **young people who had sex before age 15 years** is highest among females in Mozambique and males in Malawi. In addition, more males than girls initiate sex before age 15 years in eight of the countries (i.e., Burundi, Comoros, Malawi, Namibia, Rwanda, Tanzania, Uganda, and Zambia), but few males seem to initiate sex before the age of 15 years in Ethiopia.¹⁶

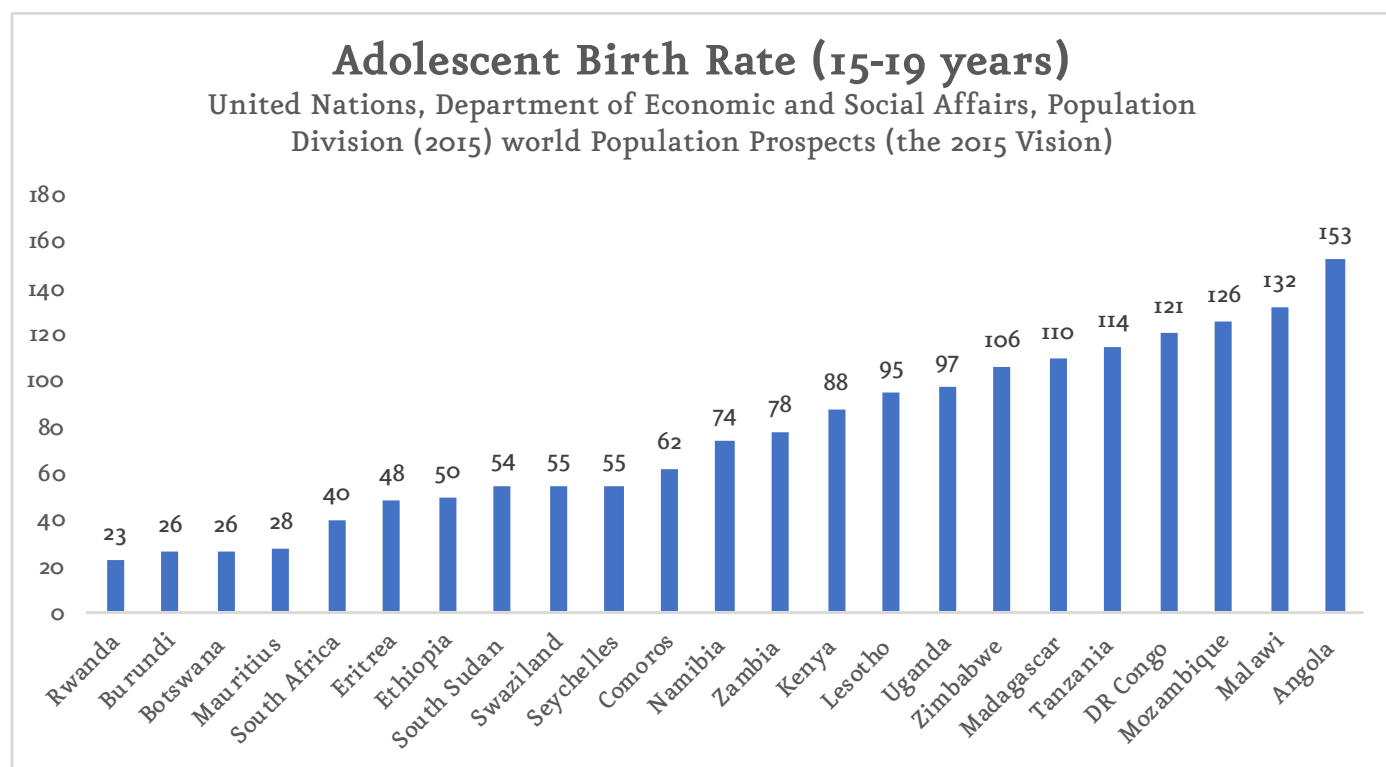
Figure 3:



The age of sexual debut is an important indicator in relation to sexual health and decision making, and needs to be considered when making policy and programme decisions with respect to initiating CSE and provision of health service to adolescents and young people.²

The **adolescent birth rate** measures the annual number of births to women 15 to 19 years of age per 1,000 women in that age group. It is also referred to as the age-specific fertility rate for women aged 15-19 years. The adolescent birth rate is highest in Angola, followed by Malawi, Mozambique, and the DRC, as demonstrated in Figure 4.¹

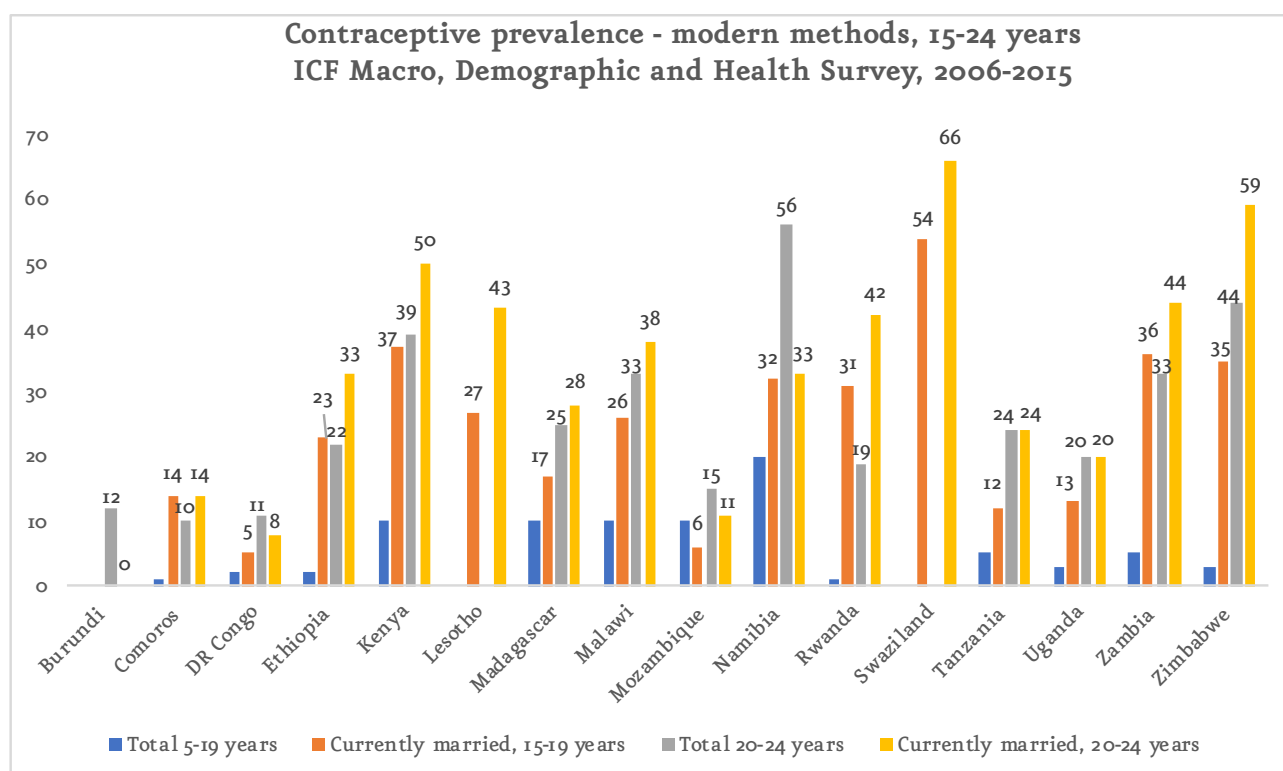
Figure 4:



The ESA region saw an estimated 3.3 million live births among girls aged 15-19 years in 2015, and this is projected to rise to 5.4 million by 2035. The proportion of unintended pregnancies among girls 15-19 years ranges from 39% in Tanzania to 59% in Kenya.¹⁷ Adolescent pregnancy increases the risk of the girl dropping out of school, as well as other socio-economic consequences. Many health problems are particularly associated with negative outcomes of pregnancy during adolescence. These include anaemia, malaria, HIV and other STIs, postpartum haemorrhage and mental disorders, such as depression. Up to 65% of women with obstetric fistula develop this as adolescents.¹⁸ Fistula among young women in rural areas is the ultimate testament to limited access to quality emergency obstetric care. Early and unintended childbearing is therefore an important aspect to consider for youth-friendly service delivery since family planning, antenatal care (ANC), and other reproductive health services tend to be geared towards older and/or married women.

The **rate of modern contraceptive use** among adolescents aged 15-19 years who are already married, remains lower than 30% in many countries with an overall demand satisfied for contraception being 65%.¹⁷ The proportion of women married or in-union aged 15 to 24 years who are currently using, or whose sexual partner is using, at least one method of modern contraception is shown in Figure 5. The percentage of sexually active women currently using any modern method of contraception is highest among married women aged 20-24 years in Namibia, Swaziland and Zimbabwe at more than 50%. The DRC has the lowest percentage at 8%, which is corresponding to the fact that the DRC also has a high adolescent fertility rate.¹⁶

Figure 5:



Access to **termination of pregnancy** is extremely restricted in the ESA region, and it is estimated that 25% of unsafe abortion cases in sub-Saharan Africa occur among adolescent girls. A high proportion of women seeking post-abortion care are aged below 20 years (i.e., 17% in Kenya, 21% in Malawi, between 49% and 58% in Tanzania, 60% in Zambia, and 68% in Uganda).¹⁷

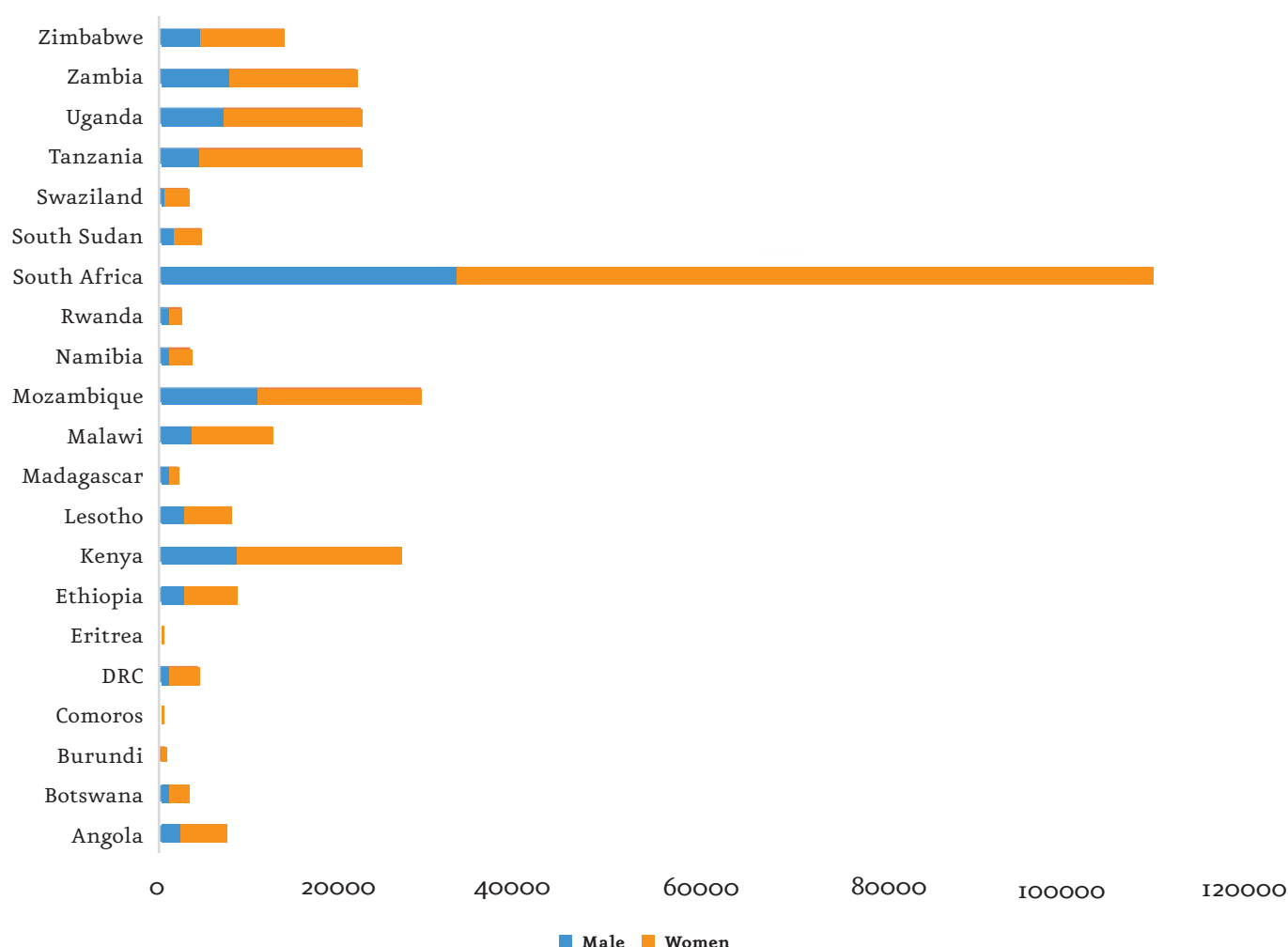
More than 3.9 million (10%) of the world's people living with HIV/AIDS are young people (aged 15-24 years), 2.2 million (56%) of whom live in ESA. About 40% of infections (people aged 15+ years) are among young people (15-24 years). The percentage of young people aged 15-24 years who are HIV positive is highest in Swaziland (14.3%) followed by Lesotho (9.3%). The lowest prevalence is in Ethiopia (0.3%), Burundi (0.5%) and the DRC (0.7%).¹⁶

This proportion, however, masks countries with larger population size that have the highest absolute numbers of adolescents and young people living with HIV and higher numbers of new HIV infections. For example, South Africa with 110,000 compared to Swaziland with 3,300 HIV infections among 15-24 year olds per year (see Figure 6).^{17, 19}

Figure 6:

New HIV infections per year among young people (age 15-24 years)

UNAIDS, 2017



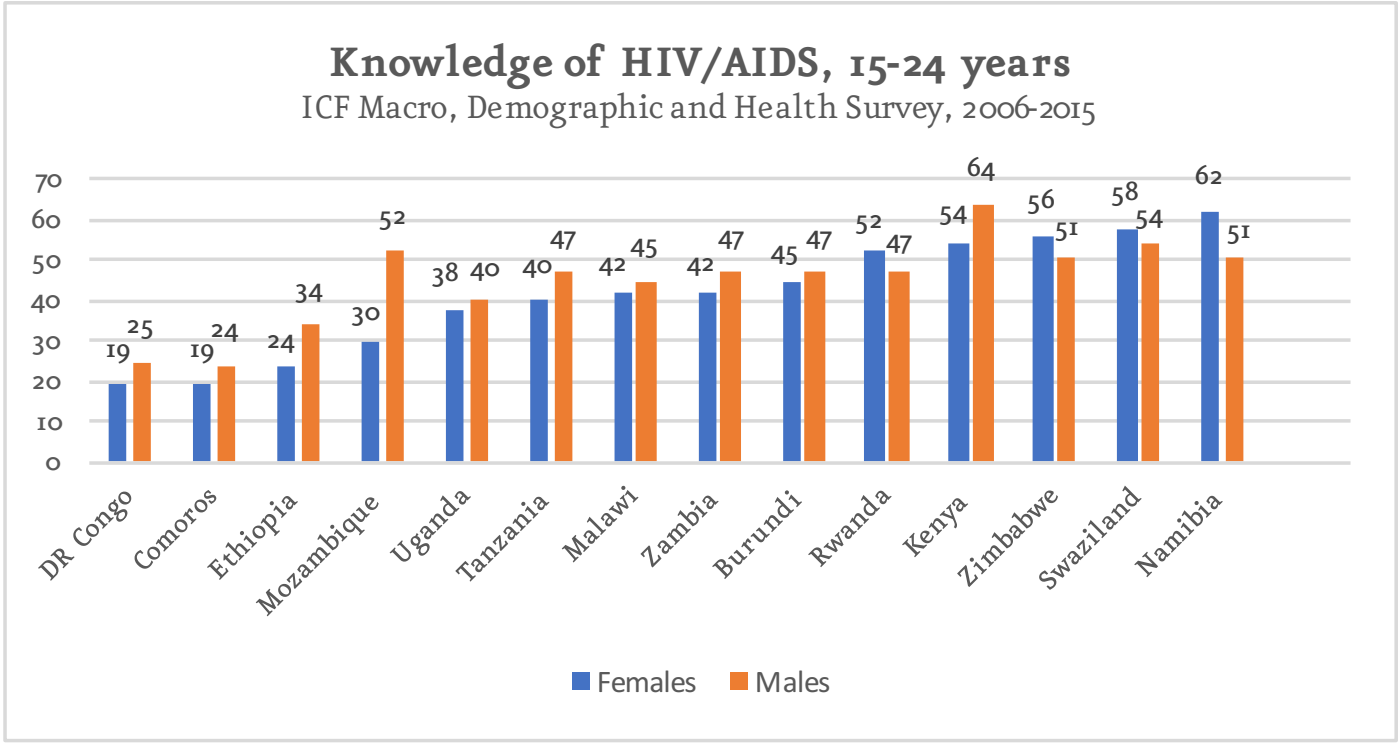
Though only 17% of the ESA region's population, adolescent girls and young women account for 25% of new adult HIV infections, and are therefore disproportionately affected by the epidemic. According to UNAIDS, by 2016, HIV prevalence among young women exceeded 1% in many countries, and averages 3.3% for the ESA region. New infections in most countries in the ESA region mainly occur in young women 20-24 years except for Kenya, where girls 15-19 years are being infected at higher rates. AIDS-related deaths for adolescent girls and young women declined by 18% between 2010 and 2015, but deaths for their male counterparts increased by 14% in the same period, due in part to lower antiretroviral therapy (ART) coverage among them.

According to UNICEF and UNAIDS in 2015, drivers for HIV among girls and young women include:

- Gender-based inequality - e.g., condom use at last higher-risk sex was as low as 8.5% in the DRC, and other countries also reported less than half adolescent girls using condoms at last higher-risk sex – Lesotho (43%), Malawi (42%), Mozambique (43%), Tanzania (35%), and Uganda (30%).
- Age-disparate sex - e.g., in South Africa, one in every three sexually active adolescent girls is involved in a sexual relationship with a sexual partner who is more than five years older.
- Intimate partner violence - e.g., in Malawi, Namibia and Zimbabwe, the prevalence of intimate partner violence was higher in the adolescent age group than among adult women aged 20-49 years.

The proportion of those aged 15-24 years who have comprehensive and correct knowledge of HIV and AIDS is varying with very low proportions in the DRC, Comoros and Ethiopia. The highest proportions are in Kenya (males) and Namibia (females). Overall, only four countries have a higher proportion of females compared to males that have comprehensive and correct HIV knowledge (i.e., Namibia, Swaziland, Zimbabwe and Rwanda) (see Figure 7).¹⁶

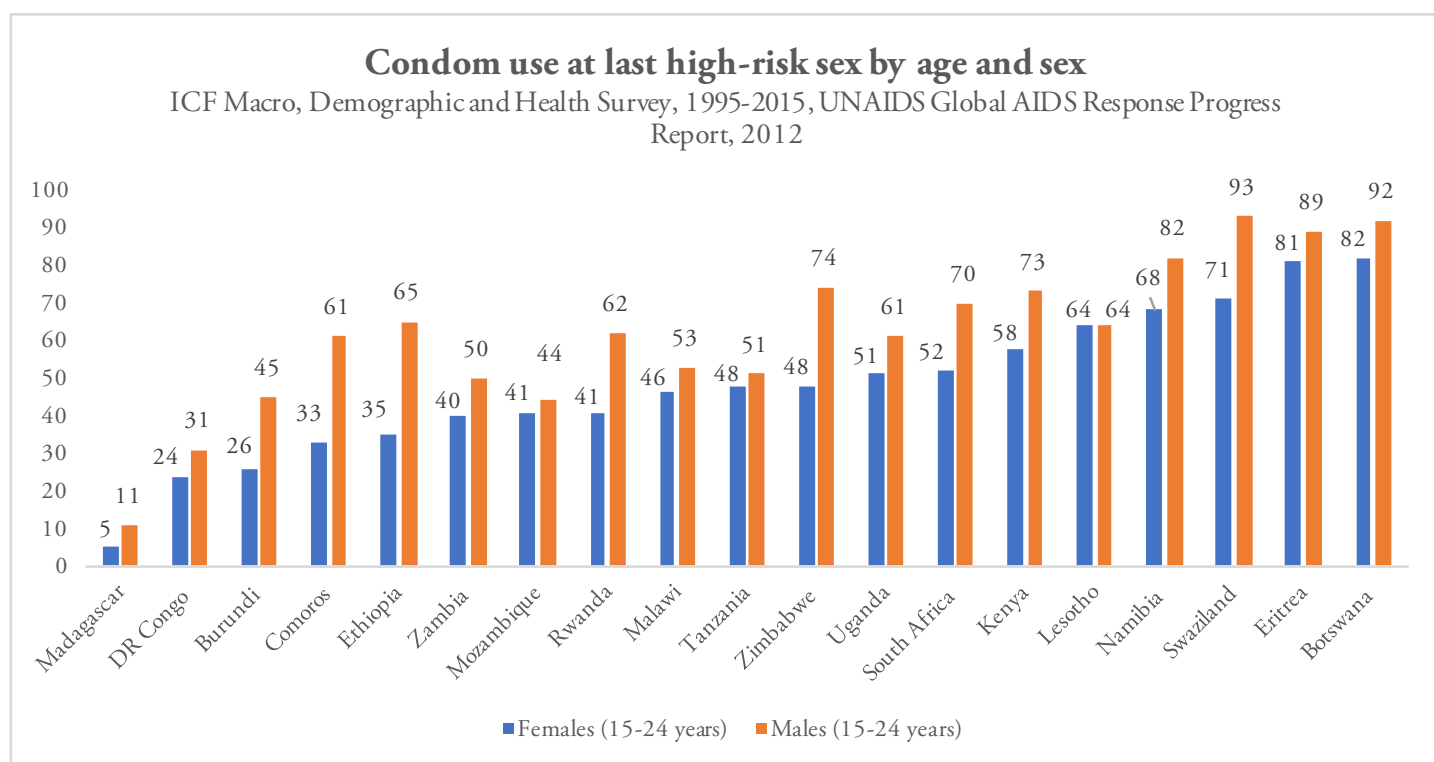
Figure 7:



HIV testing behaviour of those aged 15-24 years, on the other hand, reveals that more females are getting tested than males in all the countries of the region, except for Ethiopia.¹⁶ One explanation for this could be that females aged 15-24 years are more likely to get in contact with a health facility in connection to pregnancy.

The **rates of condom use** or condom use at high-risk sex are the proportion of young people who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner or those who have had sex with such a partner in the last 12 months. These differ between young women and young men, with young women's usage often being significantly lower than that of young men, for example, 48.8% of young women in Zimbabwe used a condom during premarital sex, compared to 72.7% of young men. In the DRC, rates were closer (24% for females and 31% for males), but males still have higher rates of condom use. Madagascar has the lowest percentage of young women using a condom during premarital sex at 5% (see Figure 8).¹⁶

Figure 8:



Married adolescents and young women have the lowest levels of condom use, and are exposed to sexual activity often with older men and are more exposed to HIV.

In addition, **sexual and gender-based violence** (SGBV) is reported by a high percentage of women, with higher rates for those aged 20-24 years than for those aged 15-19 years.² The proportion of women (15-24 years) who have experienced intimate partner violence is highest in Zimbabwe, Uganda and the DRC (see Figure 9).¹⁶

Figure 9:



Girls who experience sexual violence are at a higher risk of HIV.¹⁷ This is exacerbated by socio-cultural challenges for adolescents and young people in the ESA region, which include harmful traditional practices, such as child marriage and female genital mutilation, which has been documented in Eritrea (83%), Ethiopia (74%), Kenya (21%), Tanzania (15%), and Uganda (1%),^{21,22} weak legal infrastructure, and lack of access to child, health, social protection services, including on SGBV.

Thus, it is evident that the adolescent sexual and reproductive health and rights (ASRHR) situation in ESA requires attention. With the age at first sexual intercourse being as low as 16 years and the percentage of teenagers who have begun childbearing going as high as 42.5%, access to SRHR and HIV information, education and services is essential.

7.2 Challenges to Access to AYFHS

Adolescents' and young people's challenges to accessing AYFHS can be classified into system and structural, socio-cultural and legal, and provider bias, using the ecological model (see Figure 10). This model provides a snapshot of the drivers / causes for adolescents' and young people's lack of access to AYFHS in the ESA region at several different levels.

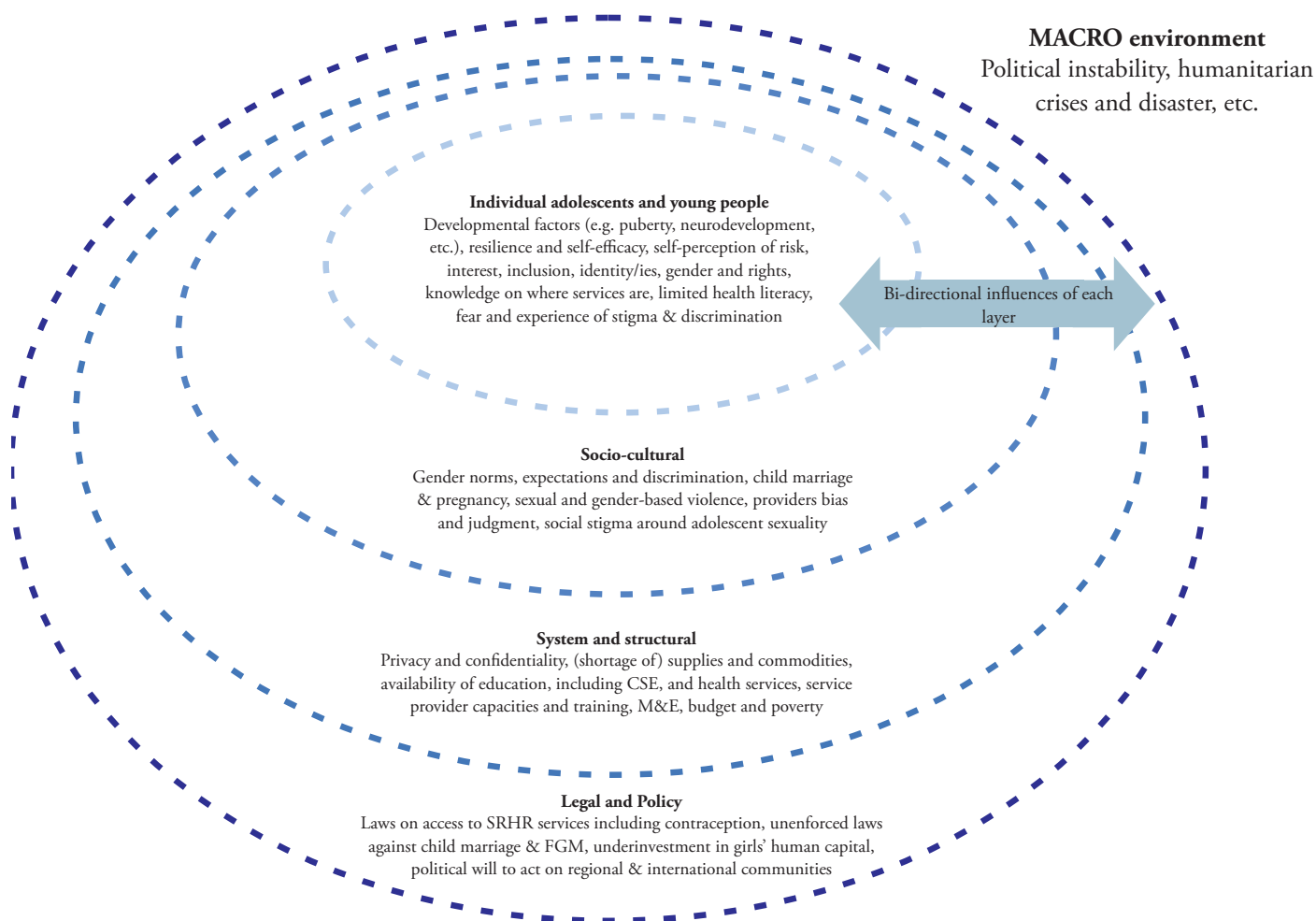
While the framework places individual **adolescents and young people in the centre** as being affected and influenced by the different factors at each level, it also provides agency to the individual adolescent or young person, in that they can also exert influence on the different levels surrounding them. At an individual level, there are not only physical and psychological developmental factors, but also those around resilience and self-efficacy, and perception of risk which evolve during adolescence. Added to this are issues of identity (i.e., related to marital status, sexual orientation, sexual activity, profession, age, etc.), as well as adolescents and young people's own interest in their health and their inclusion in promoting or providing health services. As established before, knowledge of where services are located is also key to adolescents' and young people's access to AYFHS.

The **socio-cultural level** is primarily the family, community and peers surrounding an individual adolescent or young person. Here they are faced with gender norms and expectations, harmful traditional practices like child marriage and female genital mutilation, non-medical male circumcision, and stigma around adolescent sexuality and reproductive behaviours. These socio-cultural influences also affect providers, leading to bias, discrimination and judgemental attitudes.

The **system and structural level** refers mainly to the supply side of services, and other structural constraints like poverty. The availability of quality CSE and services with competent providers and adequate equipment and supplies, combined with good M&E, are the main factors here. Despite having positive policy and legislative frameworks in place, implementation challenges can increase the impact of these barriers on access to services.

The **legal and policy level** refers to the policy and legislative framework within which AYFHS are located in a country. In addition to the apparent lack of access to contraception, safe abortion, HIV prevention, and other services evidenced by the indicators explained above, the laws and policies of the region either pose barriers for young people's access to services, or are not fully implemented to enable their access. Despite several international and regional commitments towards enhancing access to CSE and youth-friendly health services, the adoption of these commitments into domestic laws and policies remains partially or wholly unrealised. There are several policy gaps, implementation challenges, lack of costing and budgets, and/or monitoring.² As explained in the following chapter, the policy and legislative framework on AYFHS in the ESA region has improved over the last few years, but still has significant gaps.

Figure 10: Ecological Model⁺⁺



8. Regional Policy and Legislative Framework on Adolescent and Youth-Friendly Health Services

There are several global and regional commitments and frameworks for action pertinent to adolescents' and young people's health and their access to AYFHS, for example, the Convention on the Rights of the Child (1989) and its General Comments no. 20 on the implementation of the rights of the child during adolescence from 2016, the International Conference on Population and Development (1994), the Global Strategy for Women's, Children's and Adolescent's Health (2016-2030), the African Youth Charter (2006), the Abuja Call for Accelerated Action towards Universal Access to STI/HIV/AIDS, Tuberculosis and Malaria Services in Africa, the Maputo Plan of Action (2016-2030), the Africa Health Strategy (2016-2030), and other efforts by regional structures such as SADC and EAC. Since the launch of the first Maputo Plan of Action in 2006, there have been a number of efforts to place maternal health and HIV at the centre of national policies and strategies, for example through the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) which was launched in 2009. Similarly, the 21 countries that have endorsed the Ministerial Commitment on CSE and SRH services for adolescents and young people in ESA in 2013, have been working towards achieving their targets on providing CSE and reducing barriers to access for AYFHS. Nevertheless, laws and policies are yet to be harmonised in a way that allows adolescents and young people to freely access AYFHS.

⁺⁺ Adapted from Johnson et al. (2013), *Love, Sex and Young People* and UNFPA (2013) *Motherhood in Childhood*

Laws on age of consent to sex are not consistent in the ESA region, with variations from 13 years in Comoros and 14 years in the DRC, Madagascar and Namibia, to 18 years in Burundi, Ethiopia, Kenya, Mozambique,

Rwanda, Seychelles, South Sudan, Tanzania and Uganda. In Eritrea, it is not defined, and in Angola, Botswana, Lesotho, Malawi, Mauritius, South Africa, Swaziland, Zambia and Zimbabwe it is 16 years.

The minimum legal age for marriage is above 18 years without exception for only five countries in the ESA region (Eritrea, Kenya, Rwanda, South Sudan and Uganda). Finally, age of consent to health services and medical treatment is at the recommended 12 years only in Malawi, South Africa and Uganda. However, 10% of girls had their sexual debut before the age of 15 years without benefit of protective environmental factors like education, including CSE and health services. As seen in the previous chapter, in many countries a significant percentage of boys also initiate sex before the age of 15 years. While criminalisation of consensual sexual acts amongst adolescents in the ESA region appears to be minimal, there is a need to harmonise the laws and policies related to age of consent across the region in order to protect adolescents and young people, as well as recognise their sexual and reproductive rights.

Reviews of the sexuality education curricula in the ESA region have revealed gaps on several fronts including on pregnancy testing (how to find it, when and how to use it, and how to interpret it); the right to privacy; not to be harmed, to be in control over one's sexuality, and to move freely from place to place, biological and social aspects of sex and gender, contraceptive and protection methods, emergency contraceptive pills, access to prevention methods, and going to health services to assess personal risk, perceived vulnerability, and attitudes about safer sex practices.^{2,17} Many countries have revised their curricula to include CSE under the ESA Commitment and, with the support of UNFPA and UNESCO, built the capacity to deliver quality CSE. However, efforts to strengthen collaboration between the education and health sectors, and to implement CSE for in- and out-of-school youth, still need to be intensified in the ESA region.

According to the 2013-2015 Progress Review on the ESA Commitment,¹⁷ 15 countries were offering the minimum standard package of youth-friendly SRH services. While in 2014, policies, strategies or legal frameworks on AYFHS were only available from 14 countries, the latest information revealed through this Assessment is that almost all the countries have specific policies or strategies on adolescent and/or youth health, especially SRH (presented in Table 4). The newest ones (launched in 2015-2017) are from Angola, Burundi, DRC, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, South Africa, South Sudan, Zambia and Zimbabwe, while the oldest are from Mauritius. At the time of writing this report, policies and strategies for Botswana, Madagascar, Rwanda, Tanzania and Uganda were under development or revision.

Table 4: Regional Policies or Strategies on Adolescent and/or Youth Health

Country	Policies / Strategies on ASRHR	Standards / Guidelines on AYFHS	Other policies mentioning AYFHS	Multi-sectoral linkages specified / ongoing
Angola	National Comprehensive Strategy for AYFS (Estrategia Nacional de Saude Integral de Adolescentes e Jovens 2016-2020)	Standards for Youth Friendly Services 2015	Youth National Development Plan 2014-2017 Strategic Plan to Malaria, HIV/AIDS and Tuberculosis Prevention 2013-2017	Ministries of Health & Youth and Sport
Botswana	ASRH Implementation Strategy 2012-2016 (under revision)	Youth Friendly Services Pocket Guide 2008	National Youth Policy 2010 National Youth Action Plan 2010-2016 Adolescent Sexual and Reproductive Health Training Manual 2012	Ministries of Health, Local Government, Youth Sport & Culture, Education and Skills Development; Finance, UN partners, NGOs and CBOs
Burundi	La Stratégie Nationale Multisectorielle de la Santé des Adolescents et des Jeunes 2015-2020	Directives de mise en place et de fonctionnement d'un centre de santé ami des jeunes 2014 Normes des services de santé de la reproduction 2012 Normes et Protocoles en Matière d'offre des Services de Santé Sexuelle et Reproductive aux Adolescents et Jeunes 2009	La Politique Nationale de la Santé de la Reproduction 2007 Le Plan Stratégique de la Santé de la Reproduction 2013-2015 La Politique Nationale de Jeunesse 2016-2020 Plan stratégique National 2015-2019 de programmation holistique des préservatifs masculins et féminins pour la prévention des IST-VIH- et des grossesses non désirées au Burundi	Multi-sectoral linkages have been specified

*** Angola, Botswana, Burundi, Democratic Republic of Congo, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

Country	Policies / Strategies on ASRHR	Standards / Guidelines on AYFHS	Other policies mentioning AYFHS	Multi-sectoral linkages specified / ongoing
Comoros	La Stratégie Nationale sur la Santé des Jeunes et Adolescents 2014	No data available	Plan National de Développement Sanitaire 2015- 2019 Politique Nationale en matière de SR 2016-2019	Ministries of Health, Education & Youth and Sports
DRC	Politique Nationale de santé de l'adolescent 2009 Le plan stratégique national de la santé et du bien-être des Adolescents et des jeunes 2016-2020 (costed)	Les Standards des services de santé adaptés aux adolescents et jeunes 2014	Normes et Directives en matière de santé de l'adolescent 2012 Les normes de la zone de santé: volume 5: Intervention de santé adaptées aux adolescents et jeunes 2012	Ministries of Public Health & Education
Eritrea	Adolescent Health Policy 2004 National Strategic Plan on Adolescent and Young People's Health 2015-2019	Standards for Adolescent and Young People's Friendly Health Services 2014	No data available	No data available
Ethiopia	National Adolescent and Youth Health Strategy 2016-2020	Standards on Youth Friendly Reproductive Health Services, Service Delivery Guideline and Minimum Service Delivery Package 2008 Tools for Planning, Monitoring and Implementing AYFRH Services 2010	National Youth Policy 2004	No data available

Country	Policies / Strategies on ASRHR	Standards / Guidelines on AYFHS	Other policies mentioning AYFHS	Multi-sectoral linkages specified / ongoing
Kenya	<p>National Adolescent Sexual Reproductive Health Policy 2015-2025</p> <p>Costed National ASRH Policy Implementation Framework 2017-2021 (Under development)</p>	National Guidelines for Provision of Adolescent Youth-friendly Services 2016	<p>Education Sector Policy on HIV 2013</p> <p>HIV Testing Services Guidelines 2015</p> <p>National Fast Track Plan to End HIV and AIDS among adolescents and young people 2015</p>	No data available
Lesotho	<p>National Health Policy 2006</p> <p>National School Health and Nutrition Policy 2017</p> <p>National Health Strategy for Adolescents and Young People 2015-2020</p>	<p>Adolescent Health Training Package 2016</p> <p>National Minimum Standards and implementation guide for provision of adolescent friendly health services 2013</p> <p>Child-Friendly School Standards 2012</p> <p>CSE manual for young people out of school 2017</p>	<p>National Youth Policy 2017-2030</p> <p>Gender and Development Policy 2016</p> <p>Social and Behaviour Change Communication Strategy 2014-2017</p> <p>Risk Reduction and Handbook for Youth 2012</p> <p>Gender and Development Policy 2014-2024</p> <p>Child Protection Welfare Act 2011</p>	Ministry of Health, Ministry of Education, Ministry of Gender and Youth, Sports and Recreation

Country	Policies / Strategies on ASRHR	Standards / Guidelines on AYFHS	Other policies mentioning AYFHS	Multi-sectoral linkages specified / ongoing
Madagascar	<p>La Politique Nationale de Santé des Adolescents et des Jeunes 2000 (revision planned for 2017)</p> <p>Plan stratégique en Santé de la Reproduction des Adolescents (Planned for 2017)</p>	<p>Normes et Procédures en Santé de la Reproduction 2006 (revision planned for 2017)</p> <p>Curriculum de formation en Santé de la Reproduction des Adolescents et des Jeunes, pour les agents de santé et les agents non santé (revision is ongoing)</p>	Politique Nationale de la Jeunesse, promulguée 2015	No data available
Malawi	<p>National Youth Friendly Health Strategy 2015-2020</p> <p>National Sexual Reproductive Health & Rights Policy 2016</p>	<p>National Standards on Youth Friendly Health Services 2015-2020</p> <p>National Reproductive Health Service Delivery Guidelines 2014-2019</p>	<p>National HIV/AIDS Action Framework 2015-2020</p> <p>Five Year Plan to Scale up HIV Testing Services in Malawi 2014-2019</p> <p>National Youth Policy 2014</p> <p>National Gender Policy 2015-2020</p> <p>National Re-admission Policy (Education) (Draft)</p>	Ministries of Youth, Sports and Manpower Development, Ministry of Health, Ministry of Education, Science & Technology, Ministry of Gender, UN partners (WHO, UNICEF, UNAIDS, UNFPA, UN Women), NGOs and CSOs
Mauritius	National Sexual and Reproductive Health Strategy 2009-2015	No data available	No data available	No data available

Country	Policies / Strategies on ASRHR	Standards / Guidelines on AYFHS	Other policies mentioning AYFHS	Multi-sectoral linkages specified / ongoing
Mozambique	<p>Geração Biz Programme Strategic Plan 2014-2017</p> <p>National Strategy for School Health and Adolescents and Youth Health 2016-2020 (2024) being finalized (A costed action plan is planned to be prepared in 2017)</p>	No data available	<p>National strategy to prevent and fight early marriage 2016-19</p> <p>Mozambique Action Plan FP2020, 2016</p>	Ministries of Health, Education and Human Development, Youth and Sports, and Gender, Children and Social Action
Namibia	No data available	<p>National Standards for Adolescent Friendly Health Services 2011</p> <p>National Guidelines for Adolescents Living with HIV 2012</p>	<p>National Youth Policy (due for review in 2017)</p> <p>National Policy on Reproductive and Child Health 2012</p> <p>Education Sector Policy on Management and Prevention of Learner Pregnancy 2010</p> <p>National Health Policy Framework 2010-2020</p> <p>National School Health Policy (due for review in 2017)</p>	Ministries of Health and Social Services; Sport, Youth and National Service; Education, Art and Culture; NGOs
Rwanda	<p>National Sexual and Reproductive Health and Rights Policy 2011-2015</p> <p>National Reproductive, Maternal, Newborn, Child, and Adolescent Health Policy (Under development)</p>	National Manual for Adolescent SRH 2012	<p>National Youth Policy 2005</p> <p>Youth Sector Strategic Plan 2011-2015</p>	Ministries of Health, Gender and Family Promotion, Education, Local Government, & Youth, Sports and Culture

Country	Policies / Strategies on ASRHR	Standards / Guidelines on AYFHS	Other policies mentioning AYFHS	Multi-sectoral linkages specified / ongoing
Seychelles	Adolescent Sexual Reproductive Health Policy 2013	Guidelines for Providing Reproductive Health Services for Young People (draft)	Draft National SRH Policy 2011	No data available
South Africa	Adolescent and Youth Health Policy 2016-2020 (costed) National ASRHR Framework Strategy 2014-2019	National Implementation Guidelines for Adolescent and Youth Friendly Services 2013-2017	National Youth Policy 2015-2020 Integrated School Health Policy 2012	No data available
South Sudan	National Sexual Reproductive Health Policy and Adolescent Sexual Reproductive Health Strategy 2016-2020	South Sudan Standards for Adolescent & Young People Friendly Health Services 2016 Basic Package of Health and Nutrition Services: Boma Health Initiative 2016	Reproductive Health Policy, Family Planning Policy 2013 Reproductive Health Strategic Plan 2013-2016 National Youth Development Policy 2012 Ministry of Culture Youth & Sports Strategic Plan 2013-2018	Ministries of General Education & Instruction; Health; and Youth
Swaziland	National Sexual and Reproductive Health Policy 2013-2018	National Guidelines on Adolescents and Youth SRH 2013 National ASRH Standards under development	National SRH Strategic Plan 2014-2018 National Youth Policy 2009	Ministries of Health, Education and Training, Sports, Culture and Youth Affairs, Coordinating Assembly of Non-Government Organizations, NERCHA

Country	Policies / Strategies on ASRHR	Standards / Guidelines on AYFHS	Other policies mentioning AYFHS	Multi-sectoral linkages specified / ongoing
Tanzania	National Adolescent Reproductive Health Strategy 2011-2015 (Under review)	Standards for Adolescent Friendly Reproductive Health Services 2005 (Under review)	<p>National Youth Development Policy 2007 (Policy and implementation strategy are under review, draft in place)</p> <p>National Population Policy 2006 (Under review, but has been reviewed for Zanzibar and draft in place)</p> <p>National Policy on HIV/AIDS 2001 (In the process of review since 2015, not endorsed)</p> <p>National Standards in Peer Education for Young People 2009</p> <p>The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health in Tanzania 2016-2020</p>	Ministries of Information, Youth, Sports and Culture; Health, Community Development; Gender, Elderly, Children; and Prime Minister's Office
Uganda	<p>Adolescent Health Policy 2011</p> <p>Adolescent Health Strategy 2011-2015 (Under revision with plans for the development of a costed action plan)</p>	Adolescent Health Policy and Service Standards 2012	<p>National Health Policy 2010</p> <p>National Youth Policy 2016</p> <p>School Health Policy (draft)</p> <p>National RH Policy and Standards 2001</p> <p>Reproductive Maternal, Newborn and Child Health Plan 2013</p>	Ministries of Health, Girls, Labour and Social Development and Education

Country	Policies / Strategies on ASRHR	Standards / Guidelines on AYFHS	Other policies mentioning AYFHS	Multi-sectoral linkages specified / ongoing
Zambia	Adolescent Health Strategy 2017-2021	National Standards and Guidelines for Adolescent Friendly Health Services 2012 National Standards for Delivering HIV/SRH Peer Education 2010	National health strategic framework 2017 -2021 National AIDS strategic framework 2017 -2021 National school health policy 2017-2021 National Youth Policy 2015 Eight Year Integrated Family Planning Scale-up Plan 2013-2020	No data available
Zimbabwe	National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020	Standardised ASRH Training Manual 2016 National Guidelines on Clinical Adolescent and Youth Friendly Sexual and Reproductive Health Services Provision 2016	Life Skills, HIV/ AIDS and Sexuality Education Strategic Plan 2013-2015 National Youth Policy and Implementation Plan 2013 Girls Empowerment Framework 2015 Zimbabwe Family Planning Strategy 2016-2020	National ASRH Coordination Forum

In the case of Mauritius and Swaziland, ASRHR has been integrated with the national SRH policy, while South Sudan had a draft ASRH Strategic Plan 2016-2020 at the time of writing this report. AYFHS are to be integrated across all levels of the health sector in Angola, Mozambique, Rwanda and South Africa. Namibia has also integrated adolescent-friendly health services into primary healthcare.

Atenção Integral à Saúde de Adolescentes e Jovens 2016-2020 specifically refers to the training of health professionals to be respectful and welcoming of lesbian, gay, bisexual and transgender (LGBT) adolescents and young people without discrimination or judgment.

8.1 Country Definitions of Adolescents, Young People and AYFHS

The literature review and in-country studies that were done as part of this Assessment (refer to Methodology) found that the country-level definitions of adolescents and young people vary from adopting the WHO standard definition of adolescents being 10-19 years, young people being 10-24 years, and youth being 15-24 years (in Burundi, Comoros, DRC, Kenya, Mozambique, Rwanda, Tanzania and Zimbabwe) to extending the upper age limit of youth or young people up to 29 years (Ethiopia) and 35 years (Botswana, Mozambique, Rwanda, Swaziland, Tanzania and Zambia). It is important to note here that different policy documents define different age groups within the same country which is why Mozambique, Rwanda and Tanzania are cited as having the same definition as the WHO, as well as an extended definition. The Constitution in Mozambique considers adolescents and young people as those aged 10 to 35 years. However, the Geração Biz Programme (PGB) under the Ministry of Health defines them as 10-24 years. Similarly, in Rwanda, the National Youth Policy (2005) considers youth to be between 14 and 35 years of age, but the ASRHR Policy and Strategic Plan (2011-2015) classifies young people as 10-24 years. In Tanzania, the National Youth Policy defines youth as 15 to 35 years, which is consistent with the definition of the African Youth Charter, but the targeted age group for youth-friendly health services is 10-24 years. The fact that many countries focus attention on those aged 10-24 years is critically important since they often face stigma, discrimination and negative attitudes from health service providers when accessing services.

The definitions of AYFHS, on the other hand, are typically adapted from the standard WHO definition quoted in Chapter 5 (i.e., referring to services that are accessible, acceptable, affordable and appropriate to adolescents and young people, addressing their needs, and being non-judgemental and confidential).

Many of the national policies and guidelines adopted a rights-based framework for addressing adolescents and young people's SRH. These included Angola, Burundi, Comoros, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Rwanda, South Africa, South Sudan, Swaziland, Uganda and Zimbabwe. For example, the first guiding principle for the Kenya National Adolescent Sexual and Reproductive Health Policy 2015 is, *"respect for human rights...including...equality and freedom from discrimination..."* and its broad objectives include enhancing equitable access to ASRH information and services, as well as gender equity and equality. The Ethiopia National Adolescent and Youth Health Strategy 2016-2020 has 'rights-based approach' as its first guiding principle. Similarly, the Zimbabwe National Guidelines on Clinical Youth-Friendly Service Provision 2016 sets out guiding principles, one of which says: *"Service provision for adolescents and youth should be based on the understanding that sexual and reproductive health and rights are basic human rights and that every young person deserves to have a full range of sexual reproductive health services and to have their rights upheld."* The Mozambique Plano Estratégico do Programa Geração Biz 2014-2017 also has respect for human rights, sexual and reproductive rights among its principles, as does Burundi's *Stratégie Nationale Mutisectorielle de la Santé des Adolescent(e)s et des Jeunes 2015-2020*.

The South Africa National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014-2019 sets out the need for a strategy within the framework of SRHR as human rights. The Rwanda Adolescent Sexual and Reproductive Health and Rights Policy 2011-2015 is more specific in that it names diverse groups of adolescents and young people including young people living with HIV (YPLHIV), homeless youth, gay, lesbian and transgender youth, among others, recognising adolescents and young people as heterogeneous and ensuring that the unique needs of each group are met. The policy also has a whole section that posits ASRH as a right, based on several international agreements. Similarly, the Angola *Estratégia de*

Atenção Integral à Saúde de Adolescentes e Jovens 2016-2020 specifically refers to the training of health professionals to be respectful and welcoming of lesbian, gay, bisexual and transgender (LGBT) adolescents and young people without discrimination or judgment.

The Malawi National Youth Friendly Health Services Strategy 2015-2020 lays out young people's rights as recognised by the constitution and upheld by the strategy. The Swaziland Adolescent Sexual and Reproductive Health – Health Sector National Guidelines 2013 presents SRHR at the beginning of the document, and adolescents' right to information and services on SRH is one of the guiding principles. South Sudan has a draft Adolescence Sexual and Reproductive Health Strategic Plan 2016-2020 which specifies that the government recognises adolescents' reproductive health rights.

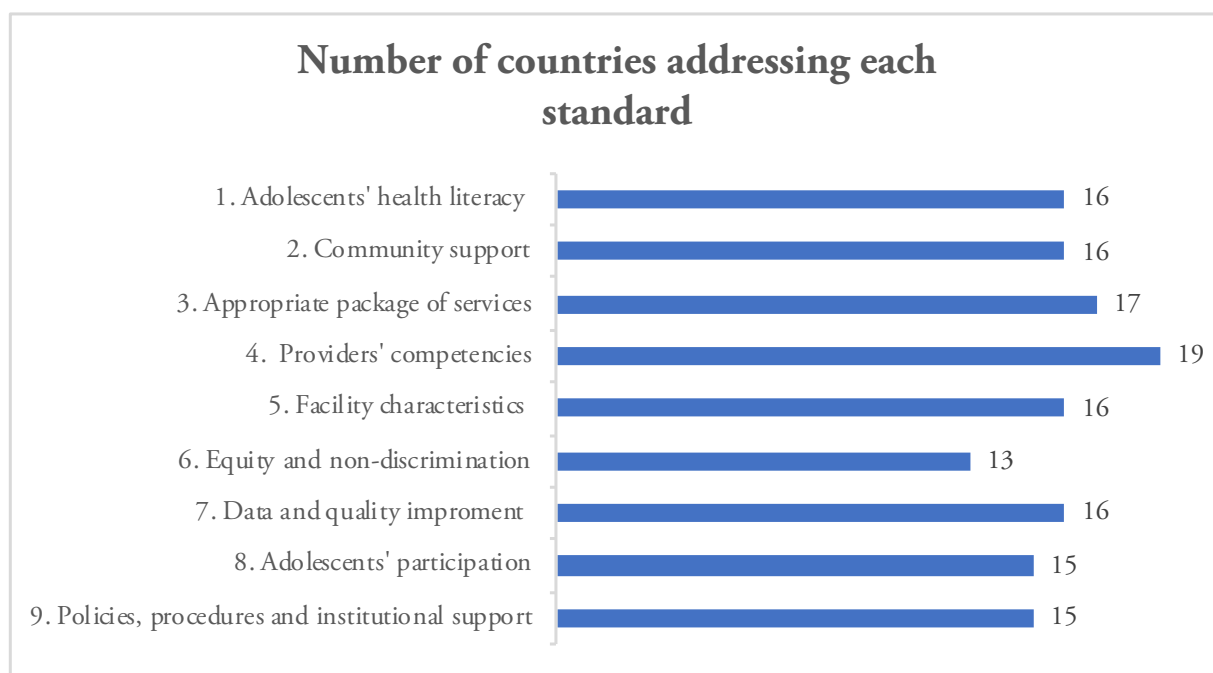
The policy documents on AYFHS of Comoros, Lesotho and Uganda also refer to observing or understanding adolescents' and young people's rights, when defining AYFHS or setting the vision for access to AYFHS. One of the policy objectives of the Uganda Adolescent Health Policy Guidelines and Service Standards 2011 is, "to protect and promote the rights of adolescents to health, education, information and care." Similarly, the guiding principles of this policy state: "Reproductive health services are a basic human right for all people including adolescents." The guiding principles of the Comoros National Strategy on Adolescent and Youth Health 2014 refers to compliance with the Convention on the Rights of the Child (1989) and the International Conference on Population Development (ICDP) commitments, and specifies adolescents' and young people's participation in all stages of the programme. Finally, the Lesotho National Adolescent Health Policy (2006) has an entire sub-section on 'Protection of health and development rights' under its chapter on 'Principles and Values underlying the National Adolescent Health Policy'.

8.2 Country Standards and/or Guidelines for AYFHS

Well-defined guidelines and/or standards for AYFHS delivery are available in 16 of 23 ESA countries (i.e., Botswana, Burundi, DRC, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda and Zambia). Namibia and Seychelles have draft guidelines, however, it is not clear whether these have been adopted yet. After the in-country research was concluded and regional analysis was being written, the governments of Angola and Zimbabwe released standards for AYFHS, which have been included in the analysis below. Zimbabwe had adopted all the nine standards used for this Assessment. South Sudan was found to be in the process of developing new standards and had a zero-draft version available. Thus, a total of 19 of 23 countries' standards have been analysed in Figure 11.

There were no guidelines or standards for delivering AYFHS found for 4 countries (i.e., Comoros, Eritrea, Mauritius and Seychelles). While guidelines from the 19 countries address most aspects of the 9 Standards being used for this Assessment, there are some areas that are not addressed by some countries.

Figure 11:



A summary review of how far each standard is addressed by different countries is provided below.

The standard on **adolescent health literacy** (Standard 1) is addressed by 16 of the 19 countries with clear standards. Botswana, Madagascar and Namibia do not have a specific standard on this. Zambia has mention of young people being made aware of the “*health and sexual reproductive health rights needs of adolescents and youth*”. The standard in the DRC, Malawi, Rwanda, Tanzania and Uganda emphasises that all adolescents should be able to obtain SRH information relevant to their needs, circumstances and development while in Burundi, Ethiopia and South Africa, the standard merely mentions information, education and communication (IEC) for behaviour change. In Mozambique, it indicates that adolescents should be provided with knowledge that can contribute to a more informed experience, more satisfying, more autonomous and thus more responsible sexuality. Lesotho only mentions that young people should be able to access information. Thus, the holistic nature of the Global Standard, aiming to ensure that adolescents and young people are knowledgeable on their own health and know how to obtain health services is not adequately addressed except to a certain extent by Kenya and to a large extent by Swaziland. Kenya mentions outreach, group discussions and peer-to-peer services, thus giving importance to the involvement of young people in information provision, as well as services. Swaziland actually mentions CSE and highlights that information is a right for adolescents which is not included in the AYFHS standards of the other countries. This is important because health literacy, accurate knowledge, and the efficacy to act on knowledge (all of which CSE seeks to address) are critical for adolescents’ empowerment and health-seeking behaviour.⁴

The standard on community support (Standard 2) is addressed by 16 of the 19 countries. Burundi, Malawi and South Africa do not have a specific standard addressing this. Those that do have a standard are mostly consistent in viewing community support as important for young people’s access to services, and engaging the community members in promoting, as well as monitoring health services. Namibia, Swaziland and Zambia explicitly mention the involvement of the community in implementation and/or management decision making of health services. Mozambique includes training of influential community members in advocacy and communication on ASRH.

The standard on the **appropriate package of services** (Standard 3) is addressed by 17 of the 19 countries, and they each define a package of services that should be provided to adolescents and young people. Angola and South Sudan do not have a standard to address this. The DRC, Kenya, Lesotho, Malawi, Swaziland and Uganda specify different service packages for the different levels / models of service delivery. These packages cover adolescent health and development needs, especially SRH.

The standard on **providers' competencies** (Standard 4) is addressed by all 19 countries referring to adequate competence, knowledge and training for the health service providers in addressing adolescent health and development. Botswana, Kenya, Madagascar and Mozambique refer to specific competencies in confidentiality, communication and respectful and non-judgemental attitudes, which as mentioned earlier when defining AYFHS are the key aspects of services that adolescents and young people identified as determinants for their access.

The standard on **facility characteristics** (Standard 5) is addressed by 16 of the 19 countries. Malawi, Rwanda and Tanzania do not have a specific standard on this. Those that do are mostly in line with what the Global WHO Standard prescribes around ensuring privacy and confidentiality, and having appropriate supplies, equipment, medicines, etc. in place. Some countries like Angola, Botswana, Kenya, Lesotho, Madagascar, Mozambique and Swaziland also put emphasis on convenient facility opening hours, location and access.

The standard on **equity and non-discrimination** (Standard 6) is addressed by 13 of the 19 countries. Those countries that address this standard refer mainly to ensuring that services provided to all adolescents and young people, are affordable (Madagascar) or free of charge (Mozambique), and serve both young women and men. Only the DRC, Kenya, Rwanda, Mozambique and Swaziland make specific reference to equity and non-discrimination, treating each client with equal care and respect, and/or providing services to disadvantaged groups. Ethiopia refers to providing services that give due attention to the rights of young people. Angola and Lesotho make specific mention of issues or groups of adolescents that may be regarded as contentious in several countries of the region, but are nevertheless important to address if a rights-based approach is taken towards adolescents and young people's health and development. The first standard in the Lesotho document mentions that all young people should have access to health services, *"including those who request abortion, mentally challenged, physically challenged, drug users, gays and lesbians, sex workers and very young adolescents."* Angola mentions prioritising and developing differentiated strategies for adolescents and young people who are sexually exploited, facing violence, sex workers, living with disability, living with HIV, and male adolescents. These are the only two countries where marginalised, under-served and vulnerable groups of young people have actually been named explicitly. Lesotho is the only country where the issue of access to abortion has been made unequivocal, despite provision of abortion being restricted to preserve the health of the woman and in cases of rape, incest, and foetal impairment.⁵⁶ Malawi, Namibia, South Africa, South Sudan, Tanzania and Zambia do not have a specific standard addressing any of these issues.

The standard on data and quality improvement (Standard 7) is addressed by 16 of the 19 countries. Botswana, Ethiopia and Kenya do not have a specific standard for this. Burundi, DRC, Malawi, South Africa, Tanzania and Uganda refer to having a management system in place. On the other hand, Lesotho, Madagascar, Namibia and Zambia specify quality improvement / assurance, supportive supervision and/or having tools and protocols in place. In fact, Lesotho and Malawi make special reference to the HMIS. Mozambique has a collection of data at various levels for evaluation of ASRH.

It also includes the promotion of regular operational research to assessment issues impacting ASRH. Rwanda and Swaziland expand on having a M&E system in place, with Swaziland specifying analysis of data disaggregated by age (i.e., 10-14 years and 15-19 years), and integration with the existing health sector monitoring system. None of the other country standards mention disaggregation.

The standard on **adolescents' participation** (Standard 8) is addressed by 15 of the 19 countries. Angola, Burundi, Malawi and South Africa do not have a specific standard on this. Botswana, DRC, Ethiopia, Madagascar and Swaziland mainly refer to adolescents' participation as being in design and implementation, including mobilisation for service access. Mozambique promotes adolescents' participation at policy and decision-making level, besides design and implementation of programmes designed for them. Kenya, Uganda and Zambia mention involvement of young people in evaluation of services and management decision making, and Namibia says they should be part of the Health Facility Committee. Lesotho also specifies that young people should be involved at all levels. However, only Rwanda views this as a right of adolescents and young people, and specifies their engagement at all levels (i.e., from conceptualisation to evaluation). This is important since young people's meaningful involvement in policies and programmes that affect their lives is not only a right as per Article 12 of the Convention on the Rights of the Child⁺⁺⁺ but also one that should be monitored and evaluated through specific policy and programme indicators.

The standard on **policies and procedures and institutional support** (Standard 9) is addressed by 15 of the 19 countries. Angola, Madagascar, Mozambique and Rwanda do not have a specific standard on this. Burundi, DRC, Kenya, Malawi, South Africa and Zambia specify that the policies and principles supporting young people's rights and standards / processes / procedures around AYFHS should be in place or available at health facilities. Botswana, Ethiopia and Swaziland are not as clear on this point, but mention what youth-friendly procedures should be, that young people should receive individualised care, and have an enabling environment. Namibia talks about having a multi-sectoral approach, while Tanzania and Uganda specify that adolescents and young people should be informed of their rights, and the same should be observed by health service providers. Only Lesotho mentions having financial plans in place for AYFHS under this standard.

As evident from the above discussion, there are different aspects of AYFHS that are viewed as the right of adolescents and young people by different countries. However, there is not a single country that has standards putting all of adolescents' and young people's rights in a holistic framework. There are several countries (i.e., Angola, Comoros, DRC, Mozambique, Swaziland and Tanzania) where the responsibility for providing comprehensive adolescent and youth-friendly services is shared by different ministries (i.e., those of education, health and youth, among others). However, coordination is often found to be inadequate and implementation of these policies, strategies and guidelines in several countries therefore, remains a challenge as described in the following section on the status of AYFHS.

⁺⁺⁺ "...children's views must be considered and taken into account in all matters affecting them, subject to the children's age and maturity"

8.3 Status of AYFHS from Literature Review and Key Informant Interviews

Nine of the 23 countries have scaled up AYFHS to varying success. These countries are Botswana, Burundi, Ethiopia, Lesotho, Malawi, Mozambique, Namibia, South Africa and Tanzania. The experiences of the Geração Biz Programme (PGB) in Mozambique and the National Adolescent Friendly Clinic Initiative (NAFCI) in South Africa are well documented, while Botswana, Malawi and Namibia have undergone recent assessments of AYFHS. Of the rest, 13 countries have AYFHS as pilots or small-scale projects, while there is no information available for Mauritius. The latest data on access to AYFHS is available from seven countries (i.e., Angola, Burundi, Kenya, South Sudan, Swaziland and Uganda), where 250,824 adolescents and young people accessed AYFHS in 2014 and 2015.¹⁷

Angola: Three provinces maintain youth-friendly services based on a 2000-2002 pilot by the Ministry of Youth and the Ministry of Education with UNICEF and UNFPA. A 2013 study by the Ministry of Youth on youth vulnerability of HIV highlights the inability of young people to access services due to lack of knowledge on the availability of services and location, as well as fears related to confidentiality and social discrimination.

Botswana: The Adolescent Sexual and Reproductive Health (ASRH) programme has been implemented since 2003 and ASRH services by both government and non-governmental youth-friendly centres are part of the general SRH structure. There have been annual assessments of the youth-friendly centres, which are sometimes dedicated spaces within health facilities, however the quality improvement interventions were not implemented consistently. A youth-friendly services project was implemented from 2000-2004 by Pathfinder International and UNFPA, which worked in 18 health facilities across 8 districts.

Burundi: The Ministry of Public Health has adopted an integrated approach to providing youth-friendly services through the health system in 2008; however, coverage remains weak, with only 10 targeted health centres integrating AYFHS, which amounts to 2.16% of the public health facilities. There are several challenges including the restricted opening hours, lack of trained personnel, equipment, and IEC materials. A 2014 baseline survey among young people, health service providers and community health workers by Swiss TPH also revealed that health workers reported low levels of confidence in addressing young people's SRH. Key informants said that the Ministry of Public Health does not have a specific budget line for the SRH of adolescents and young people. Nevertheless, the Ministry of Youth, Sports and Culture has budget lines geared towards the departments from three Directorates-General, namely the Directorate-General for Youth, the Directorate-General for Sport and the Directorate-General for Culture. Key informants also believe that the reasons for the absence of these budget lines are multiple including, lack of vision, inadequate funds, priorities directed elsewhere, and lack of people advocating for budget allocation for AYFHS.

Comoros: The Ministry of Health, in collaboration with NGOs and the financial and technical support of UNFPA, established four information and entertainment centres for young people, as well as a clinical centre each for young people on three islands in 2008-2010. All these structures are located in urban areas. A 2013 evaluation highlighted the lack of privacy, long waiting times, poor reception, cost of drugs and poor quality of services as barriers to AYFHS in public health centres. Despite the existence of a national policy on adolescent health, there is not budget allocation by the state towards the provision of AYFHS, as revealed by the key informants. While the government has adopted a multi-sectoral approach to AYFHS, and there are several actors and partners working on it, there is lack of a coordinating mechanism that can align all actors

around a single action plan. Most of the key informants highlighted that AYFHS required high-level commitment from government and stakeholders to raise adequate funds and coordination.

DRC: It is estimated that the coverage of AYFHS is at 17% with a wide disparity between provinces, as well as between urban and rural areas. Through the Programme National de Santé de l'Adolescent (PNSA) and its partners, a minimum package of youth-friendly services was integrated into 280 health facilities in 56 health zones as a pilot. The key informants tended to agree with the findings of the literature review (i.e., that the integration of AYFHS is low across the country): *"The PNSA must make an effort to speed up the integration process, because the majority of young people do not have access to quality services, especially those living in rural areas."* As recommended in the PNSA, the Ministry of Public Health has established a task force for the coordination of AYFHS integration efforts. However, key informants highlighted that this task force was not functioning as required since it had irregular meetings, there was verticalisation of certain actions, and almost total dependence on partner support.

Eritrea: Youth-friendly services are being provided by the National Union of Eritrean Youth and Students (NUEYS), as well as by the Ministry of Health. The Union has a total of 52 youth-friendly centres, 29 of these are in premises owned by the NUEYS and the other 23 are in rented premises. These are located in the six regions of the country, including in higher education institutions; however, they are not equally distributed. In addition, none of the centres provide a uniform set of services, and the ones providing health services focus mainly on voluntary counselling and testing (VCT), condom provision and IEC on reproductive health and STIs. The Ministry of Health has nine youth-friendly centres, three of which are fully functional and located in three major cities. The rest were equipped to be inaugurated and start services in early 2016. Thus, rather than improving the regular health services to be responsive to adolescents and young people and offer them services, the government of Eritrea seems to be focusing on stand-alone youth centres for AYFHS delivery.

Ethiopia: Since 2005, the Federal Ministry of Health (FMOH) and Pathfinder International in partnership integrated youth-friendly services in the public health system to 248 health facilities across six regions, including thirteen university campuses. However, there are significant regional variations in the health coverage of young people with a third of youth not yet being covered by reproductive health services, mainly vulnerable groups and rural youth.³⁶ According to 2015 assessment findings on adolescent and youth health by the FMOH,³⁷ despite the availability of guides and standards on AYFHS packages, services for adolescents are *"highly fragmented, poorly coordinated and uneven in quality"*. Services often remain unacceptable among young people due to *"perceived lack of respect, privacy and confidentiality,"* in addition to concerns of stigma, discrimination and bias or value judgment of healthcare providers. Most of the key informants noted challenges on the mainstreamed or integrated model of AYFHS, mentioning that it entails effective decentralisation, flexible budget utilisation, coordination, continuous staff capacity building trainings and adequate resource allocation. However, all the above factors appear difficult to be realized considering the existing bureaucratic system and budget shortage. One key informant said: *"I think it is difficult to say that the health centers offer quality youth-friendly services even in the health delivery points that are considered as best performers in the area. Due to not only absence of commitments from leaders and health service providers but also lack of skilled professionals, confidentiality, convenient infrastructure, budget and supplies all are hampering the quality of services for the young people."*

Kenya: 47 youth empowerment centres were established by the Ministry of Youth and Sports, providing a wide range of services including SRH, and only 11% of health facilities provided AYFHS in the country, according to

a 2011 review of adolescent and youth reproductive health programmes in the country. Interviews with key informants indicated a lack of budgetary allocation towards AYFHS both at the national and county levels of government: *“The national and county government do not have specific budget lines to enable them to provide youth-friendly services. There is generalized budgeting towards health, commodities, human resource and operating costs, and therefore there is no specific budget allocation towards youth-friendly services.”* Key informants also revealed that most of the health facilities in the country do not offer AYFHS, despite the government having guidelines on provision of a comprehensive package of health services to all young people: *“Currently in Kenya, it is estimated that on average about 12% of national health facilities provide youth-friendly services. That is a very huge gap at the national level. There could be many problems that are making this happen, one of which is lack of appreciation and understanding of youth-friendly services. Another one is non-investment in the form of resources, infrastructural problem including spacing in facilities, and health providers who are not trained about youth-friendly services in Kenya.”* Another key informant revealed, *“We don’t have a costed implementation plan. We only have one for family planning which has a section on adolescence but it doesn’t stipulate how the money is to be spent on adolescents.”*

Lesotho: Adolescent and youth health services are a part of the health delivery system since 1998; however, a 2008 study found that only 17 of the 23 adolescent health corners were functional. A 2015 situational analysis conducted by the Ministry of Health along with WHO, UNICEF and UNFPA found that the adolescent health corners were merged with other services due to lack of adequate staff. While the guidelines have been developed and aligned with international policies and guidelines, they have not been implemented as emphasised by one key informant; *“Yes, the national documents align with international standards specifically the sexual and reproductive health strategy. The only challenge is that it [the policy] will take time to be finalized and implemented.”* Besides lack of political will, key informants pointed out a lack of coordination as a barrier to the implementation of the AYFHS programme in Lesotho: *“There is lack of political will and poor coordination between health, education and youth ministries. The fragmentation of interventions, lack of ownership and leadership within these three ministries leads to failure of planned projects.”*

Madagascar: The Ministry of Youth and Recreation established eight pilot sites for the youth-friendly services network to ensure comprehensive youth services according to the website of the youth service programme. Maisons des Jeunes, which are youth-friendly centres, were established nationally. Out of the 40 that were established, only 20 are actually functional.⁴⁰ UNFPA and UNICEF are supporting the rehabilitation of the other Maisons des Jeunes. The Maisons des Jeunes provide education and training to adolescents and young people on sexuality and reproductive health, nutrition, violence, civic rights and culture, as well as environmental/conservation activities, recreational services and internet access.⁴¹

Malawi: The 2014 evaluation of youth-friendly health services in Malawi, funded by USAID in collaboration with the UN, reveals that the five government AYFHS standards are not being implemented consistently across SDPs. Though the youth-friendly health services (YFHS) programme has been in place since 2007, awareness and utilisation of YFHS was seen to be less than 50% among community members. While the percentage of adolescents and young people reporting ever had sex was 45.9% (females) and 54.50% (males), the ever use of YFHS by community survey respondents was only 12.6%.⁴²

Mauritius: There are two youth-friendly clinics in Port Louis and the University of Mauritius, but these have low uptake. In addition, the Ministry of Health conducts school health programmes.⁴³

Mozambique: The Geração Biz Programme (PGB), supported by UNFPA and other donors and implemented by ministries of health, education and youth, in collaboration with youth networks and NGOs, has been evaluated at least three times, the latest evaluation being in 2011-12, funded by the Danish International Development Agency (DANIDA). These evaluations have consistently found that the PGB addresses young people's health needs in an appropriate, affordable and acceptable manner. However, the involvement of young people remains a challenge as does nationwide scale up and expanding multi-sectoral linkages. In addition, a 2013 assessment on AYFHS by the Ministry of Health revealed that the services are partially functional or even non-existent in those health facilities that are not specifically designated as providing youth-friendly health services.⁴⁴

The programme has been expanded to the national level by the government in the last few years, but has faced challenges in scaling up as it required stronger foundation and capacity building in the new areas before the scale up to ensure quality. According to key stakeholders, the programmes currently implemented in Mozambique do not have sufficient support, compared to what they had in 1999-2009 under the PGB, in which SRH programmes for adolescents and young people had direct support from UNFPA, and participation of youth associations as implementers.

Namibia: Namibia conducted a situational analysis of adolescent-friendly health services in 2014, led by the Namibia Planned Parenthood Association and supported by WHO. This analysis found that while the minimum package of services as stipulated in the national standards were being provided, there was very minimal adolescent participation, especially in decision making, and privacy and confidentiality were not always maintained due to infrastructure. In addition, there were long waiting times, shortages and stock-outs of essential supplies, and inadequate knowledge among adolescents on SRH.⁴⁵

Rwanda: Assessments by the Ministry of Health and USAID in 2011, and UNFPA in 2012, have revealed that despite a large number of programmes in the country on ASRHR there is a lack of youth-friendly characteristics, and existing health services have largely ignored adolescents' reproductive health needs.^{46,47} Youth-Friendly centers are located in over 20 districts, and some of them provide a minimum package of services to meet the needs and expectations of adolescents and young people.

Seychelles: In 1995 the Ministry of Health established the Youth Health Centre (YHC) in the capital Victoria, which remains the main provider for ASRH in the country. Service provider attitudes are judgemental and parental consent laws pose barriers to accessing services for adolescents and young people.⁴⁸

South Africa: In South Africa, the Department of Health took over the National Adolescent Friendly Clinic Initiative (NAFCI) from LoveLife, an NGO, in 2006. It has been highlighted as a successful model for implementing AYFHS within a public health system by WHO in 2009. The most recent assessment of AYFHS conducted by UNICEF from 2014,⁴⁹ revealed that while SDPs were located in accessible places, their opening times were not seen as convenient by adolescents and young people. Similarly, educational materials were mostly available for adolescents, and there were outreach efforts to inform them of the services; however, health service providers were reported to be unfriendly, judgemental, and with unhelpful attitudes.

South Sudan: The Adventist Development and Relief Agency (ADRA) South Sudan, an NGO, is a partner of the Ministry of Health and has been providing youth-friendly services in Central Equatoria State since 2008. Also,

UNFPA is currently supporting two youth-friendly centres, as well as assisting the Ministry of Health to integrate AYFHS in six health facilities. These services were a pilot for AYFHS in the country and the finalisation of the ASRH Strategy is now awaited. There is a need for studies on ASRHR in South Sudan as there is a lack of adequate information on the situation of adolescents and young people's health and development issues.⁵⁰

Swaziland: At present, the country has 287 health facilities of which just above half of them reported to be providing youth-friendly health services.⁵¹ A 2015 assessment of ASRH by the Ministry of Health revealed that 59% of health facilities were located in rural areas, and while the location of health facilities and their opening times were mostly found to be convenient, only 15% health facilities had IEC material for young people, and young female clients were mainly dissatisfied due to long waiting times.⁵² Despite the emphasis on equity in the documents of Swaziland, young adolescents are denied SRH services unless they are accompanied by parents to provide informed consent. When asked whether young adolescents ages 10-14 years access SRH services, a key informant observed: *"They access [SRH] services at clinics but must be accompanied by their parents because they are still under their parents' care. Guidelines exist that prohibit young ones from consenting for medical services."* In general, while progress has been made towards the development and piloting of AYFHS policies and guidelines, several challenges exist, such as a slow implementation process, limited capacity for M&E of the programme and discrimination against young adolescents. A key informant summed up by saying, *"National policies are aligned to them [to international policies]. However, there is an issue with [regard to] policy implementation and monitoring in the country."*

Tanzania: According to the website of the Ministry of Health and Social Welfare of Tanzania, only 30% of SDPs meet the national standards for adolescent-friendly reproductive health services, and the attitudes of the health service providers are reported as barriers to access. There are also inadequate resources for AYFHS.

Uganda: While only 5% of health facilities were rated to be youth-friendly by the Ministry of Health in a 2007 study, in 2013, 59% of health facilities were found to be providing adolescent health services. However, only 37% health facilities had at least one staff trained in providing adolescent health services in the last two years.⁵³ In-depth interviews with key officials at the Ministry of Health confirmed that AYFHS should be implemented nationwide at district levels, at health centre IV (HCIV) and health centre III (HCIII); although not all health facilities have youth corners, some failing due to lack of funding while others due to lack of space. A few health facilities had been supported to implement AYFHS through support from UNFPA and the Uganda Red Cross Society. A 2015 Ministry of Health / UNICEF Rapid Assessment on Adolescent Health in Uganda showed that 85.7% of Regional Referral Hospitals, 59.4% of General Hospitals, 71% of HCIVs and 24.8% of HCIIIs were providing adolescent health services. Key informants highlighted disparity in resource allocation and management. Some District Health Officers indicated that the Ministry of Health did not send resources for AYFHS, and that the non-government health facilities independently raised additional AYFHS funds from potential donors, an arrangement that government health facilities cannot conduct without clearance from the parent ministry, which is a complex bureaucratic procedure.

Zambia: Some youth-friendly corners have been established in health facilities since 1996, on a pilot basis, providing a standard package of services. However, they function more as youth clubs and have not been expanded to other health facilities.⁵⁴ While guidelines exist, implementation is wanting due to a lack of political will to allocate funds to the AYFHS programme and ignorance of health service providers as

demonstrated by some key informants who said, “The country should start implementing policies and guidelines on AYFHS. The Government has not allocated enough resources for implementation of these documents. Again, there is no coordination between NGOs that work in the same area of AYFHS in Zambia.” Another key informant said, “There has not been a deliberate action by the ministry of health to prioritize AYFHS due to other competing needs.”

Zimbabwe: There are 27 functional youth centres and four youth interact centres which provide a basic package of services. Infrastructure and financial resources are inadequate, and there are no M&E processes to measure effectiveness and impact. However, collaboration and referrals with NGOs and community-based organisations (CBOs) is good.⁵⁵ Some key informants expressed that Zimbabwe did not have ASRH standards of its own, but has minimum requirements for ASRH service delivery. The guidelines were considered very general, not calling for action and “lacking in the tactical approach,” as expressed by one key informant. These shortcomings resulted in the failure to enforce implementation and develop an M&E framework for the ASRH programme according to key informants. Contrarily, some key informants felt that at the point of development, the guidelines on ASRH were in line with international guidelines, but required updating, and that resources were not forthcoming to fully implement the strategy. The poorly performing economy and dependency on donor support was blamed for lack of scale up and implementation of policies by some policy makers.

9. Assessment of Current Status of Adolescent and Youth-Friendly Health Services in the ESA Region

The findings from the in-country Assessment tools, including health facility observation, service provider interviews, exit interviews with young clients, and FGDs with adult outreach workers, peer educators and potential young clients in the community are presented in this chapter.

9.1 Background Characteristics

This section provides background information for the health facilities visited, and the people participating in interviews/exit interviews, FGDs or key informant interviews.

Health Facility Profile

The health facilities that were visited in the 12 countries are characterised in Table 5.

Table 5: Health Facilities Profile

Country	Ownership	Level	Location	Type	Total Number
Cluster 1					
DRC	Public = 29% Private = 29% Contracted ^{***} = 29% NGO = 14%	Hospital = 29% Health centre = 50% Youth centre = 21%	Urban = 93% Peri-urban = 7%	Stand-alone = 28% Integrated = 68%	14

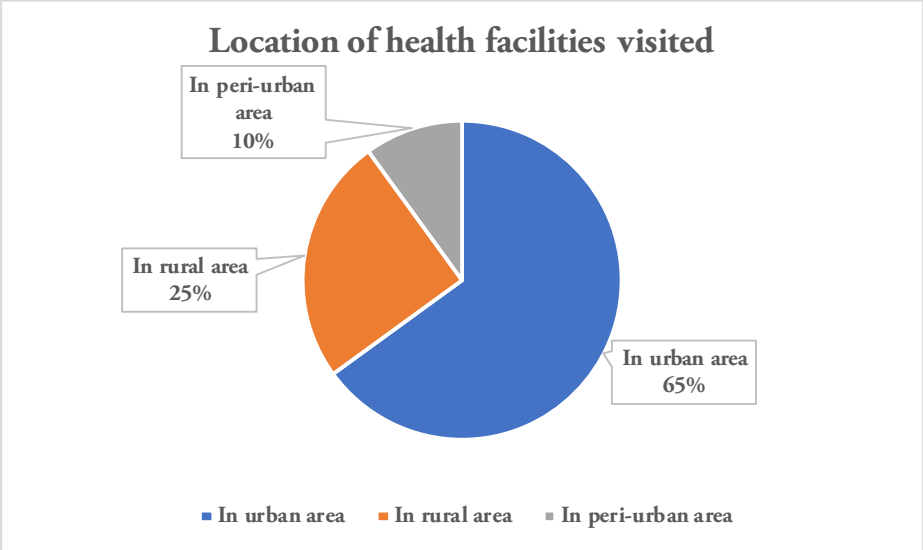
^{***} This means subsidised by religious institutions (catholic and protestant)

Country	Ownership	Level	Location	Type	Total Number
Ethiopia	Public = 64% (including 14% University-based) Private = 7% NGO = 29%	Primary = 21% Secondary = 64% Tertiary = 14%	Urban = 86% Semi-urban = 7% Rural = 7%	Stand-alone = 35% Integrated = 65%	14
Kenya	Public = 53% Private / NGO = 47%	Primary = 60% Secondary = 40%	Urban = 67% Peri-Urban = 6% Rural = 27%	Stand-alone = 47% Integrated = 53%	15
Mozambique	Public = 79% Private = 21%	Primary = 21% Secondary = 50% Tertiary = 29%	Urban = 42% Peri-urban = 29% Rural = 29%	Stand-alone = 21% Integrated = 79%	14
Uganda	Public = 71% Private = 29%	Primary = 36% Secondary = 57% Tertiary = 7%	Urban = 64% Rural = 36%	Stand-alone = 57% Integrated = 43%	14
Cluster 2					
Madagascar	Public = 67% Private = 33%	Secondary = 42% Tertiary = 58%	Urban = 92% Rural = 8%	Stand-alone = 8% Integrated = 92%	12
Zambia	Public = 78% Private = 22%	Primary = 93% Secondary = 7%	Urban = 86% Rural = 14%	Stand-alone = 20% Integrated = 80%	14
Zimbabwe	Public = 83% Private = 17%	Primary = 83% Secondary = 17%	Urban = 50% Rural = 50%	Youth centre = 33% Integrated = 67%	12
Cluster 3					
Burundi	Public = 30% Private = 70%	Primary = 100%	Urban = 30% Semi-urban = 20% Rural = 50%	Integrated = 100%	10
Comoros	Public = 38% Private = 63%	Secondary = 86% Tertiary = 14%	Urban = 71% Rural = 29%	Stand-alone = 63% Integrated = 38%	8
Lesotho	Public = 44% Private = 11% NGO = 22% Christian = 22%	Primary = 56% Secondary = 33% Tertiary = 11%	Urban = 50% Peri-Urban = 20% Rural = 30%	Defined adolescent health corners = 44% Semi-separate spaces = 22% Integrated = 22%	9
Swaziland	Public = 80% Private = 20%	Primary = 50% Secondary = 20% Tertiary = 30%	Urban = 40% Peri-urban = 20% Rural = 40%	Stand-alone = 20% Integrated = 80%	10
Total number of health facilities assessed					146

Except from the DRC, Burundi and Comoros, the majority of health facilities assessed in each country were government-run. In the DRC, the percentage of government, private and contracted health facilities that were visited were the same. In Burundi and Comoros, there were a significantly higher number of private health facilities visited. In the case of Comoros, this was because of the sheer lack of AYFHS in the country.

Sixty five per cent of all the health facilities visited across the different countries were located in urban areas with the exception of those in Burundi and Zimbabwe, where there were equal numbers of health facilities visited based in urban and rural areas (see Figure 12). Most of the health facilities were integrated within other health facilities except in Uganda (57%) and Comoros (63%), where the percentage of stand-alone health facilities for adolescents and young people visited exceeded those that were integrated.

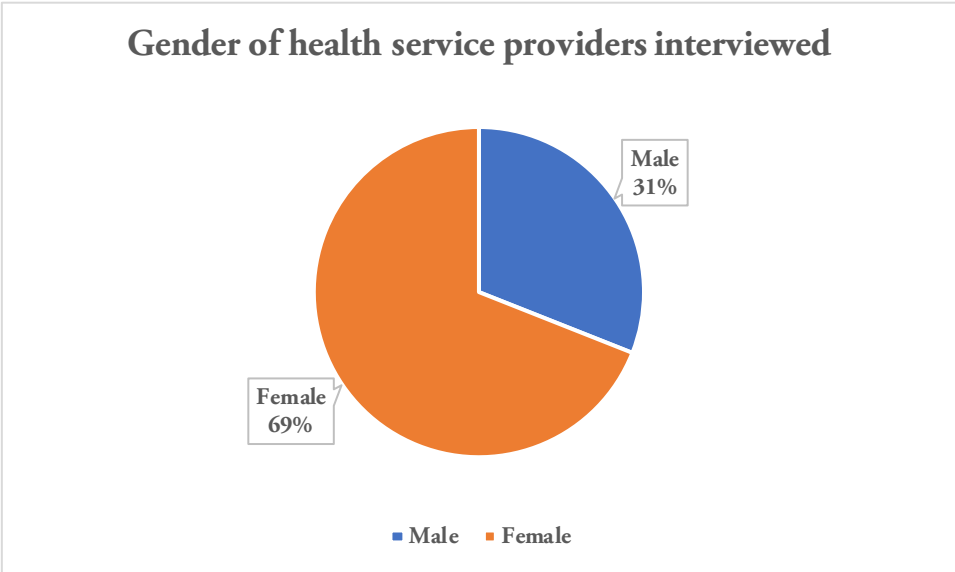
Figure 12:



Profile of Health Service Providers

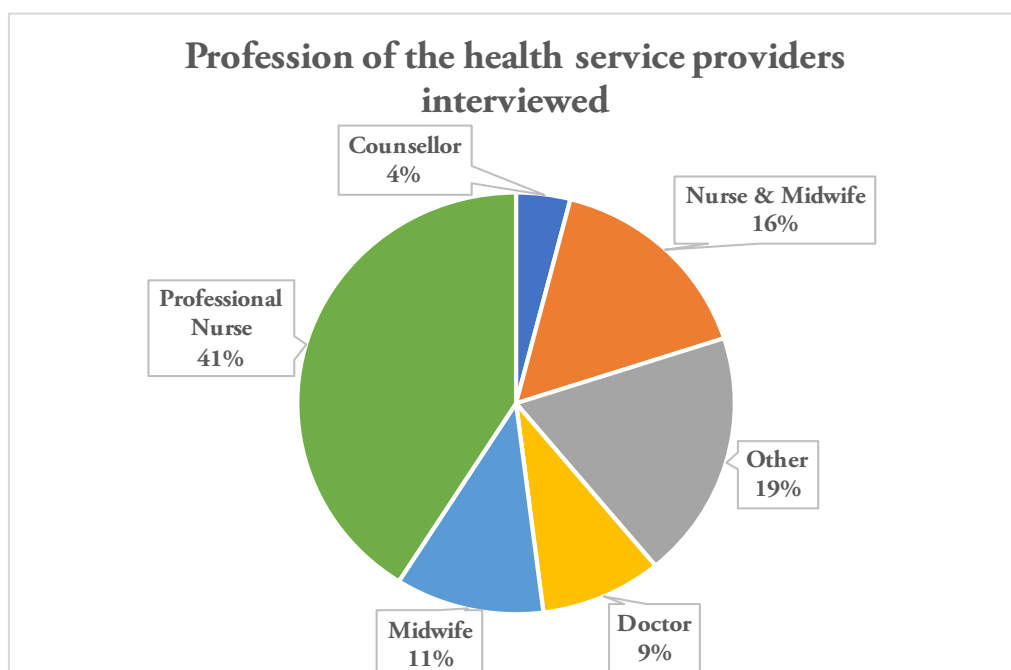
Most of the health service providers interviewed were female (see Figure 13). In Lesotho and Mozambique, 100% of the health service providers interviewed were female. Only in the DRC and Burundi were more male health service providers interviewed than female (i.e., 64% and 60% respectively).

Figure 13:



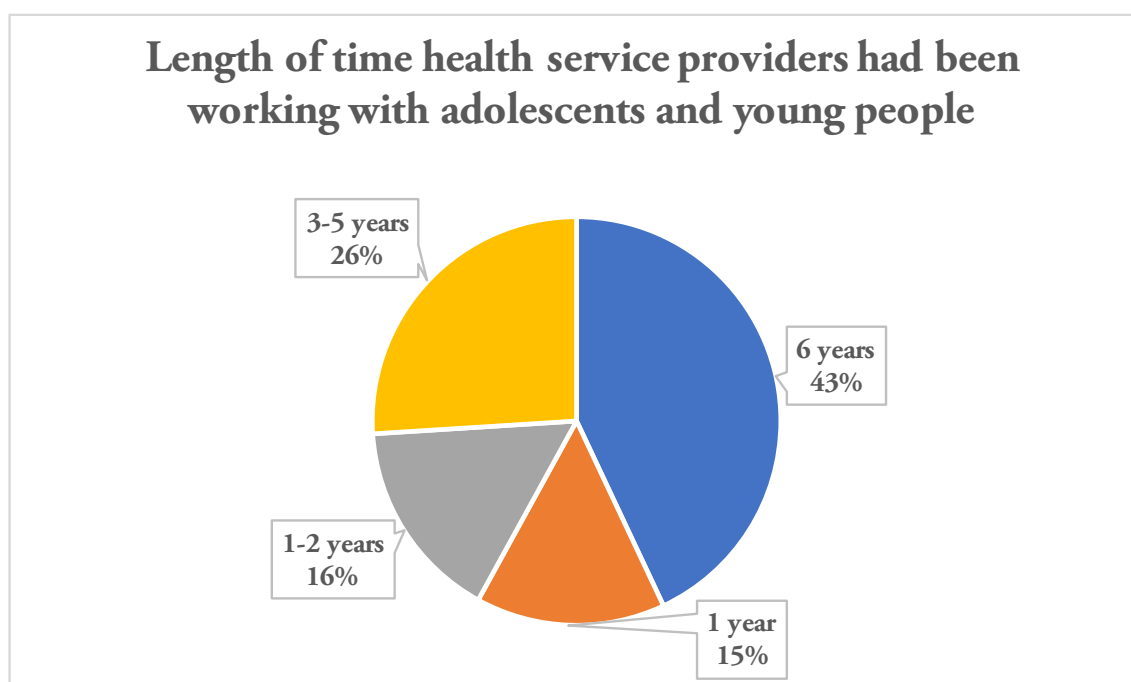
Most of the health service providers interviewed were professional nurses (see Figure 14). In Madagascar, 67% of the health service providers interviewed were doctors, while in Comoros 57% of them were midwives.

Figure 14:



Forty-three per cent of the health service providers interviewed said that they had been working with adolescents and/or young people for over 6 years, and 26% of them said between 3 and 5 years, signifying a good number of years of experience working with adolescents and young people (see Figure 15).

Figure 15:



Profile of Young Clients

The majority of clients who responded to the exit interviews were between the ages of 20-24 years (61%), while 39% were 15-19 years (see Figure 16). 71% of the young clients interviewed were female and only 29% were male (see Figure 17). The only exception was in Comoros, where more male clients (74%) were interviewed than female.

Figure 16:

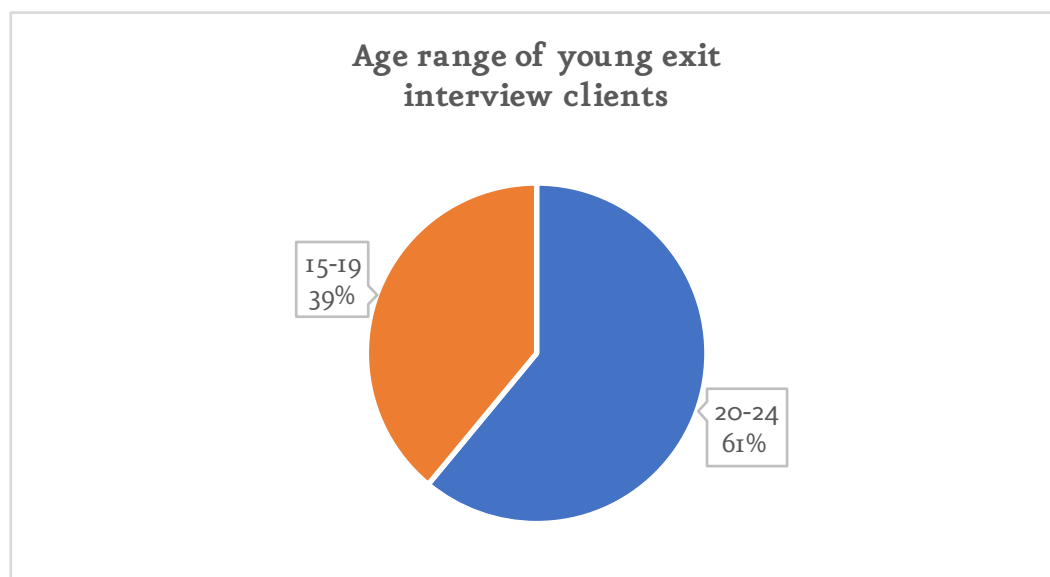
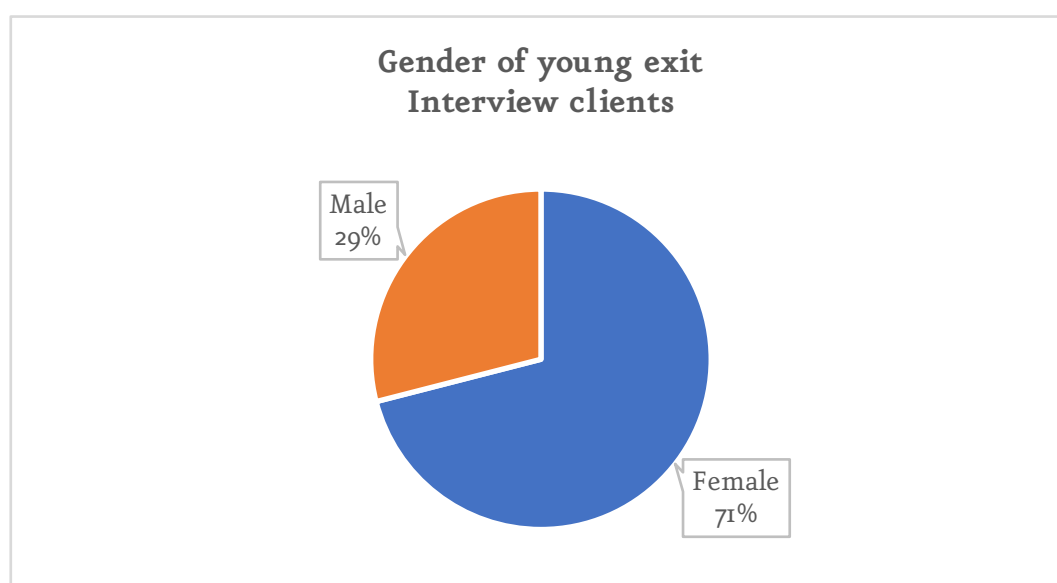


Figure 17:



Forty-eight per cent of the young exit clients were single and 23% were married (see Figure 18). There were more young clients who reported that their relationship status was 'dating' in Mozambique (50%) and Swaziland (45%), and married in Madagascar (41%). When asked about their living situation, 56% of the young clients interviewed after availing services said that they lived with parents or guardians. 28% said they lived with a partner and 10% lived alone (see Figure 19). Among those who said 'other' many (34%) were students from Ethiopia and Zimbabwe, living in university accommodation or off-campus with friends / roommates. Others said they lived with siblings, their children, grandparents, in-laws or friends. There were more young clients reporting living with their partners in Ethiopia (36%) than those saying they lived with their parents or guardians (28%), and the same in Madagascar (49% living with partners). 64% of the young clients interviewed said that they did not have any children (see Figure 20), and 74% were repeat clients.

Figure 18:

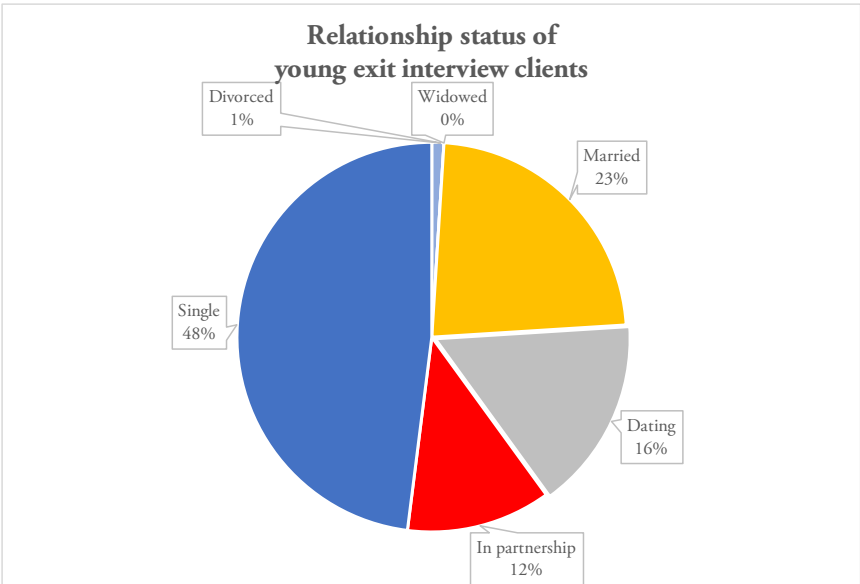


Figure 19:

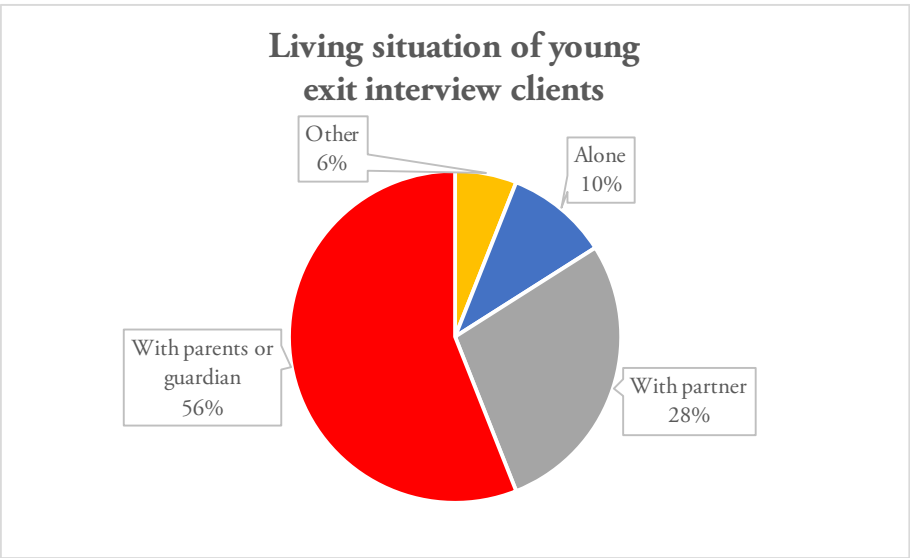
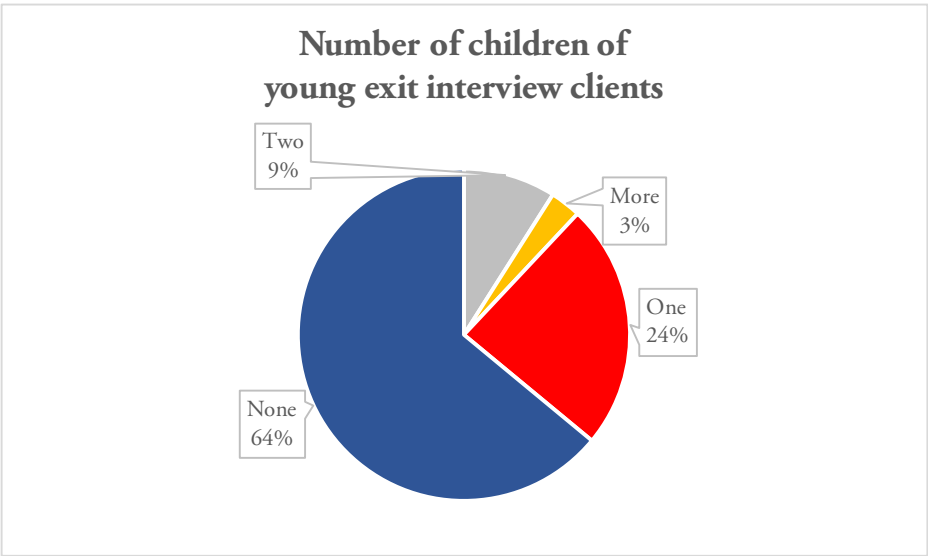


Figure 20:



The following sections present the findings and inferences per standard.

9.2 Standard 1: Adolescent Health Literacy

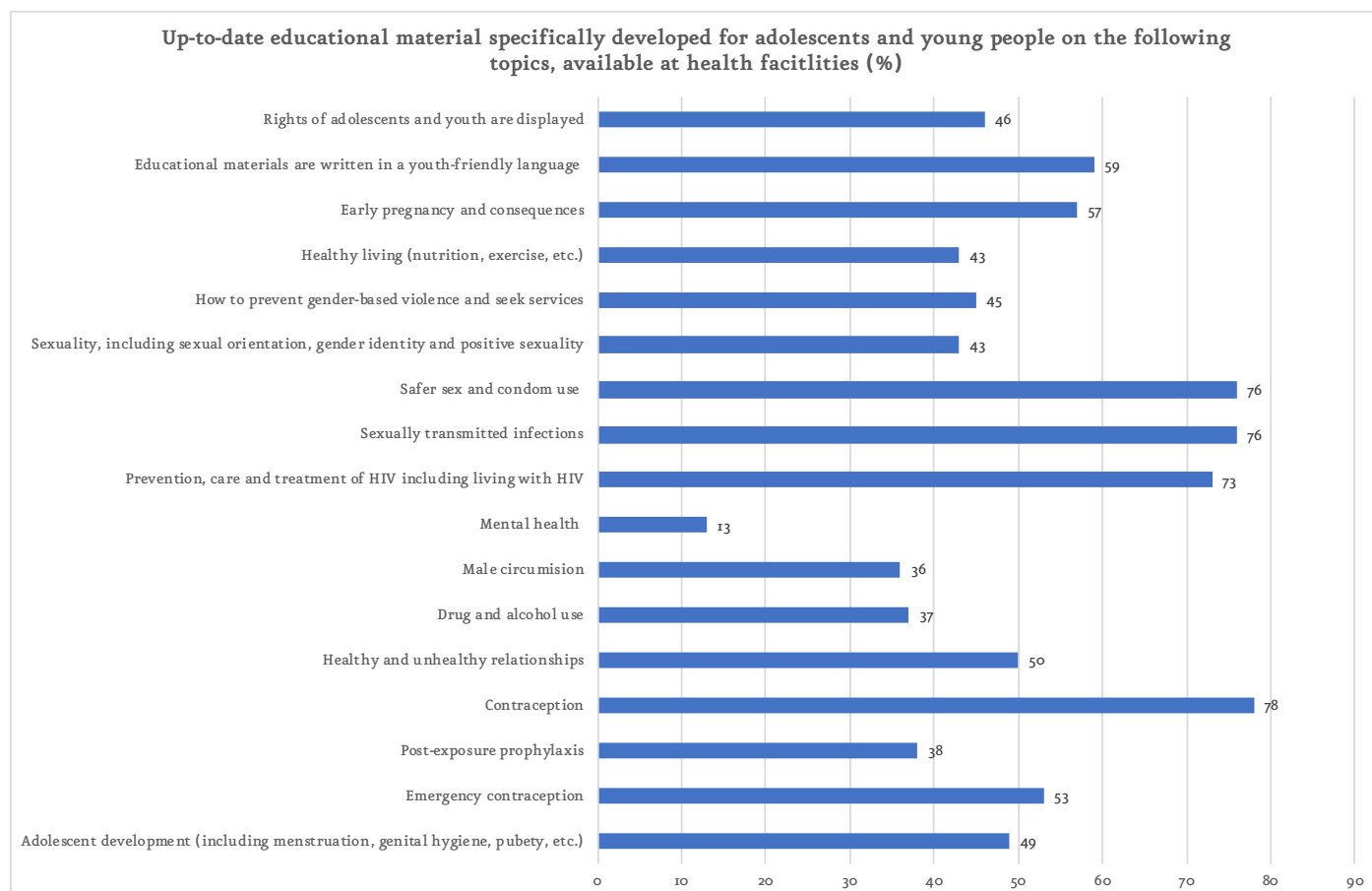
Under this standard, the in-country Assessments examined aspects related to convenience of the health facilities visited, signage, branding for AYFHS, source of information about the health facility for young clients, how the waiting time was utilised for health literacy (using IEC material, audio-visuals, health talks, peer education, etc.), plans for and implementation of outreach activities for adolescents and young people.

From the facility observation tool, the Assessment teams found that 92% of the health facilities that were included in the Assessments across the region were conveniently located and easy to reach. 70% of all the health facilities visited were reported to be signposted from the main road and 78% had visible signboards. 91% were within walking distance of a public transport hub. 83% of all the health facilities visited had clean surroundings and a welcoming environment.

With regard to operating hours, only 45% of all the health facilities visited mentioned them on the signboard, and only 27% of all health facilities visited mentioned specific operating hours for adolescents and young people. Only 47% of all health facilities visited were branded to show AYFHS, and only 34% of all health facilities had a separate brand name for AYFHS. On the other hand, 62% of all the health facilities visited included 'family planning' in the brand name, and 51% had a logo that showed the picture of a family.

Figure 21 shows the materials on display (i.e., posters, brochures, leaflets, etc.), specifically targeting adolescents and young people, in the health facilities visited.

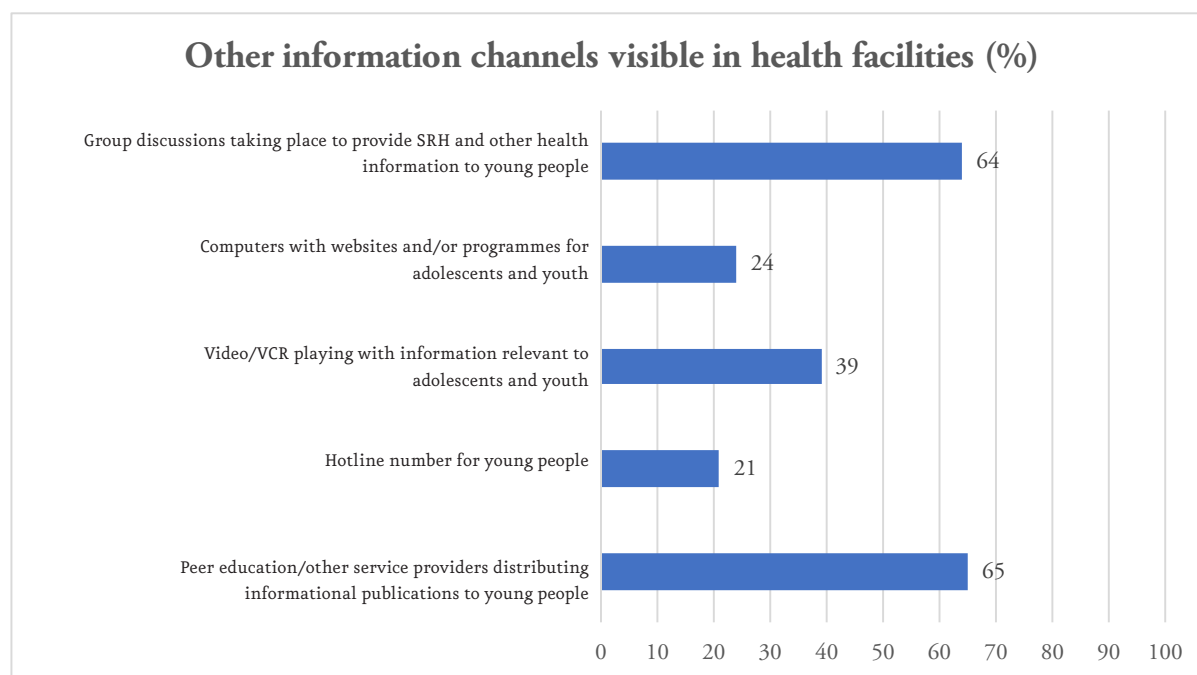
Figure 21:



Most health facilities visited (78%) had educational materials available on contraception, followed by materials on STIs, and safer sex and condom use (76%). The smallest percentage of health facilities had materials on mental health (13%), male circumcision (36%), drug and alcohol use (37%), and PEP (38%). This is significant considering that more of the health facilities visited were integrated health facilities rather than stand-alone services focused only on SRH.

Other information channels observed in the health facilities are shown in Figure 22.

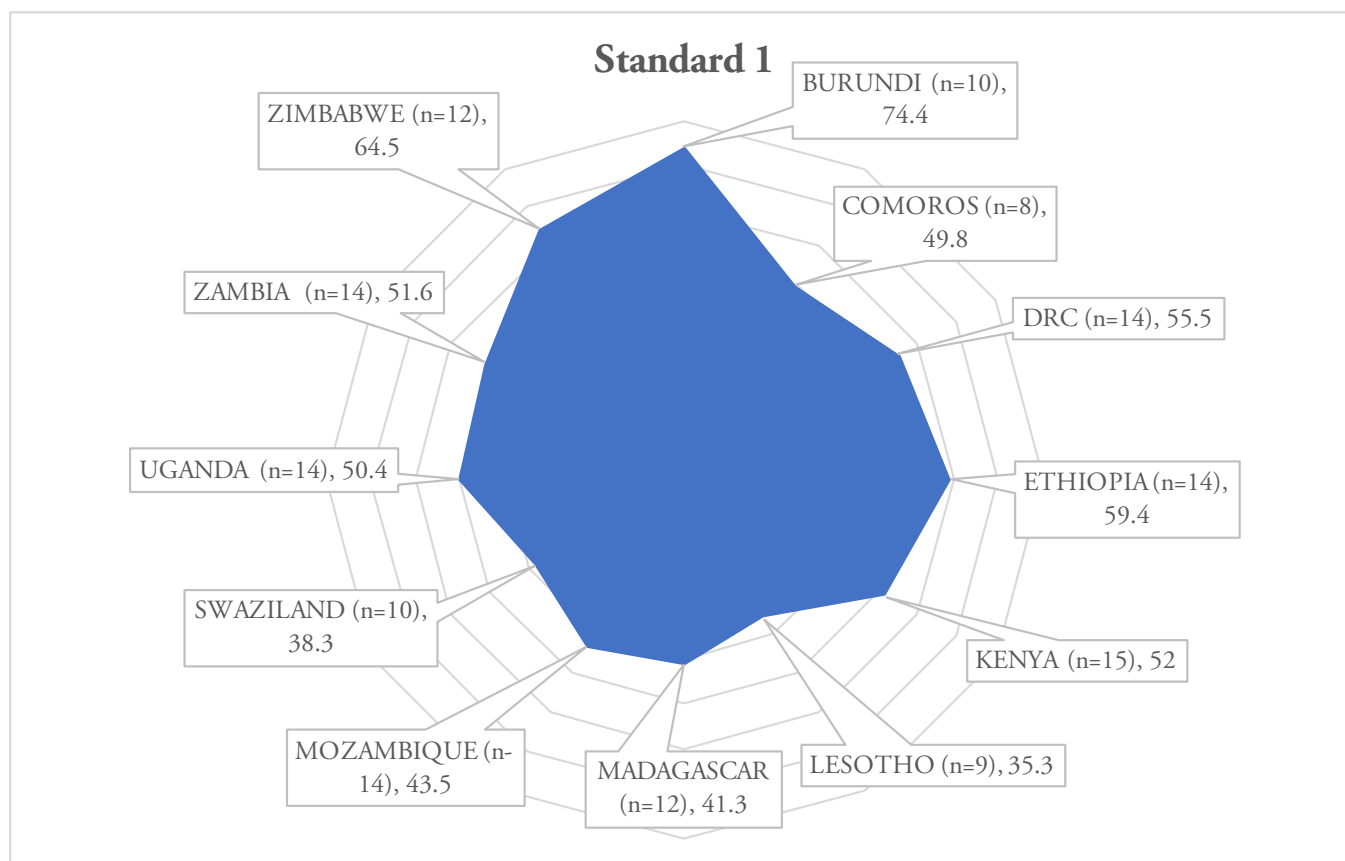
Figure 22:



Sixty-five per cent of all the health facilities visited had peer educators or other providers distributing informational publications to adolescents and young people, and 64% of all the health facilities visited had group discussions taking place to provide SRH and other health information to adolescents and young people. Only 21% of all the health facilities visited had hotline numbers for adolescents and young people displayed, while 24% of all health facilities had computers that linked to websites and/or programmes on SRHR for adolescents and young people.

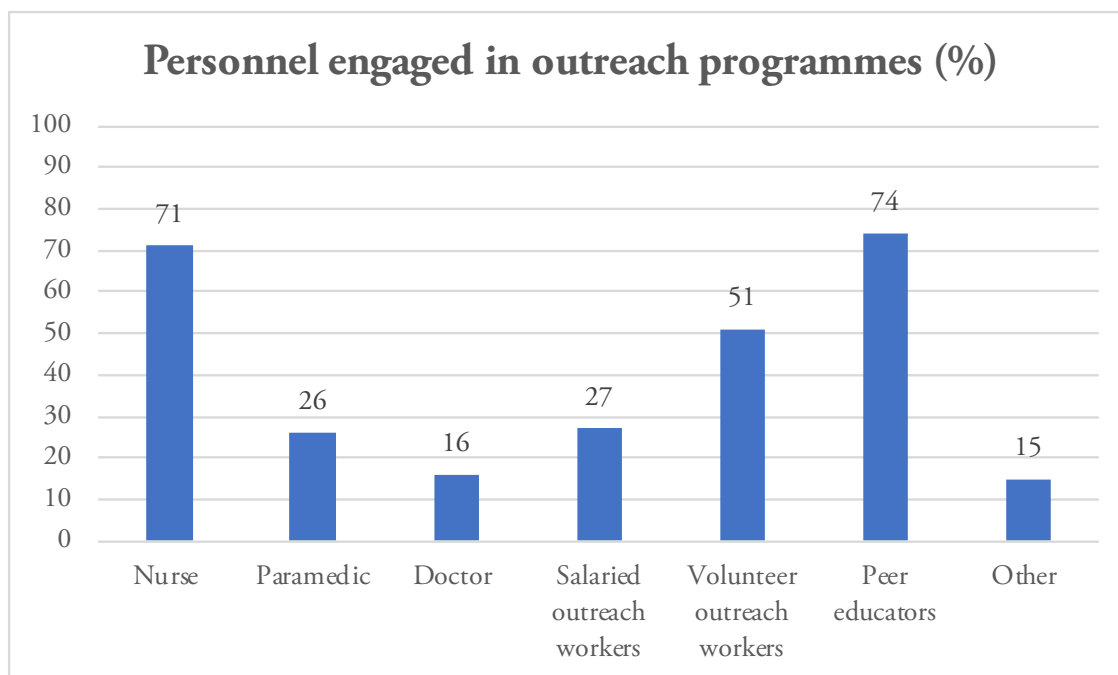
Figure 23 demonstrates how countries compared with each other on Standard 1 when looking at the data from the facility observation tool. Burundi showed the best performance, followed by Zimbabwe and Ethiopia, while Lesotho, Swaziland and Madagascar showed the least compliance. In Madagascar and Zambia, there is no standard addressing adolescents' health literacy, and Madagascar has scored low on this standard on the facility observation tool.

Figure 23: Results for Standard 1



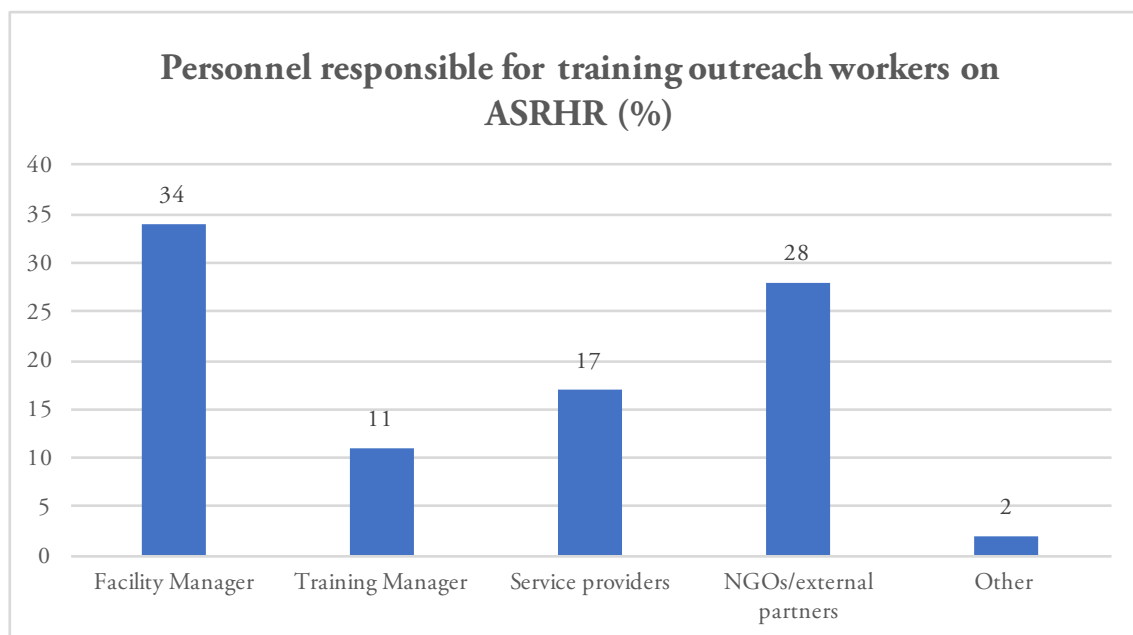
The health service providers were asked whether they offered an outreach programme for adolescents and young people from the health facility, and 60% of all health service providers interviewed said they did. All the providers in Zimbabwe affirmed this, while the least number of health service providers who confirmed that such a programme was in place was in Ethiopia at 36% (5 of 14). As can be seen in Figure 24, 74% of the health service providers interviewed reported that peer educators were engaged in the outreach programme, and 71% reported that nurses were engaged.

Figure 24:



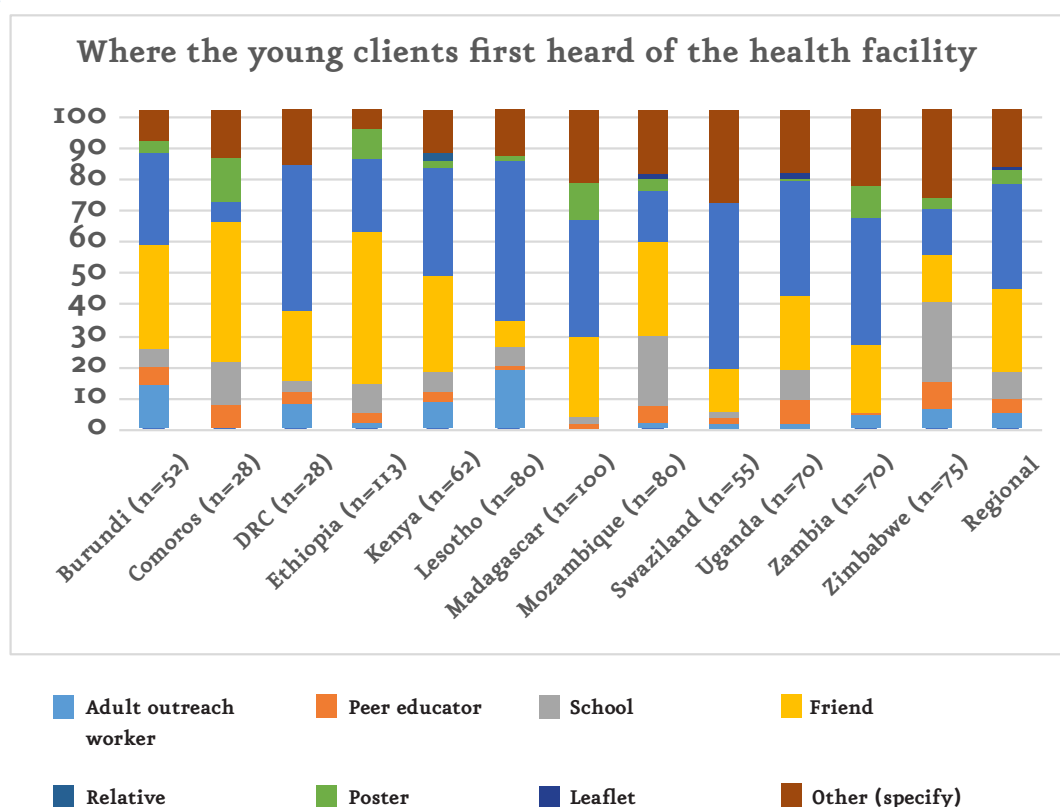
It was found that the health facility manager was most often reported to be responsible for the training of outreach workers on ASRHR, with 34% of all health service providers interviewed reporting this, followed by 28% reporting that such training was carried out by NGOs or external partners (see Figure 25).

Figure 25:



When asked where the young clients first heard of the health facility they were attending, 33% said through relatives and 26% through friends. Fewer young clients reported school (9%), adult outreach workers (5%) and peer educators (4%) as the source for information about the health facility. Those saying 'other' said they had heard of the health facility through referral from other health facilities, they lived in the area where the facility was located, they had seen the health facility in their neighbourhood or had local knowledge of the health facility, or through church announcements (see Figure 26).

Figure 26:



Exceptions from these findings were in Zimbabwe, where the most common source of information is from school, and in Mozambique, where 'school' was the second most common source of information after 'friend'. Interestingly, posters and leaflets are seen as the least common source of information on the health facility.

Adult outreach workers and peer educators do not seem to play a major role in informing adolescents and young people about the health facilities in most of the countries assessed. One explanation for this could be the limited attention to outreach programming for adolescents and young people as reported above and confirmed by responses from young people. For example, in FGDs in Zimbabwe, the peer educators and community workers alike reported lack of basic or refresher training, which resulted in a lack of confidence in discussing SRHR issues with adolescents and young people. Some extension workers professed ignorance in dealing with adolescents and young people, while one said, "I fear they may ask me difficult and hypothetical questions to expose my limited knowledge as they read too much." They perceived adolescents and young people to have more information than them, and thus avoided engaging with adolescents and young people. This was also seen in Burundi. Similarly, outreach workers and peer educators in Comoros also said, "We occasionally receive awareness sessions about 3 times a year, and this does not allow us to provide the entire population of young people with information focusing on adolescent sexual and reproductive health."

A potential young client in an FGD in Zambia said: "We don't really have in-depth knowledge on SRH issues. Unfortunately, we don't know what to do or who to talk to about our challenges," young people do not know who they can get health information from. Similarly, although providers of youth and adult community health services in the DRC reported promoting their health facilities, the majority of young potential clients did not know about these health facilities. A potential young client living in the vicinity of one of the health facilities visited said, "I see the centre just in passing, I often see people of all ages attend when they get sick, I do not think that this centre is for us young people, and I fear that I will be pointed out..."

FGDs with health extension workers (HEWs) in Ethiopia revealed that they did not reach adolescents and young people as this did not fall within their focus on ‘national health priorities’ which were child and mother’s health, tuberculosis (TB), personal hygiene and sanitation. While most of the HEWs and peer educators do supply condoms to adolescents and young people including vulnerable groups like sex workers and street youth, the HEWs do not target adolescents and young people with health services. The peer educators in Ethiopia cited lack of adequate and up-to-date teaching aids due to inadequate budget allocation as reasons for limited outreach activities. In Swaziland, only two of the health facilities visited had a peer education programme in place. In Lesotho as well, there are limited programmes to ensure efficient and effective transmission of SRH information to adolescents and young people. A peer educator said, *“They [the youth] have no IEC materials to provide comprehensive information on topics of concern to them. The television is available in the waiting room, but the walls have no information for youth to read and be informed.”*

In Zimbabwe, while youth corners and centres had four peer educators, more than the minimum two trained ‘peer counsellors’ specified in the national strategy, some of these peer educators were operating without standardised training, and a health service provider revealed that the peer educator recruitment was not done according to procedure. One of the reasons given for this by the service provider was that there was no strategy for handling peer educators that aged out (i.e., crossed the age of 24 years). They were simply asked to stop providing services without having recruited and trained new people. This was combined with limited resources for training. In some cases, trained peer educators continued to operate in the health facilities even after they aged out, indicating lack of other opportunities for them, including linkages with employment.

In Burundi, the capacity of peer educators seemed higher than in other countries as evidenced by qualitative data from the peer educators that revealed that they knew about adolescents’ and young people’s rights and entitlements (e.g., the legal age of marriage, children’s right to health, education and information, etc.). They also said that there was no policy in the country that prevented adolescents and young people from attending health training, but cited cultural restrictions to adolescents’ and young people’s access to sexual health information.

When asked whether they had noticed any signboard in a language they understood mentioning the operating hours of the health facility, 49% of all the young clients interviewed responded in the affirmative. This resonates with the findings from the facility observation tool where only 45% of the health facilities visited had a signboard mentioning the operating hours of the health facility. The maximum clients responding ‘yes’ to this were from Zimbabwe (79%) and the DRC (71%). The least percentage of clients responding ‘yes’ to this were from Lesotho (27%), Mozambique (28%) and Swaziland (29%).

The waiting time was utilised by the young clients in different ways at the different health facilities as shown in Table 6.

Table 6: Utilisation of Waiting Time by Young Clients

Country	Talk to other clients / friends / accompanying person	Watch an educational video	Listen to health talks	Read educational materials	Other (expanded in footnotes)
Regional	49%	10%	5%	18%	33%
Burundi	45%	29%	20%	4%	20% ¹
Comoros	63%	0%	0%	48%	4%
DRC	30%	14%	15%	28%	50% ²
Ethiopia	62%	11%	0%	31%	16%
Kenya	19%	12%	4%	19%	48% ³
Lesotho	77%	21%	10%	13%	6%
Madagascar	60%	3%	5%	9%	35% ⁴
Mozambique	54%	6%	1%	18%	29% ⁵
Swaziland	37%	4%	4%	8%	48% ⁶
Uganda	60%	7%	0%	23%	26% ⁷
Zambia	55%	3%	2%	6%	42% ⁸
Zimbabwe	49%	8%	1%	16%	45% ⁹

The table above reveals that most clients (49% interviewed) spent their time in the waiting area talking to other clients / friends / accompanying persons, ‘doing nothing’, and/or being on the phone / social networking (33%).

Many young clients reported spending time on their phone or social network sites, a channel for information that could be explored as an option for providing health information within and outside the health facilities (e.g., with information posters that encourage viewers to scan a QR code and get more information or be directed to a site that gives more information or enabling Bluetooth transfer of information to clients in the clinic). This strategy to use social media was also highlighted in FGDs with adult outreach workers and peer educators in Kenya, “Using the social media platform has been good and the results have been positive. You find that after treatment, somebody makes a comment on social media...well I went here and I got this service and it was very nice.”

The young clients were also asked if there was any educational material at the health facility, to which 62% of all young clients interviewed responded ‘yes’, with the maximum being in Comoros (93%), Uganda (84%) and Zimbabwe (80%). The smallest percentage of young clients confirming that there was any educational material at the health facility was in Madagascar at 37%. Of the 62% clients who said there was educational material at the health facility, 95% said that it was easy to understand.

¹ waiting for their turn, nothing, playing on their telephone

² doing nothing

³ didn't have to wait, on the phone, watching TV, nothing, playing with or breast-feeding child

⁴ just sat and waited

⁵ did nothing, on the phone, watched TV

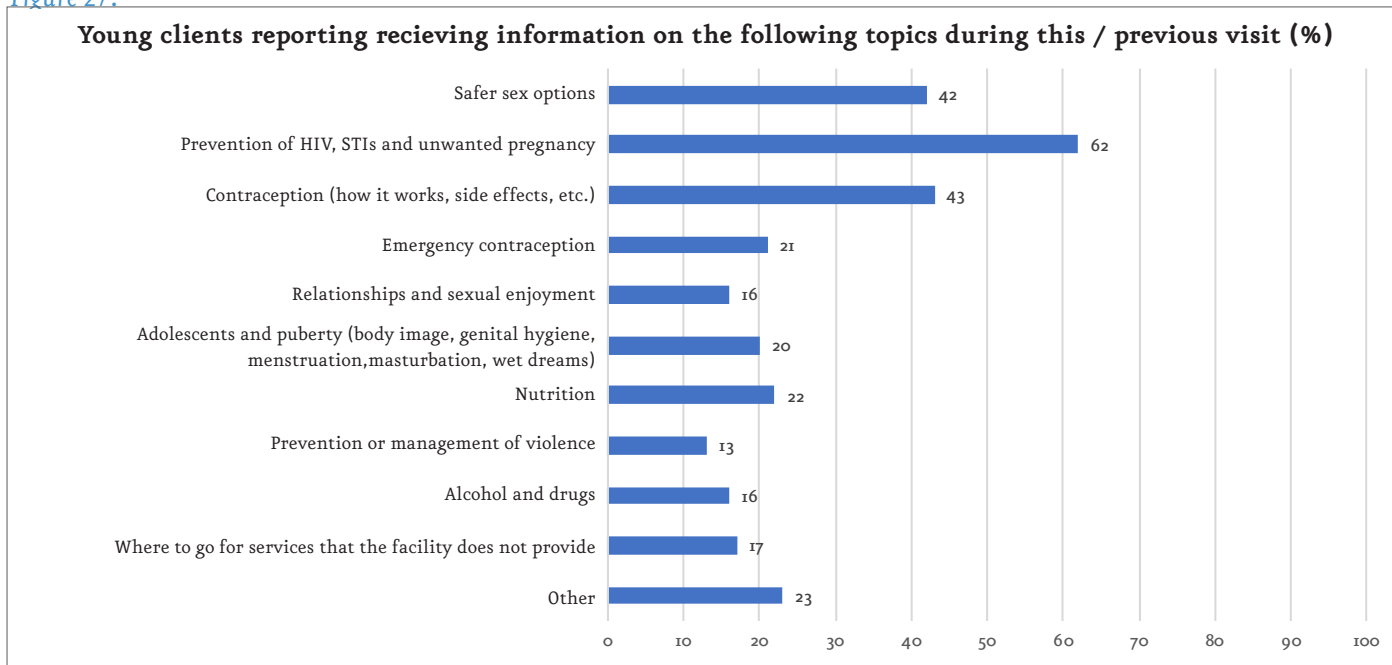
⁶ doing nothing, social networking

⁷ walking around the facility, playing board games, watching TV, playing with their phone, doing nothing

⁸ did nothing, was on the phone

The young clients were asked if they had received information on several different topics during this visit or a previous visit (see Figure 27). 62% reported receiving information on prevention of HIV, STIs and unwanted pregnancy. The young clients reported receiving information on prevention or management of violence (13%). Most of the 23% of client who said 'other' specified that they had not received any additional information.

Figure 27:



Potential clients in FGDs in Zimbabwe said that they would prefer to get ASRH information from parents or aunts as this would save the time and cost involved in accessing youth centres. In one focus group with young people living with disabilities in Zimbabwe, it was revealed that they felt there was “*nothing for them at the AYFHS facilities*” (i.e., that the health facilities were either not meant for them or that their specific needs were unlikely to be met there). In similar focus groups in Ethiopia, it was revealed that the adolescents and young people had limited knowledge on where to get relevant information and services, including on policies and regulations. On the other hand, in Swaziland, potential clients said that they used services located further away from their homes because they were worried about breaches in confidentiality. They knew some of the peer educators or nurses who worked in the health facilities located near them, and were thus reluctant to use these.

Potential young clients in Mozambique revealed that if they wanted information on health or relationships or sexuality, they would go to people closest to them, and who had more life experience than them.

The young exit clients were asked whether they would recommend the health facility to family and friends, and 92% of interviewed said they would. Thus, it can be concluded that these young clients are trusting of the services and likely to access services again. On the other hand, those young people who had not used the services, but were within the catchment area of the services, revealed through the FGDs that they either did not know that the services were for them, or did not trust that the services would provide them with privacy, confidentiality, respect, or quality services. Hence, outreach programmes to reach adolescents and young people even before they need services, so that they know where they are and believe they are for them.

Summary and Discussion

Despite the availability of educational materials in a large number of the health facilities visited, the young clients were mainly talking to other waiting clients, or spending time on their phones, and/or doing nothing. For example, while 76% of the health facilities visited had educational materials on safer sex and condom use, only 42% of young clients interviewed said they had received information on safer sex during this or previous visits. Similarly, only 43% young clients reported receiving information on contraception, even though 78% of health facilities visited had educational materials on contraception. Thus, reinforcing that having educational materials at the health facility may not be the most effective way to transmit knowledge to young clients.

There was some amount of consistency on the findings on peer education programmes, between the facility observation tool and the health service provider interview. 65% of the health facilities visited were observed to have peer educators or other providers distributing informational publications to adolescents and young people, and 74% of health service providers reported that peer educators are involved in outreach programmes. However, most of the young clients interviewed did not quote the peer educators or the outreach workers as their source of information about the health facility. In addition, there was confusion and lack of adequate information and trust among potential clients about the health facilities. Considering that most clients spent their waiting time talking to each other, having peer educators available to talk to clients, may be another good strategy for information dissemination. This suggests that there is a need to put in place targeted outreach plans for adult outreach workers to focus on adolescents and young people, while investing in continuous recruitment, training and mentorships of both adult outreach workers and peer educators to ensure their confidence in addressing adolescent sexuality. Using social media and smartphones to target adolescents and young people with information about ASRHR is also a strategy worth exploring.

9.3 Standard 2: Community Support

This standard focused on systems of engagement with parents, guardians and community members, including organisations, to support the provision and utilisation of health services for adolescents and young people, including referrals. It examined the modes of engagement with, and feedback from, the community, as well as any evidence of outreach activities targeting parents, schools and community structures. Providers and clients were asked about the support or lack thereof by parents / guardians in accessing health services. The FGDs also focused on community perceptions of young people's access to health, especially SRH services.

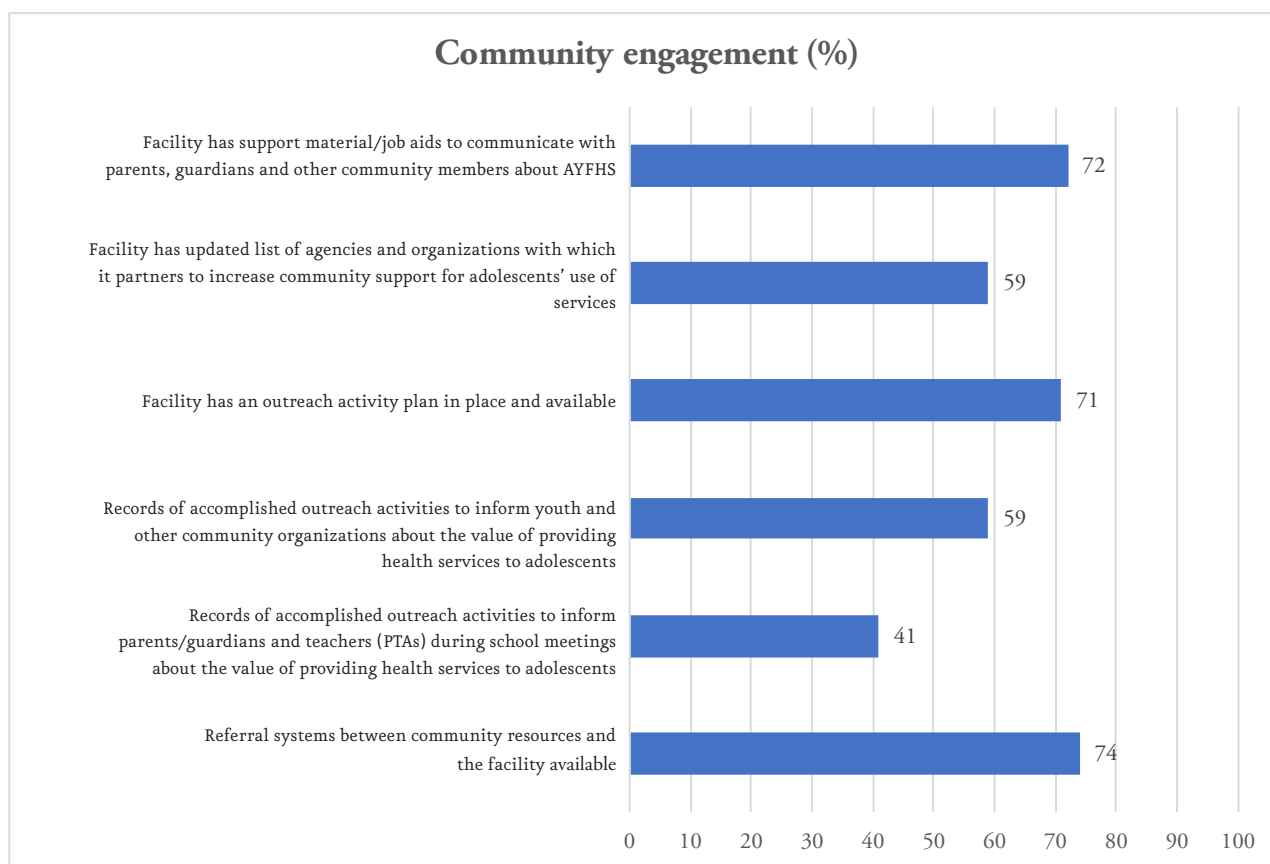
While 71% of health facilities visited had an outreach activity plan in place:

- Only 59% of the health facilities had records of accomplished outreach activities to adolescents and young people and other community organisations about the value of providing health services to adolescents and young people.
- Only 41% of the health facilities had records of accomplished outreach activities to inform parents/guardians and teachers during school meetings about the value of providing health services to adolescents and young people.

Seventy four per cent of health facilities observed had referral systems between the health facility and community resources (e.g., legal, psycho-social, and/or rehabilitative services, schools, youth centres and other levels of care health facilities), and 72% of health facilities visited had support materials or job aids to communicate with parents/guardians and other community members and organisations (including youth-led organisations) about the value of providing health services to adolescents and young people. However, only

59% of health facilities visited had an updated list of agencies and organisations with which it partnered to increase community support for adolescents' use of health services (see Figure 28).

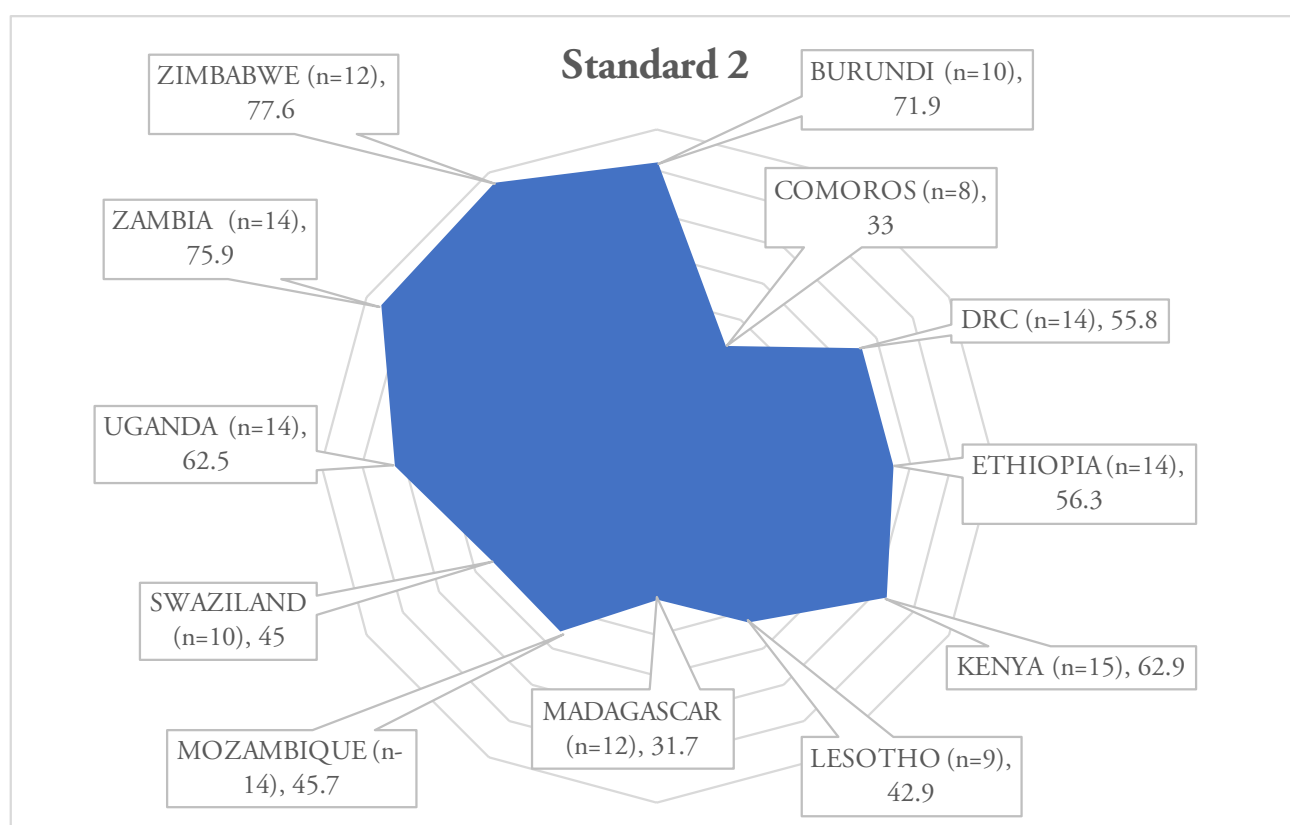
Figure 28:



Records of outreach activities actually undertaken to inform adolescents and young people and other community organisations about the value of providing health services to adolescents and young people were found in all the health facilities in Zambia, 83% of health facilities in Zimbabwe (10 of 12), and 80% in Burundi (8 of 10) (where there is no national standard on community support), but only 64% of health facilities in Uganda (9 of 14) and 50% health facilities in Lesotho (4 of 8). Swaziland (10% or 1 of 10) and Comoros (43% or 3 of 7) had low percentages of health facilities with a record of outreach activities undertaken, despite 50% health facilities in Swaziland (5 of 10) and 71% health facilities in Comoros (5 of 7) having outreach activity plans in place.

Figure 29 demonstrates how countries compared with each other on Standard 2 when looking at the data from the facility observation tool. Zimbabwe, Zambia and Burundi had the highest scores, while Madagascar, Comoros and Lesotho had the lowest.

Figure 29: Results for Standard 2



The health service providers were asked whether they engaged with parents/guardians or other family members of their young clients, and 66% of health service providers responded in the affirmative. Ethiopia (21% or 3 of 14), Comoros (29% or 2 of 7), Madagascar (36% or 4 of 11) and Burundi (40% or 4 of 10) were the countries where the least number of health service providers reported engaging with the families of their young clients. Of those who said they did engage, most said they did so through awareness raising sessions (64%), home visits (35%) and by telephone (30%).

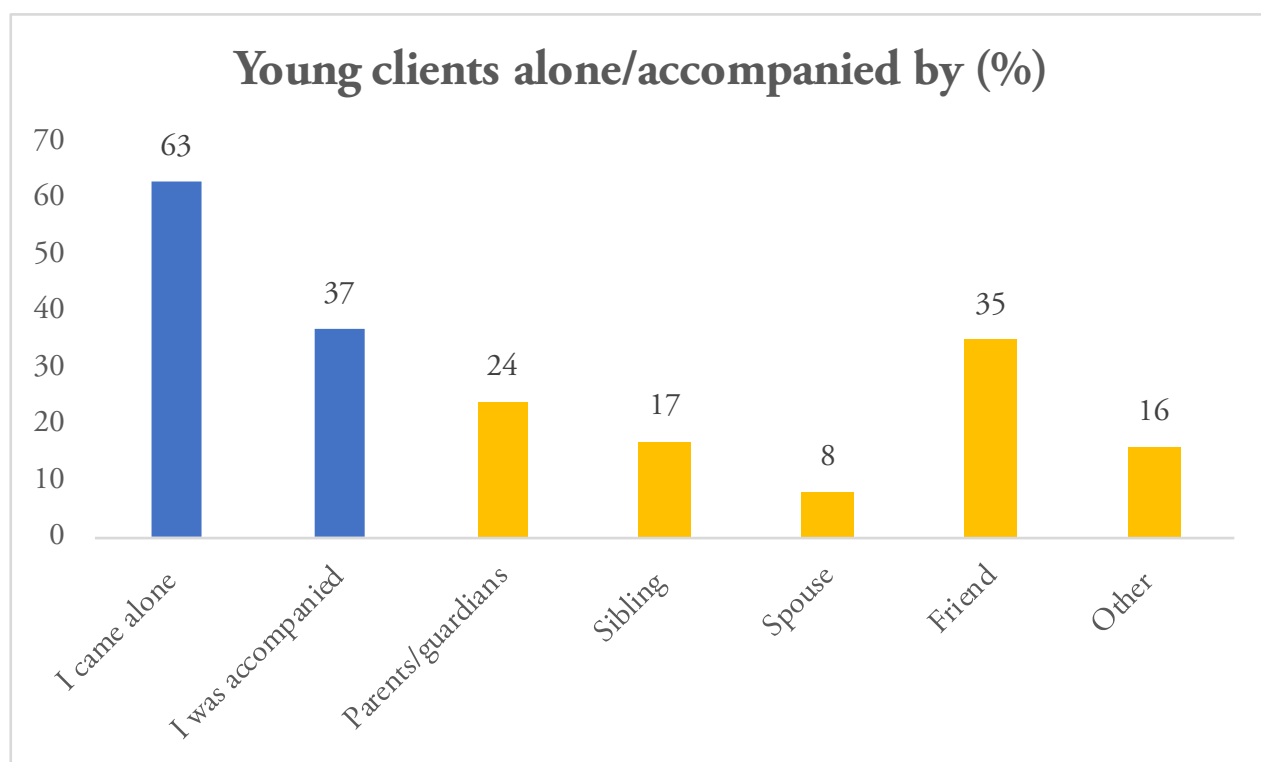
Sixty per cent interviewed said that parents or influential community members supported service provision to adolescents and young people. This was affirmed by all the health service providers interviewed in Zimbabwe (12 of 12), 88% in Swaziland (7 of 8), and 83% in Lesotho (5 of 6). The lowest number of health service providers affirming that parents or community members supported AYFHS were in Madagascar (9% or 1 in 11), Comoros (17% or 1 in 6) and Ethiopia (21% or 3 in 14).

When asked whether parents or community members had a platform for providing feedback to the health facility, 58% of all health service providers interviewed said they did. Most of these platforms were reported by the health service providers to be feedback or suggestion boxes (63%) and regular meetings with the community (52%). Only 10% of the health service providers who said there were feedback platforms reported these to include governing boards, which were in the DRC (1 of 10), Kenya (2 of 11), Lesotho (1 of 5), Uganda (2 of 12), Zambia (1 of 9) and Zimbabwe (1 of 10). The health service providers who said that such platforms did not exist were asked why this was so, and many responded that they did not know, while others said that it was simply not planned for.

In Kenya, the adult outreach workers and peer educators said that they visited schools, conducted community awareness sessions, and used social media. Adult outreach workers and peer educators in Ethiopia, Mozambique, Kenya, and parts of Zimbabwe recounted their challenges in addressing community members, including adolescents and young people about AYFHS. They cited culture as one of the main barriers, with an adult outreach worker in Kenya saying, “We are sometimes prevented from teaching adolescents about the use of sexual and reproductive health commodities. In other occasions, we teach parents but they don’t have that confidence to talk to their kids...they are very shy, in fact they don’t participate.” In some areas in Ethiopia, young volunteer health service providers reported that they were viewed in the community with suspicion and beliefs that they were engendering ‘love affairs’ and risky sexual practices. Similarly, in some rural areas of Zimbabwe, extension workers said that those of them who dealt with family planning were perceived to be influencing early sexual activity among adolescents and young people. Peer educators in Swaziland further revealed that they lacked formal recognition among the community leadership, saying, “We have never been formally introduced to the inner councils, the chiefs and the community at large, so our work is limited to only few places and institutions in the community, because no one knows us.” Equally, in the DRC, most peer educators said that community members did not always see their work as good, “The subjects around sexuality in the DRC are generally a taboo for the majority of the population. When I educate about sexuality and distribute condoms to young people, I am sometimes the object of bad considerations, especially on the part of uninformed people.”

Young exit clients were asked whether they came to the health facility alone or were accompanied by someone. Figure 30 highlights that 63% of all young clients interviewed came alone to the health facility. Of the 37% who were accompanied, 35% came with a friend and 24% came with a parent or guardian. This corresponds with the finding under Standard 1 where most of the young clients reported first learning of the health facility from friends or relatives.

Figure 30:



The young clients were also asked whether their guardian / parent / spouse / in-laws / other supported their using this health facility, to which 80% of clients interviewed responded 'yes'.

Potential young clients in Mozambique, Kenya and Swaziland said that they did not get much support from their community members in accessing AYFHS, especially for SRH. For example, in Kenya, a young person said, *"The community is not that supportive. For example, when a girl gets pregnant, she is looked at in a bad perspective."* Another young person in Swaziland said, *"We do not use the facility and our parents do not even know we access ASRH services anywhere."* On the other hand, the young clients who were interviewed while exiting the health facility after availing services were also asked whether their guardian / parent / spouse / in-laws supported their using the health facility. In most cases across all the countries, the young clients answered in the affirmative. This would imply that adolescents and young people who have support from family to access health services are more likely to access them than those whose family or community members do not support AYFHS.

Summary and Discussion

Overall, it can be inferred that while there appears to be an understanding about the need for community engagement and outreach, and plans for this tend to be in place (available in 71% of the health facilities visited), inadequate funding and training results in the plans not being fully implemented (records of accomplished outreach activities for community in 59% of health facilities visited, and for parent-teacher meetings in schools only in 41% of health facilities visited, or a lack of ability to deal with difficult opinion leaders in the community (as evidenced by the adult outreach workers and peer educators). Ethiopia stands out as an example of low investment in community engagement and high resistance to AYFHS within the community. Comoros was also consistent in its lack of engagement with the community with only 3 of 7 health facilities having records of outreach activities implemented, and only 1 of 6 health service providers saying that the parents/guardians or community members were supportive of AYFHS.

It is interesting to note that while 60% of the health service providers interviewed felt that parents and community members supported AYFHS, 80% of the clients interviewed felt that their family members supported their accessing AYFHS. This, of course, contrasts with the opinions expressed by the young people not accessing the services, or the potential clients, who did not think that the community was supportive. Thus, community engagement mechanisms need to be strengthened to enable those adolescents and young people who are not yet accessing the health services to reach them. In fact, the engagement needs to go beyond simply raising awareness to actually ensuring that adolescents and young people receive the support they require to access services. As seen under Standard 1, most young clients first heard of the health facility from family and friends, thus this needs to be capitalised on. It also indicates that there needs to be a prioritisation of communities and households that do not already access the services vis-à-vis those who do, to ensure equity of access.

9.4 Standard 3: Appropriate Package of Services

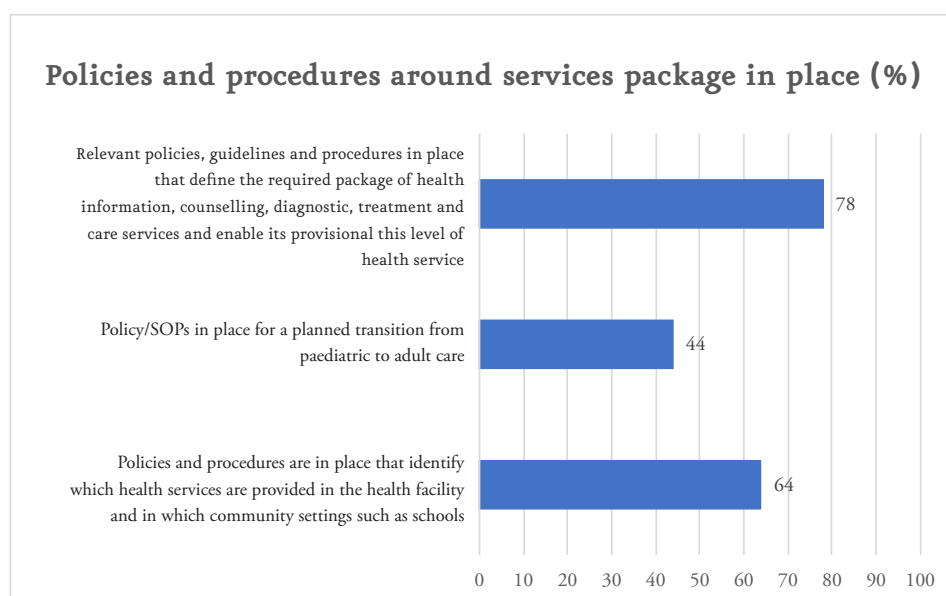
This standard focused on the types of services provided to adolescents and young people at each of the health facilities visited comparing them with the national package of services where this existed, as well as the package of services recommended by WHO and IPPF (refer to Table 7 for list of services). Health service providers were also asked about how the decision was made to provide a package of services (i.e., from the ministry, by health facility management, or in consultation with community members, including adolescents and young people). Young exit clients were asked whether they had been denied any services due to age, marital status, lack of availability, etc.

Table 7:

Package of Health Information, Counselling, Diagnostic, Treatment and Care Services	
Contraceptive counselling	Pap smear or other cervical cancer screening method
Oral contraception	Screening for sexual and gender-based violence
Condoms	Pregnancy testing
Injectable	Medical male circumcision
Intra-uterine device (IUD)	Mental Health
Implant	Antenatal care
Post exposure prophylaxis (PEP)	Postnatal care
Emergency contraception (IUD or pill)	Sex and sexuality counselling
Induced surgical abortion	Relationship counselling
Induced medical abortion	SGBV management and referral
Treatment for incomplete abortion	SGBV counselling
Pre-/post-abortion counselling	Tuberculosis
Pre-/post HIV test counselling	Life skills counselling
HIV sero-status laboratory test and monitoring laboratory test	Chronic diseases
At least one RTI/STI treatment method	Injuries from accidents and violence
At least one RTI/STI laboratory test	Nutritional needs and healthy eating
Manual pelvic exam for symptomatic clients	Physical disabilities
Manual breast examination	Drug and alcohol abuse

The facility observation tool assessed whether the policies and procedures around the service package were in place or not. Figure 31 demonstrates that while 78% of health facilities visited had relevant policies in place to define the required package of services at that health service level, only 64% had policies and procedures in place to identify which of the health services were to be provided in the health facility, and which within community settings (e.g., schools).

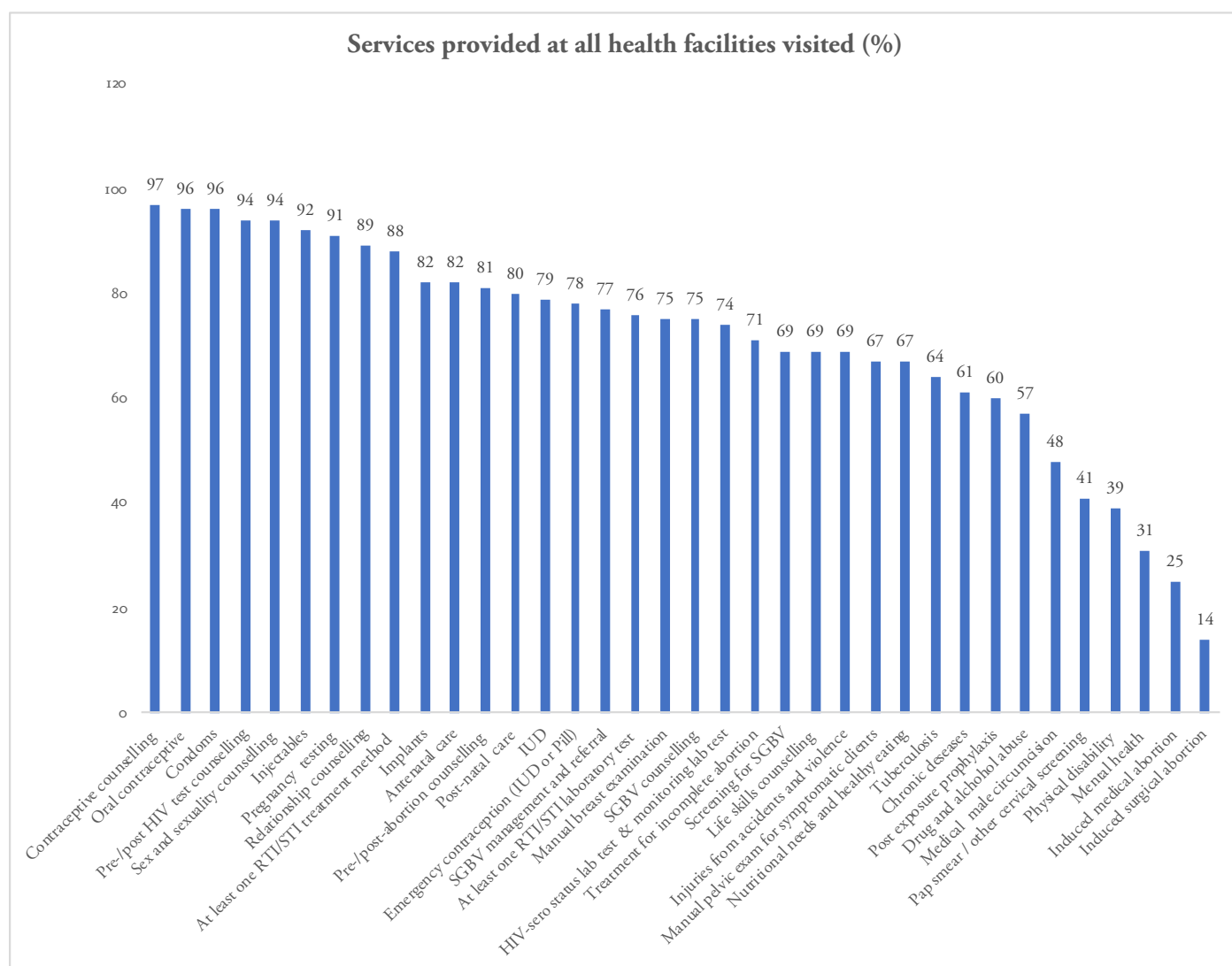
Figure 31:



It is concerning that in countries that likely have high numbers of young clients transitioning from paediatric to adult HIV related care who have been infected from birth, only 44% of all the health facilities visited had standard operating procedures (SOPs) or policies in place to support this transition.

Figure 32, shows the services most provided across the health facilities visited (i.e., contraceptive counselling, oral contraception, condoms, pre-/post HIV test counselling, sex and sexuality counselling, injectables and pregnancy testing), and those that were least provided (i.e., medical male circumcision, pap smear / cervical cancer screening, physical disabilities, mental health, induced medical abortion, and induced surgical abortion).

Figure 32:



Ninety-seven per cent of all the health facilities visited were observed to provide contraceptive counselling. 94% of all facilities visited provided pre- and post-HIV test counselling, while HIV sero-status laboratory test and monitoring test was available in 74% of all health facilities visited. In Ethiopia, all the visited health facilities were observed by the Assessment team to have inadequate amounts of HIV test kits, to the extent that eight health facilities were conducting HIV tests only for ANC clients, but not their spouses due to lack of kits. Reproductive tract infection (RTI) and STI treatment (88%) and testing (76%) were available in most of

the health facilities visited. As noticed under Standard 1 with respect to the educational materials available, despite most of the health facilities visited providing integrated services, there are fewer health facilities providing a comprehensive package of health services that adolescents and young people may need. The emphasis appears to be on contraception and pregnancy related services while drug and alcohol use, mental health and others are not being adequately addressed in the service package.

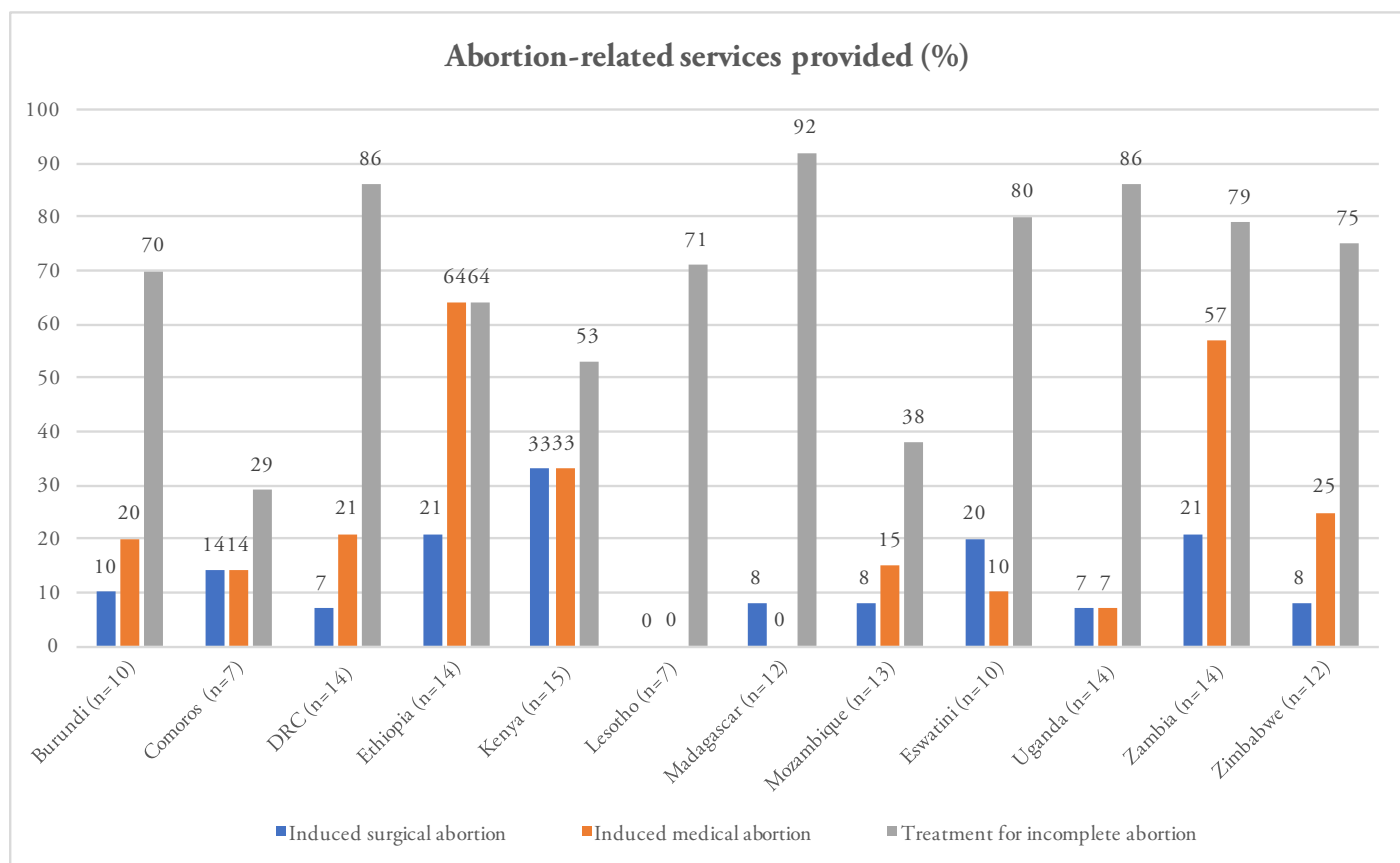
With regard to the provision of abortion related services, the laws are as follows:

- Mozambique – without restriction as to reason.
- Zambia – on socio-economic grounds and in cases of foetal impairment.
- Burundi, Comoros, Ethiopia, Kenya, Lesotho, Swaziland and Zimbabwe – to preserve the health of the woman, and, except in Burundi, Comoros and Kenya, in case of foetal impairment, incest and rape.
- Uganda – to save a woman's life.
- DRC and Madagascar – no explicit life exception.

The highest percentage of health facilities providing surgical abortion were in Kenya, Ethiopia and Zambia, and induced medical abortion were in Ethiopia, followed by Zambia and Kenya. Mozambique, which has the most liberal abortion laws, had low percentages of health facilities providing surgical abortion (1 of 13) and medical abortion (2 of 13).

With 71% of health facilities visited providing treatment for incomplete abortion, Comoros (29% or 2 of 7) and Mozambique (38% or 5 of 13) stood out with the least percentage of health facilities providing this service (see Figure 33). 78% of health facilities visited were providing emergency contraception.

Figure 33:



While health facilities may not be able to provide the full service package as recommended by the national guidelines, they may be able to extend their package by providing referral to other services outside the health facility. The Assessment showed that while referral systems, registers and guidelines were in place in a large number of the health facilities visited (70%), referrals for legal services (e.g., for victims of SGBV (27%) and rehabilitative services (22%), like for drug and alcohol use or physical and mental disability), were found in fewer health facilities (see Figure 34).

Figure 34:

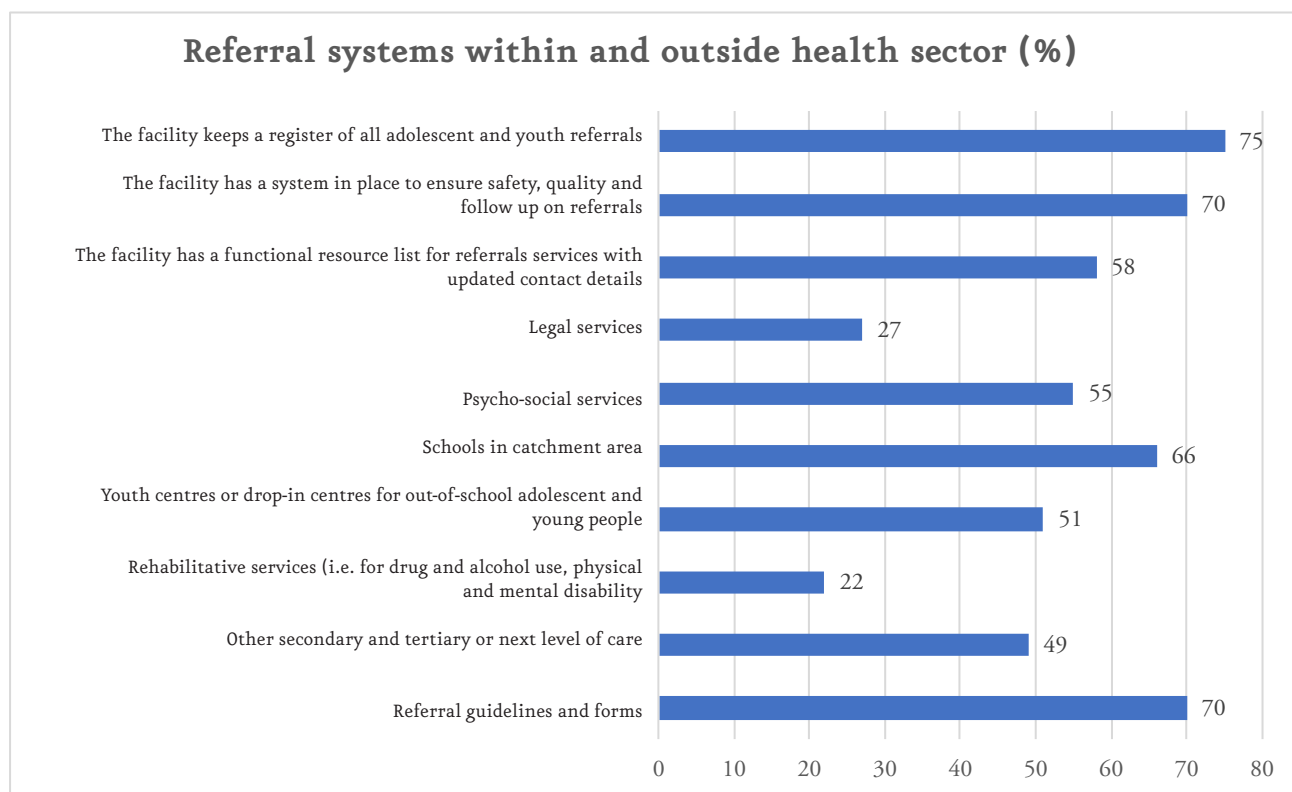
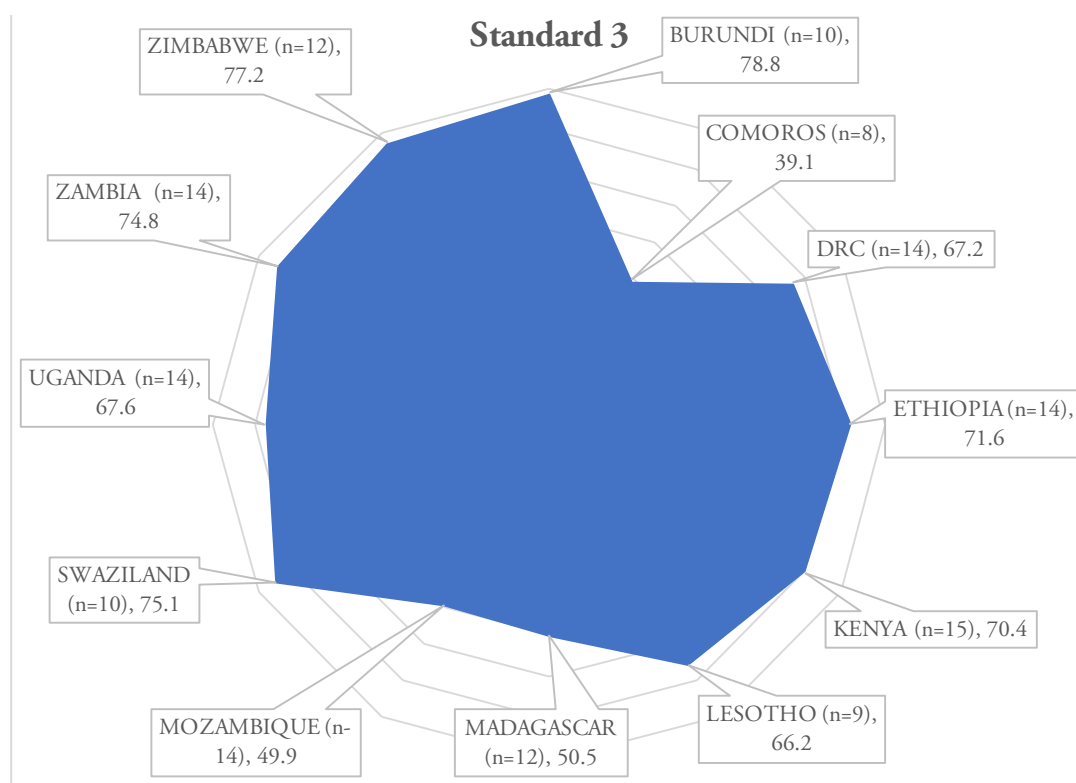


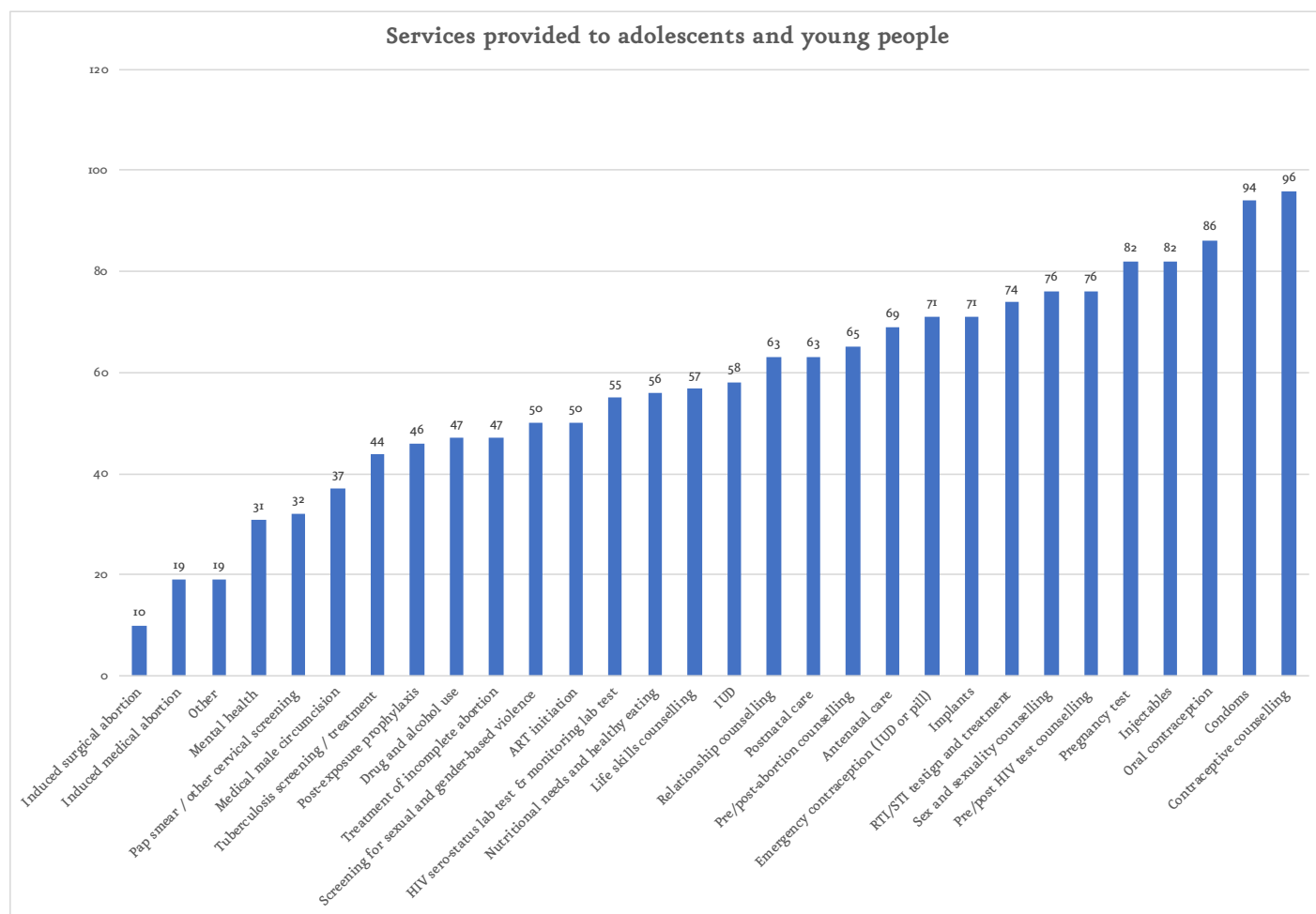
Figure 35, demonstrates how countries compared with each other on Standard 3 when looking at the data from the facility observation tool. The best performing countries on this standard are Burundi, Zimbabwe, Swaziland, Zambia, Ethiopia and Kenya. The countries with the lowest scores are Comoros and Mozambique.

Figure 35:



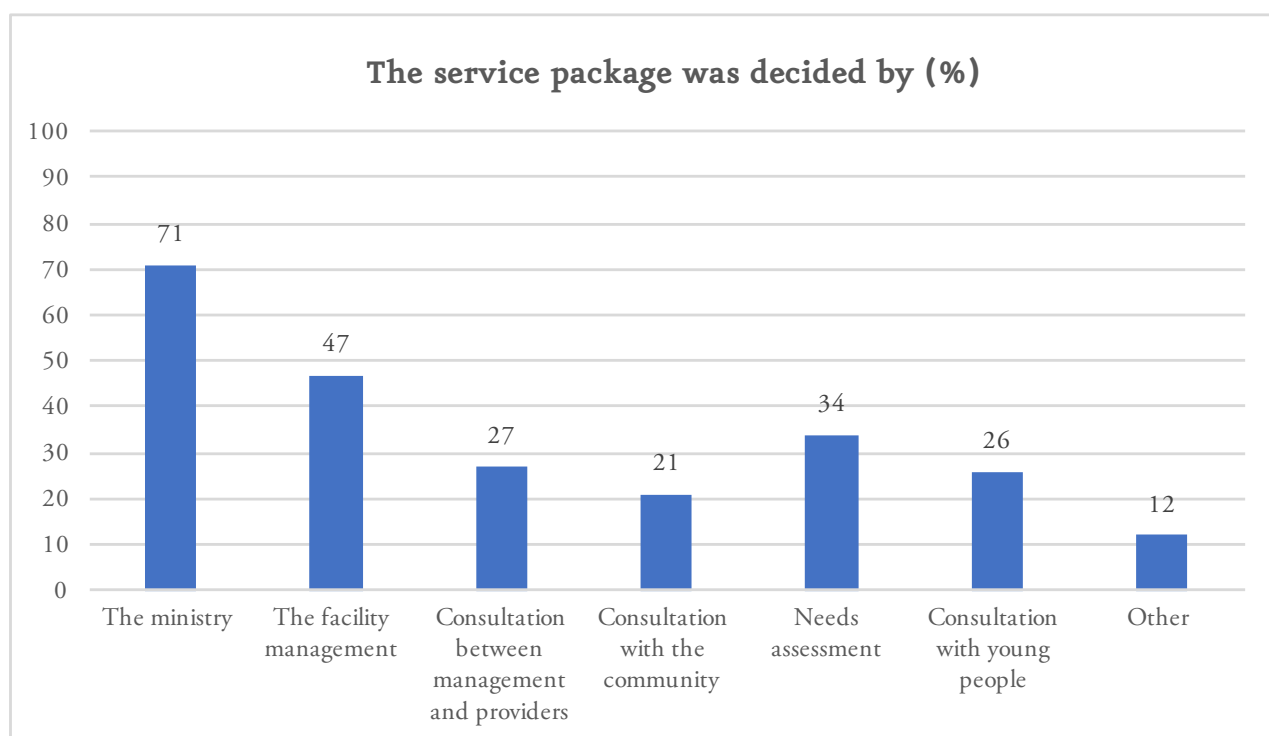
The health service providers were asked what services were provided to adolescents and young people at the health facility (using the package of services recommended by WHO and IPPF – refer to Figure 35). As shown in Figure 36, most of the health service providers mentioned contraceptive counselling, condoms, oral contraception, injectables and pregnancy testing. Services mentioned by the least number of health service providers were induced medical abortion and induced surgical abortion. This confirms the findings from the facility observation tool. Again, as mentioned earlier, the same services, (i.e., mental health, drug and alcohol use and SGBV related services), are among the ones least provided, and were the ones with least educational materials available (as seen under Standard 1).

Figure 36:



Most health service providers (71%) reported that the service package was decided, in most cases, by the health ministry. Only 26% of health service providers interviewed said that the service package was decided in consultation with adolescents and young people (see Figure 37).

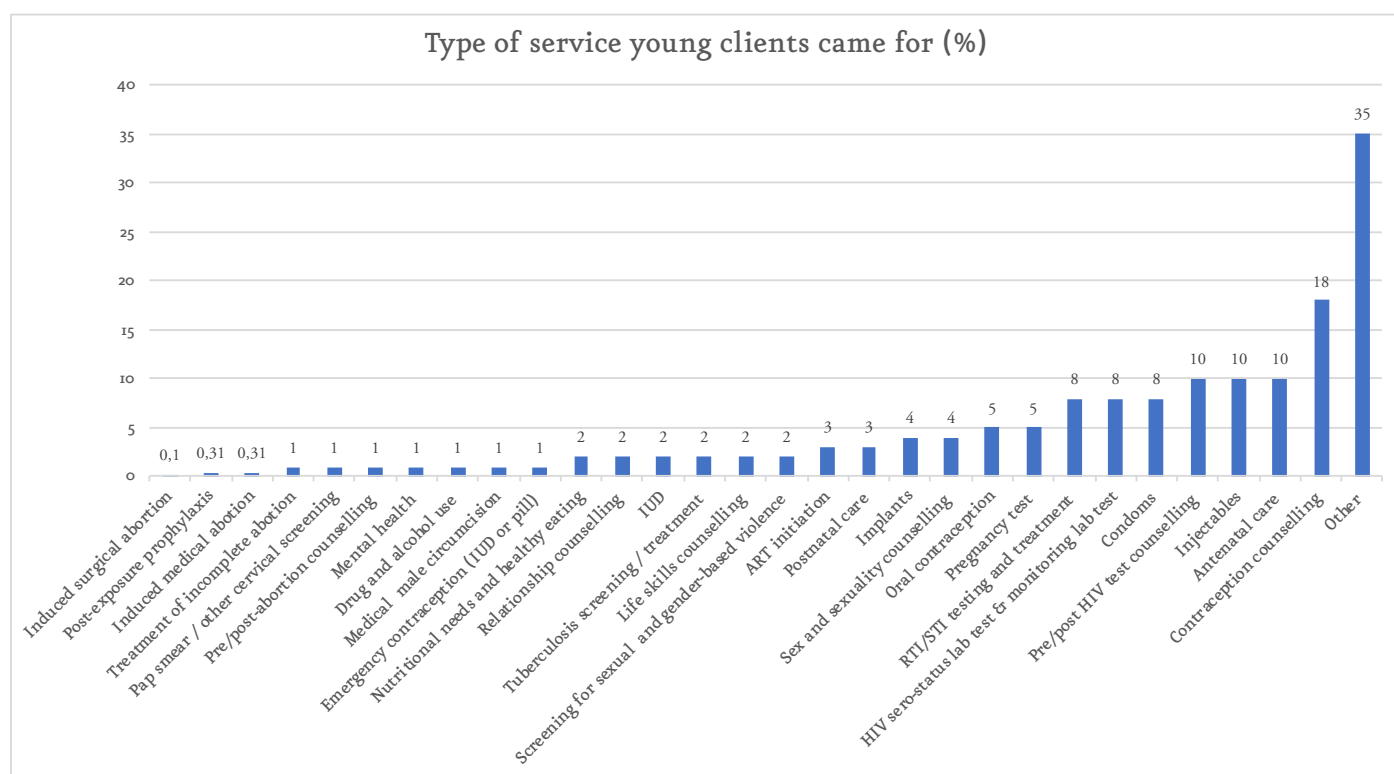
Figure 37:



The health service providers were also asked about what they thought was missing from the service package. Many said that training on youth-friendly services, adequate equipment, supplies and medicines, the services as per the country standards, improved capacity of health facilities to attract young people to the services including more privacy, a one-stop shop, and games, were missing. Some health service providers also mentioned HIV related care and treatment including ARVs and CD4 tests, abortion related care services, and STI screening and medicines.

The young exit clients were asked what services they had come in for that day (see Figure 38). While 35% of all young clients who were interviewed came for 'other' services (explained below), 18% of them came for contraceptive counselling. Other services that were most sought were ANC, injectables and HIV test counselling. The least sought after services were abortion related services (10 clients in all for induced surgical and medical abortion and treatment for incomplete abortion) and PEP (3 clients in all).

Figure 38:



The 'other' services were specified mainly as general health services, with 12% of these being non-medical services like the library, games, television or films, etc. 10% of those who said 'other' had brought their children to access services, 9% had come for malaria related services, 7% had come for gastro-intestinal tract related issues, and 3% had come for gynaecological problems.

Ninety three per cent of all young clients interviewed said that they had got the services they had come for that day, which corresponds with the fact that 92% of all clients were satisfied with the services they received. The smallest percentage of clients affirming this was in Uganda at 87%. Of those who said that they had not received the services they came for, most said this was because it was unavailable in the health facility. Half of all the young clients interviewed said that they had been told what other services they could obtain from the health facility.

Lesotho (31%) and Swaziland (35%) had the smallest percentage of clients saying they had been told about the other services. 59% of all young clients interviewed said that they would know where to go or whom to ask if they needed services that were not provided in this health facility. Most of these young clients mentioned hospitals or other health facilities they knew of, while others said that they would ask the health facility staff.

In Swaziland, some young people in FGDs reported that they did not use the health facilities as they were forced to undertake HIV testing and counselling as a routine procedure. In fact, young people were refused services at that health facility if they did not take the test.

Summary and Discussion

Overall the health facilities in Comoros were observed to provide the lowest number of services from the list used for standardisation. The university-based health facilities in both Ethiopia and Zimbabwe were reported to provide fewer types of services. The most provided service was contraceptive counselling, and other than general health services, this was also the most sought service by the young exit clients. This was followed by, condoms, oral contraception, pre-/post HIV test counselling, sex and sexuality counselling, injectables, pregnancy testing, relationship counselling, RTI/STI treatment, implant and ANC. It is pertinent to note that more young exit clients were seeking injectables than other contraceptive methods. ANC and HIV counselling and testing were also frequently sought by the young clients.

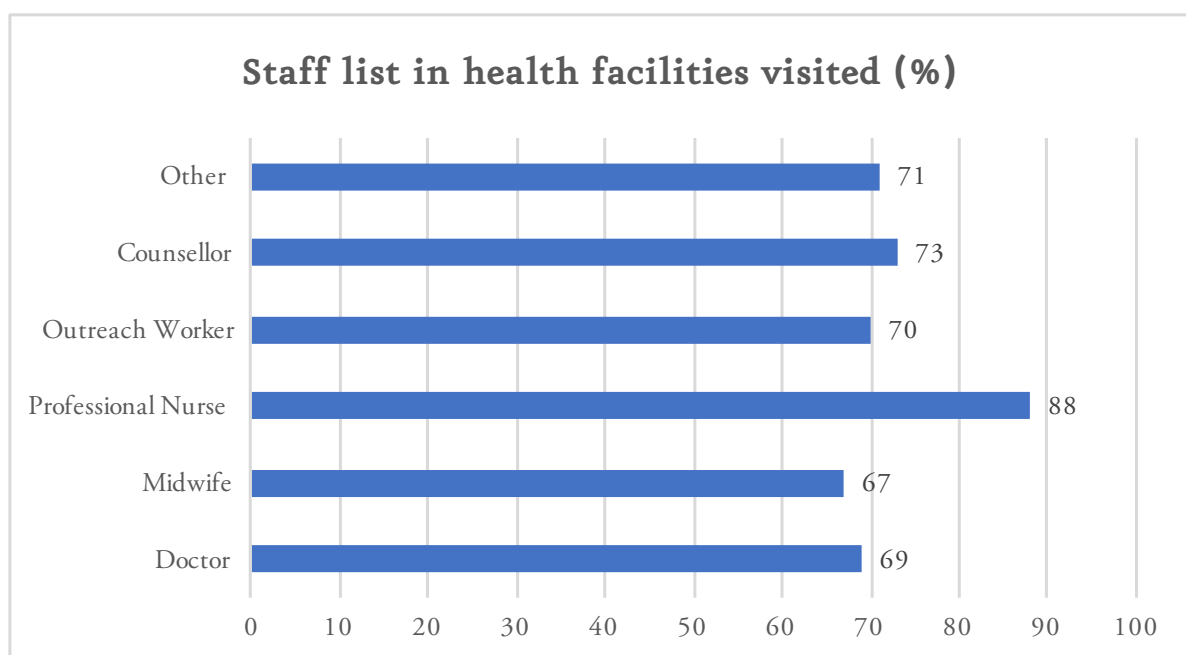
The services least provided and in turn, among the least sought by young exit clients were PEP, drug and alcohol use, medical male circumcision, pap smear / other cervical cancer screening, mental health and induced medical and surgical abortion. The referral systems for legal, psycho-social and rehabilitative services were seen to be in even fewer health facilities. Considering the situation of adolescent SRHR laid out in Chapter 7, it is possible that those young people in need of these services are not presenting at the health facilities visited since they do not provide services responding to their needs and realities. There is data to show that SGBV is high in all these countries, but the service packages are not adequately addressing this issue. Similarly, (unsafe) abortion is a high contributor to maternal mortality, but not enough health facilities are providing post-abortion care services. Since the service package in more than half the health facilities is decided without consultation with adolescents and young people, community members or needs assessments, it may be pertinent to re-orient the package to reflect needs and realities on the ground.

9.5 Standard 4: Providers' Competencies

Health service providers' competencies were assessed through this standard by observations (availability of job descriptions, training records, continuous professional development records, job aids and tools, and relevant guidelines and SOPs), health service provider interviews regarding trainings attended and training needs, exit interviews with young clients on their experience with the health service provider, as well as interviews with Ministry of Health policymakers on in-service and pre-service training programmes that they were implementing and challenges faced in improving provider competencies at the national level.

The staff lists observed in the health facilities showed that 88% of the health facilities visited had professional nurses, though doctors were only found in 69% of the health facilities (see Figure 39). The kind of staff available depended on the level of health facility visited, for example, primary healthcare facilities would have a different set of staff requirements from secondary or tertiary healthcare facilities where more staff would be expected.

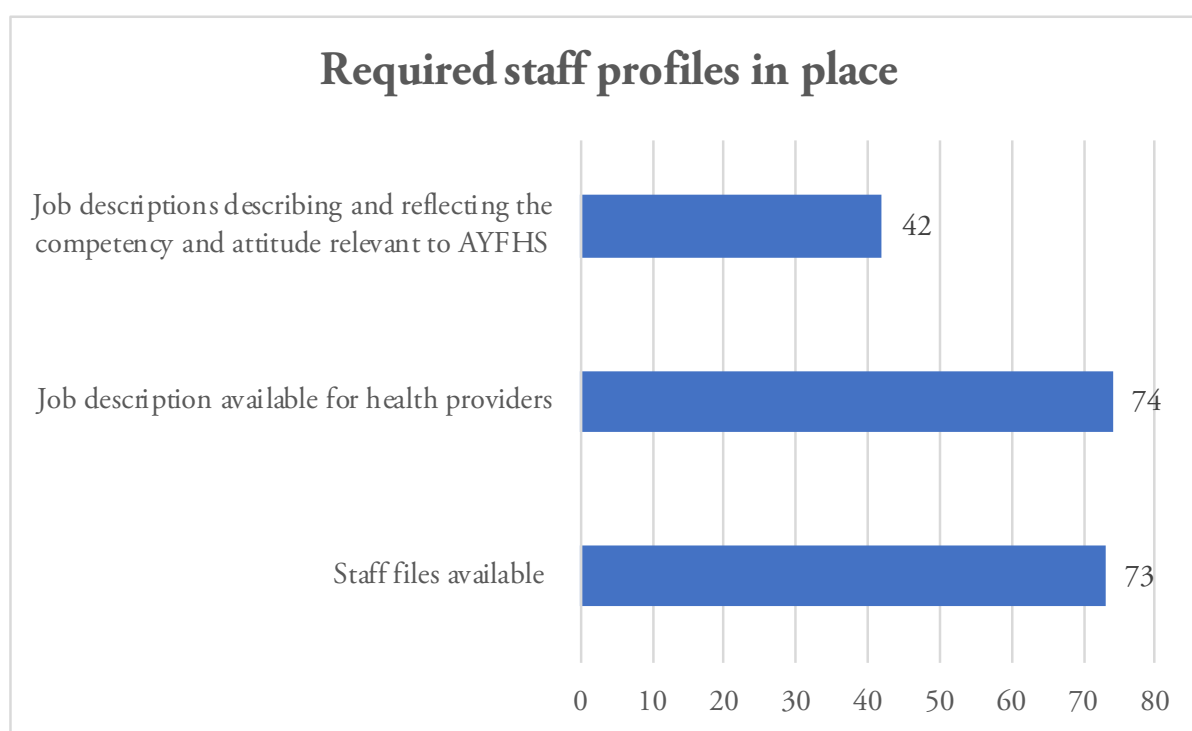
Figure 39:



The 'other' staff included coordinators, health officers, nursing assistants, pharmacists, support staff, managers, lab assistants / technicians, and security staff.

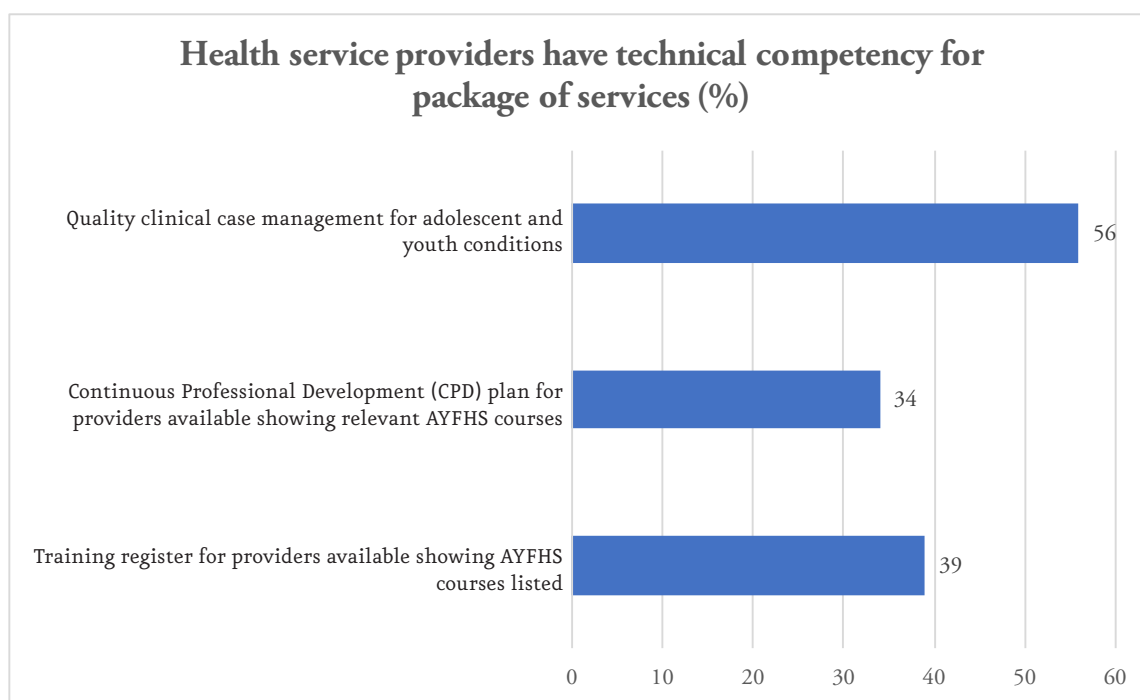
Seventy-three per cent of all the health facilities visited had staff files available, and job descriptions were found in 74% of the health facilities. However, job descriptions describing and reflecting the competency and attitude relevant to AYFHS (i.e., reflecting knowledge, skills and attitudes in regard to the provision of AYFHS), were only found in 42% of all health facilities visited, as can be seen in Figure 40.

Figure 40:



Training registers for the providers, showing AYFHS courses completed, were found in 39% of the health facilities visited (see Figure 41), with 78% (7 of 9) of the health facilities in Burundi showing this, and only 14% (1 of 7) in Lesotho.

Figure 41:



Similarly, Continuous Professional Development (CPD) plans (i.e., short courses or competency development for health service providers) for AYFHS trainings for health service providers were available in only 34% of the health facilities, with 67% of the health facilities in Burundi (6 of 9) and Zimbabwe (8 of 12) having these. None of the health facilities in Comoros and Lesotho had these, while only 14% of health facilities in Uganda (2 of 14) had them. The lack of adequate training and CPD was evident also among the community health workers and peer educators, as already noted under Standard 1 and 2. As mentioned by a community health worker in Ethiopia, “There is no continuous or comprehensive training program particularly on AYFHS. It is very hard to say, as health professionals, that we have received adequate training that enables to provide services efficiently. If available, we took the training long time ago.”

Figure 42 shows the training topics that health service providers had been trained on, as observed in the health facilities visited. The topic that most health facilities had trained staff on was prevention of HIV (90%), followed by physical examination (85%), sexuality and relationships counselling, and testing and diagnosis of HIV (both at 84%). The topics least covered were related to mental health and bullying.

Figure 42:

Training Topics

Involving adolescents and youth in the planning, monitoring and evaluation of health services and in decisions regarding their own care/certain appropriate aspects of service provision.
Collecting, analysing and using data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement.
Providing quality services to all adolescents and youth irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
Operating hours, welcoming and clean environment, privacy and confidentiality, equipment, medicines, supplies and technology needed to ensure effective AYFHS
Providing effective health services that respect, protect and fulfil adolescents' and youth's rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.
Providing a package of information, counselling, diagnostic, treatment and care services to adolescents, including referral linkages and outreach.
Implementing systems to ensure that parents/guardians/peers/community members/community organizations recognize the value and support provision and utilization
Implementing systems to ensure that adolescents and youth are knowledgeable about their health and know where and when to obtain health services.
Advocating adolescent health in the community
Communication with young people who live alone (e.g. poor young people in urban settings - homeless)
Communication with parents and caregivers
School health and the role of schools in health promotion
Ethical issues
Human rights-based approach to adolescent and youth health care
National laws and policies that affect adolescent and youth health-care provision
Assessment of adolescent's competency in decision-making; evolving capacities
Motivational interviewing; asking for consent
Health education and counselling including the ability to discuss issues around sexuality in a sex-positive manner
Gender norms in adolescent health care
Factors influencing effective communication with adolescents
Physical examination
Taking a history, including psychosocial assessment; skills to act in the best interests of the client, including taking the time to understand their needs and circumstances, and offering clear choices supported by easy-to-understand information
How to ensure a trustful atmosphere in the consultation (privacy, confidentiality)
Community and personal values and values conflict
Local attitudes, beliefs and practices regarding adolescents' health and development
Epidemiology of adolescent health outcomes and health-related behaviour
Protective and risk factors in the context of adolescent development
Assessment of adolescent developmental stages
Sexuality and relationships
Psychosocial development
Cognitive development
Normal growth and puberty, including impact on body image
Definitions and concepts of adolescence

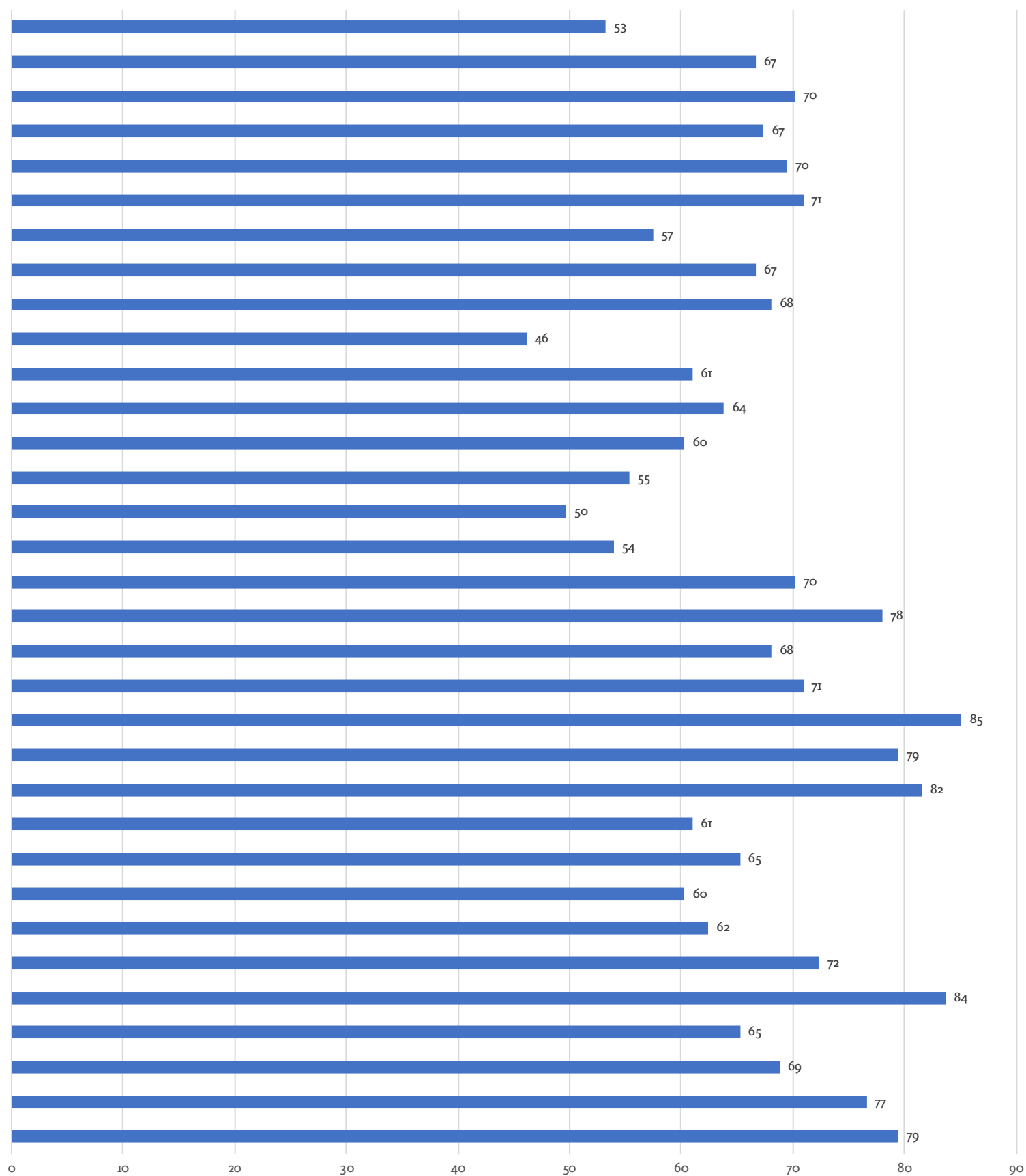


Figure 42:

Training Topics (continued)

Prevention of HIV
Special issues in perinatally HIV-infected adolescents
Transition to adult care
Treatment of adolescents who are HIV positive through sex, injected drug use, etc.
ARV Treatment and Adherence to treatment
Testing and diagnosis (HCT) of HIV especially for females including multiple concurrent partnerships, inter-generational sex, intimate partner violence
Testing and diagnosis (HCT) of HIV
Diagnosis, treatment and prevention of STIs, including consequences of STIs (such as PID and infertility) and gender dimensions of STIs
Preventive and comprehensive interventions for safer sex
Voluntary medical male circumcision and HIV
Prevention of Female genital mutilation
Safe abortion; consequences of unsafe abortion
Adolescent parenthood and consequences
Effects of child marriage on adolescent pregnancy, adolescent and youth pregnancy, antenatal and postnatal care
Adolescent and youth pregnancy prevention, contraception, dual protection (male and female condoms) and emergency contraception
Acute scrotal pain
Foreskin problems
Menometrorrhagia, irregular menstruation
Menstruation and menstrual hygiene
Sexual and reproductive health history-taking
Sexual attitudes and behaviours with a sex-positive approach
Gender identity and sexual orientation (including lesbian, gay, bisexual, transgender)
Vaccinations: diphtheria-tetanus; meningitis, HBV, HPV, etc.
Skin conditions (e.g. acne, piercing, tattoos, skin whitening)
Respiratory infection, pneumonia, asthma
Poor vision
Poor hearing
Orthopaedic problems
Headache
Fatigue
Birth defects and disability
Endemic diseases

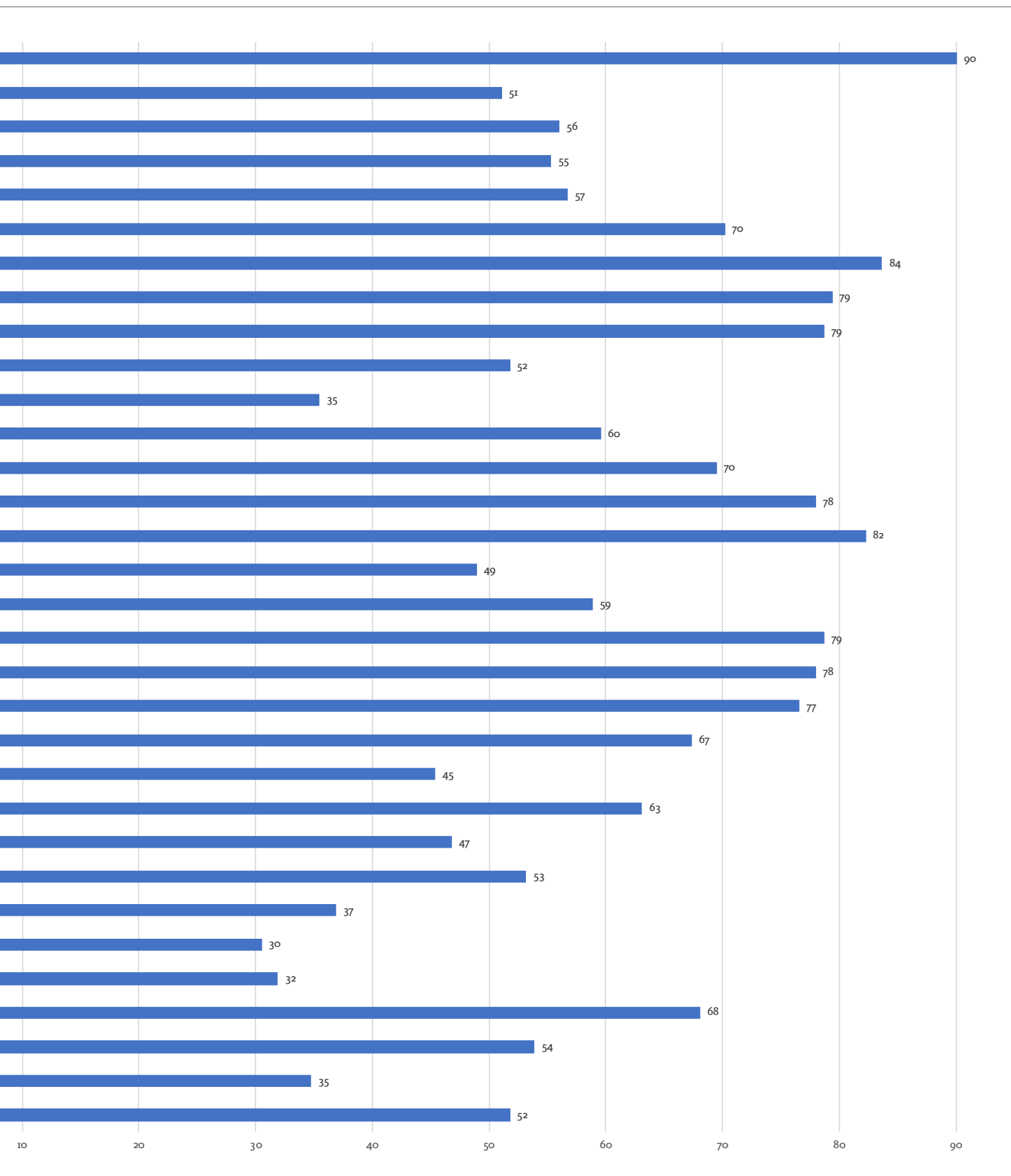
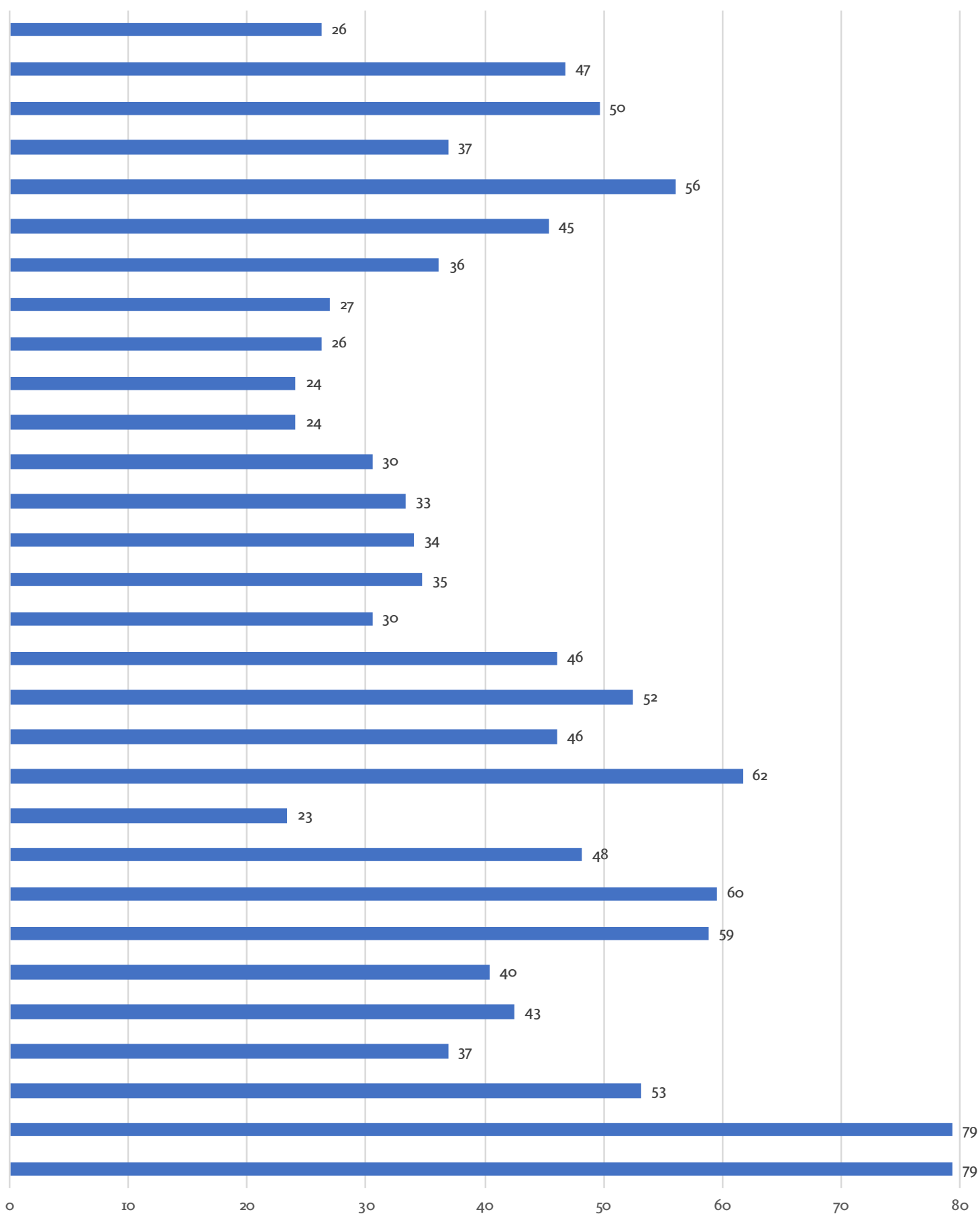


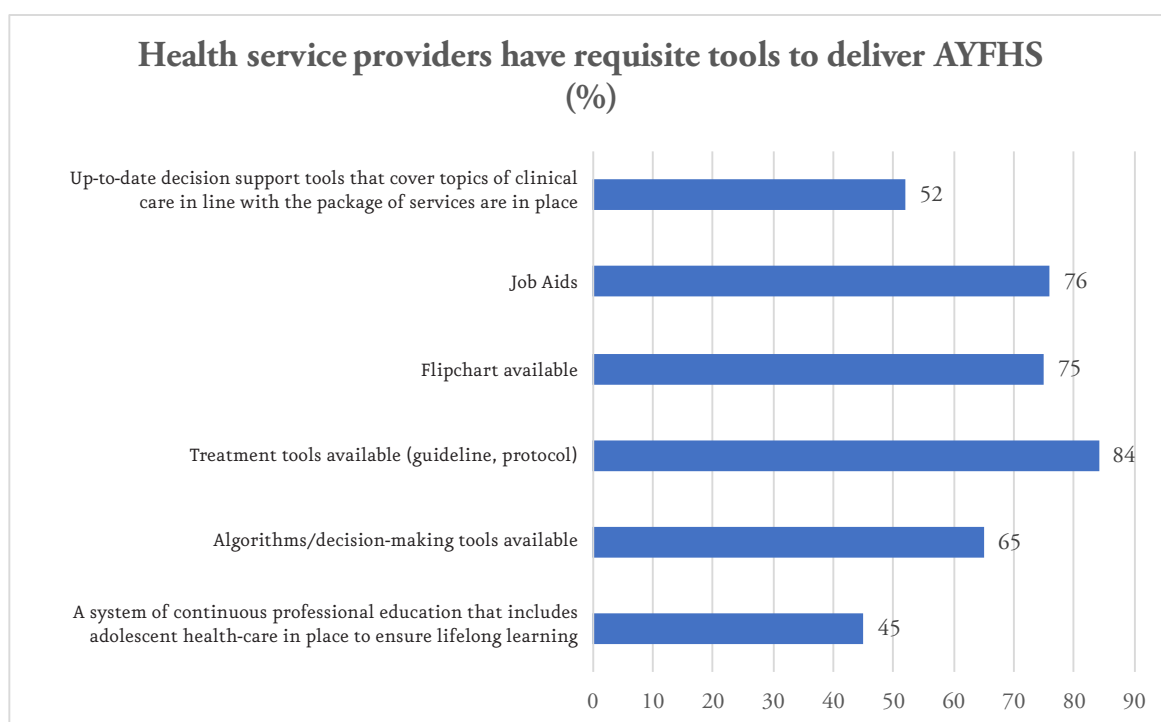
Figure 42: Training Topics (continued)





The situation with having the requisite job tools to deliver AYFHS was better than that of training and professional development, as 84% of all health facilities visited had treatment tools available (i.e., guidelines, protocols, etc.). Other job aids (76%) and flipcharts (75%) were also available in a majority of all the health facilities visited. A system of continuous professional education (i.e., lifelong job-based learning), including on adolescent health, was seen only in 45% of the health facilities (see Figure 43), with 83% of health facilities in Zimbabwe, but only in 8% of health facilities in Madagascar and 14% in Lesotho.

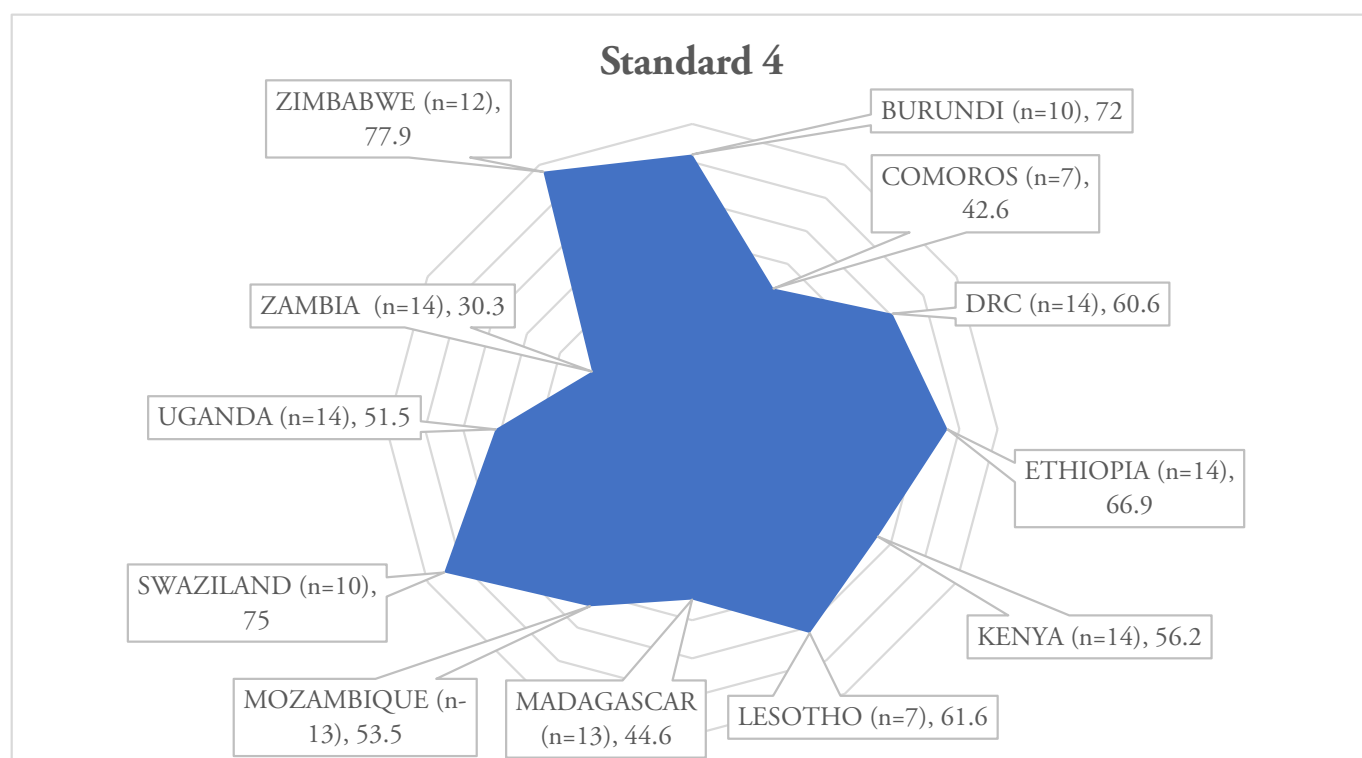
Figure 43:



Evidence of the last supervisory visit (not specific to AYFHS) in the last 3 to 6 months was seen in 71% of health facilities, with 94% of health facilities in Zambia (15 of 16), 93% in the DRC (13 of 14), 93% in Uganda (13 of 14), 92% in Zimbabwe (11 of 12), and only 23% in Mozambique (3 of 13) and 29% in Lesotho (2 of 7). Health service provider's obligations and adolescents' rights were displayed in only 33% of all health facilities visited, with 100% (10 of 10) health facilities in Burundi, but only 8% of health facilities in Uganda (1 of 14) and Madagascar (1 of 12), and none in Comoros. National AYFHS policies / guidelines / standards were available in 51% of health facilities; with 83% in Zimbabwe (10 of 12), while Lesotho was at 14% (1 of 7) and Comoros at 17% (1 of 6).

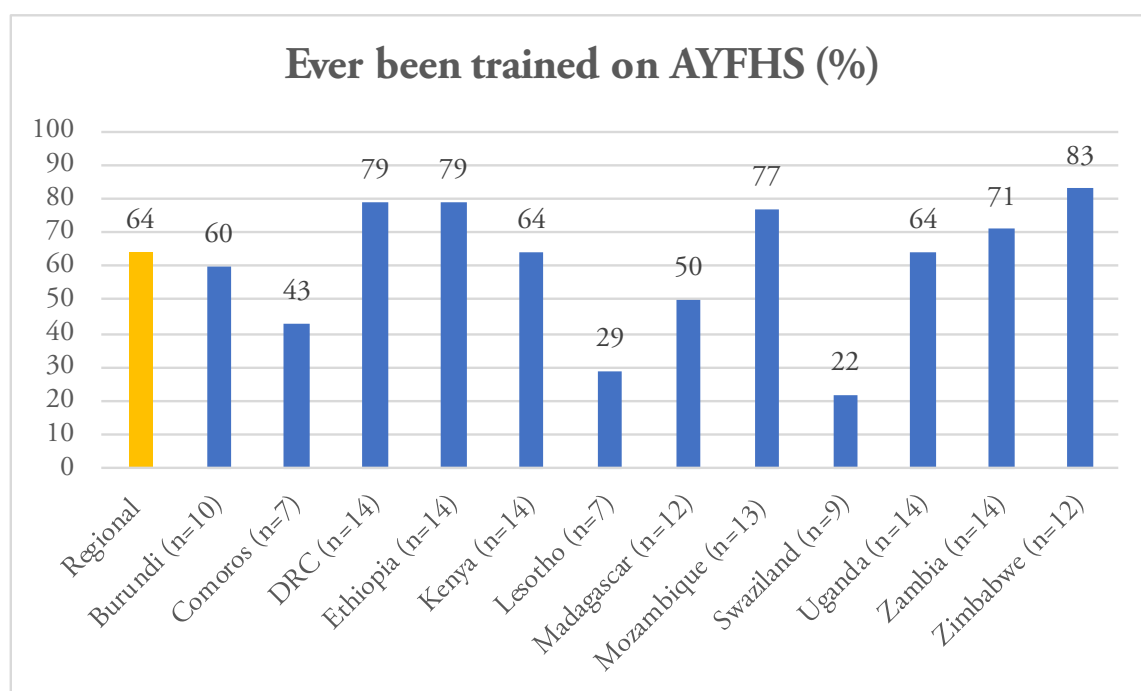
Figure 44 demonstrates how countries compared with each other on Standard 4 when looking at the data from the facility observation tool. As can be seen, Zimbabwe, Swaziland and Burundi had the highest scores on this aspect, while Zambia had the lowest, followed by Comoros and Madagascar.

Figure 44: Results for Standard 4



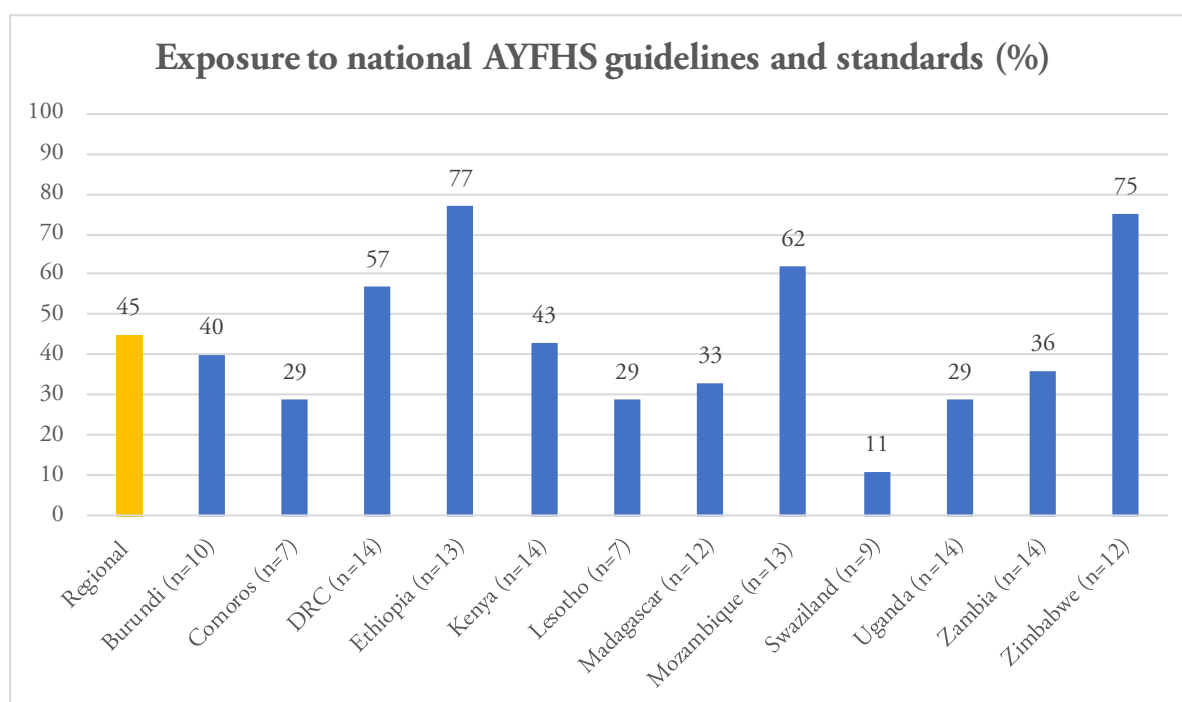
The health service providers interviewed, were asked whether they had been trained in AYFHS. Those who said 'yes' are shown in Figure 45 (64% in all), with Swaziland (22% or 2 of 9), Lesotho (29% or 2 of 7) and Comoros (43% or 3 of 7) having the lowest numbers of health service providers reporting ever being trained in AYFHS, while between 77% and 83% (10 of 12 in Zimbabwe, 10 of 13 in Mozambique and 11 of 14 in the DRC and Ethiopia) reported this. These responses differ from the findings of the facility observation tool where a much lower percentage of health facilities were observed to have records of completed AYFHS courses. Thus, it would appear that health service providers are being trained, but there is no system of recording or following up with this training. Of those who had ever been trained, 26% had received training for 7 days, while 13% had been trained for only one day. Only 13% had been trained for two weeks or more, and 52% of those who had been trained said that this training had been conducted in 2015.

Figure 45: Ever been trained on AYFHS (%)



Forty-five per cent of the health service providers interviewed reported having been exposed to the national AYFHS policies / guidelines / standards (see Figure 46). The highest number of health service providers who have been exposed to national guidelines were in Ethiopia (77% or 10 of 13) and Zimbabwe (75% or 9 of 12). However, in Swaziland (11% or 1 of 9) and in Comoros (2 of 7), Lesotho (2 of 7) and Uganda (4 of 14), much fewer health service providers (29%) reported the same.

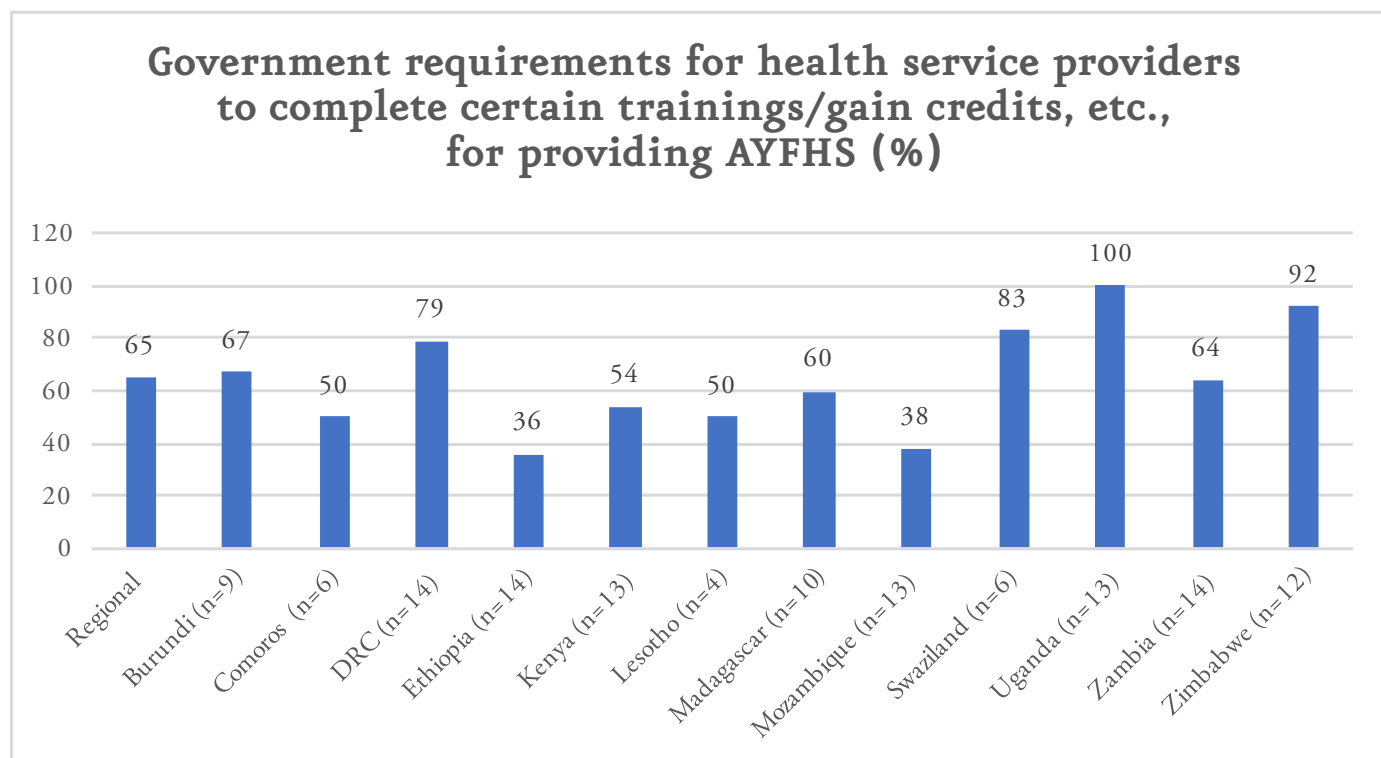
Figure 46:



Qualitative data from Zambia also demonstrates that adult outreach workers lacked exposure to the guidelines and standards with one FGD participant saying, “We do not have any knowledge about the guidelines and policies because that kind of knowledge has not yet been availed to us.”

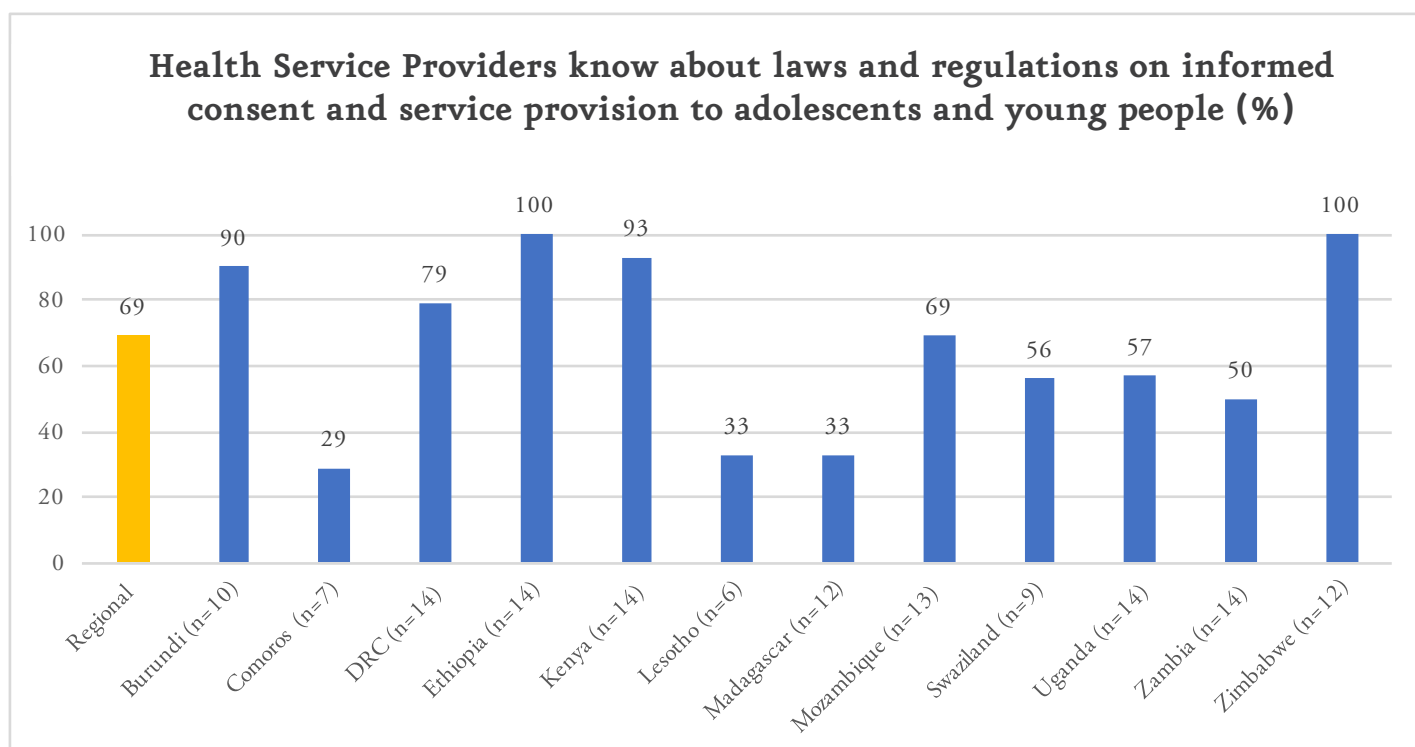
The health service providers were also asked whether they were aware of any government requirements for health service providers to complete certain trainings / gain credits for providing AYFHS, and 65% of all health service providers interviewed affirmed this (see Figure 47). While 100% of the health service providers who answered this question in Uganda, 92% in Zimbabwe and 83% in Swaziland said there were such requirements, only 36% in Ethiopia and 38% in Mozambique affirmed this. While in Zimbabwe there were initially no specific standards on AYFHS, the National ASRH Strategy and the Standardised ASRH Training Manual laid out guidance related to the Global Standards. Subsequent to the in-country research, the Government of Zimbabwe finalised its National ASRH Strategy II: 2016-2020 and National Guidelines on Clinical Youth Friendly Sexual and Reproductive Health Services Provision. These National Guidelines have adopted the nine Standards used for this Assessment and used the WHO Global Standards document as guidance.

Figure 47:



With regard to knowledge about laws and regulations on informed consent and service provision to adolescents and young people, 69% of all health service providers interviewed said that they knew about these laws and regulations (see Figure 48) 100% of the health service providers in Ethiopia (14 of 14) and Zimbabwe (12 of 12), 93% in Kenya (13 of 14) and 90% in Burundi (9 of 10), while only about a third of health service providers interviewed said that they knew about these laws and regulations in Comoros, Madagascar and Lesotho.

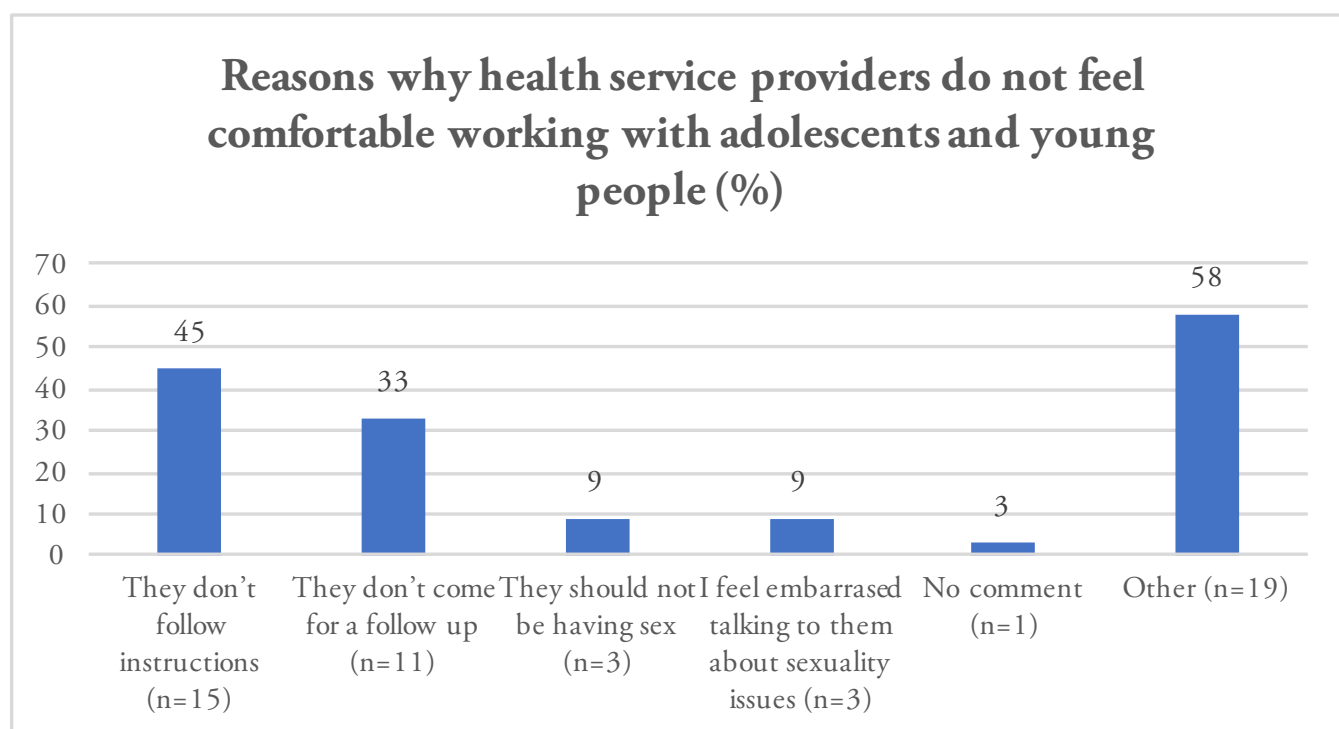
Figure 48:



There was regional consistency in the number of health service providers reporting there being government requirements for health service providers to complete certain trainings or gain credits for providing AYFHS, and those reporting that they had been trained in AYFHS. However, there were more health service providers reporting being trained on AYFHS and having knowledge of laws and regulations on informed consent and service provision to adolescents and young people, and fewer reporting having been exposed to national AYFHS guidelines and standards. Thus indicating that the AYFHS trainings may not consistently include information on the national guidelines and standards.

The interviews with the health service providers were also designed to get an assessment of their attitudes towards adolescents and young people. The health service providers were asked whether they found it easy to work with adolescents and young people, and 76% of interviewed said that they did, with 100% health service providers in Uganda, 92% in Zimbabwe, 90% in Burundi, and only 33% in Swaziland agreeing to this. Of the health service providers who said that they did not find it easy to work with adolescents and young people, 45% said it was because young people do not follow instructions, and 33% noted they do not come back for follow up. 9% of the health service providers opined that adolescents and young people should not be having sex, and that they felt embarrassed to talk to adolescents and young people about sexuality issues (see Figure 49).

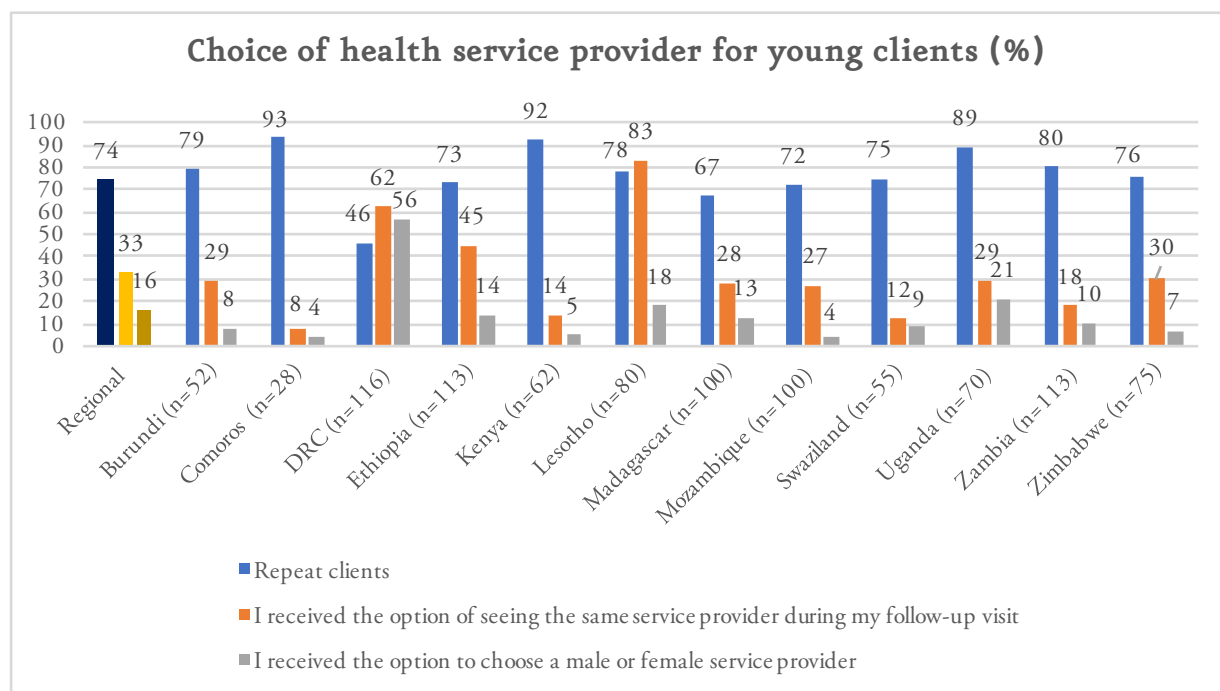
Figure 49:



Those who said 'other' cited cultural barriers to open discussion, adolescents and young people requiring a lot of attention, patience and understanding, not being open to advice, as well as being sexually active and having unprotected sex. Thus, despite only 24% of the health service providers demonstrating these attitudes, it is crucial to include value clarification in training for health service providers to ensure they have positive attitudes towards adolescents and young people.

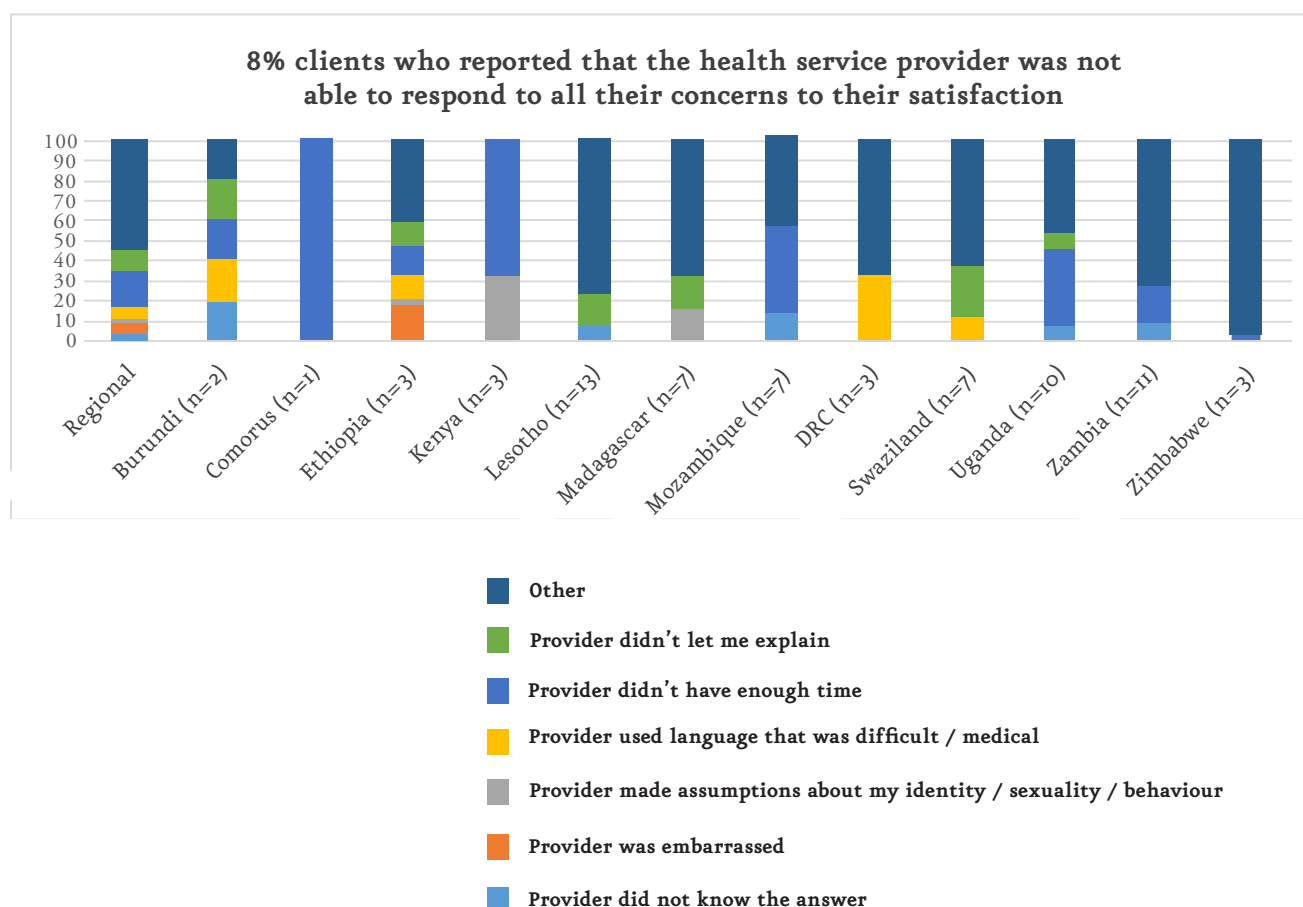
From the young clients' perspectives, 33% of those who were on repeat visits (n = 236) were given the choice of seeing the same health service provider they had seen on previous visits, and only 16% of all clients were given the choice of a male or female service provider (see Figure 50). More young repeat clients in Lesotho (83%) and the DRC (62%) were able to exercise the choice of seeing the same service provider as they had seen on a previous visit. In Comoros this was only 8%, in Swaziland 12% and in Kenya 14%. The DRC had the highest percentage of young clients (56%) reporting that they had received the option to choose a male or female health service provider.

Figure 50:



Ninety-two per cent of the young clients interviewed reported that the health service provider they had just seen had been able to respond to all their concerns satisfactorily. Of the 8% that responded negatively, 20% said it was because the health service provider did not have enough time, and 63% responded 'other' (see Figure 51).

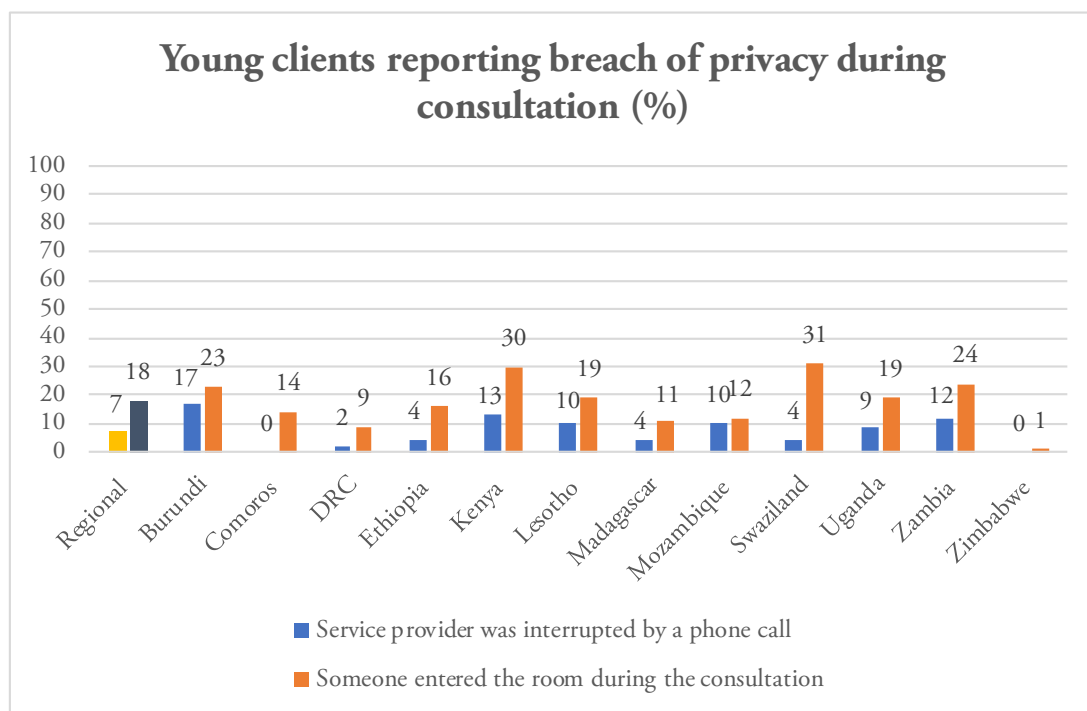
Figure 51:



Most of those who responded 'other' (27%) specified that they did not have any questions from the health service provider (all those who responded 'other' in Lesotho said they did not have any questions from the health service provider, 2 of 3 who responded 'other' in Zimbabwe said they did not have questions from the health service provider. 12% of those who said 'other' who reported that the service they wanted was not available or they were referred, and another 12% who said that drugs or test kits were not available. A further 13% said that they had to wait a long time or got delayed. There were two clients in Swaziland said they were too scared to ask, and one in Zambia who said the health service provider was rude. There was one client in Ethiopia who said that her husband's approval was required for her to get long-term methods.

Eighteen per cent of all the young clients interviewed said that someone had entered the room during their consultation, with Swaziland (31%) and Kenya (30%) having the highest percentage of clients reporting this. 48% of the young clients who had someone enter the room during their consultation said that they did not feel comfortable when other people were present during their consultation. Only 7% of clients said that the health service provider was interrupted by a telephone call (see Figure 52).

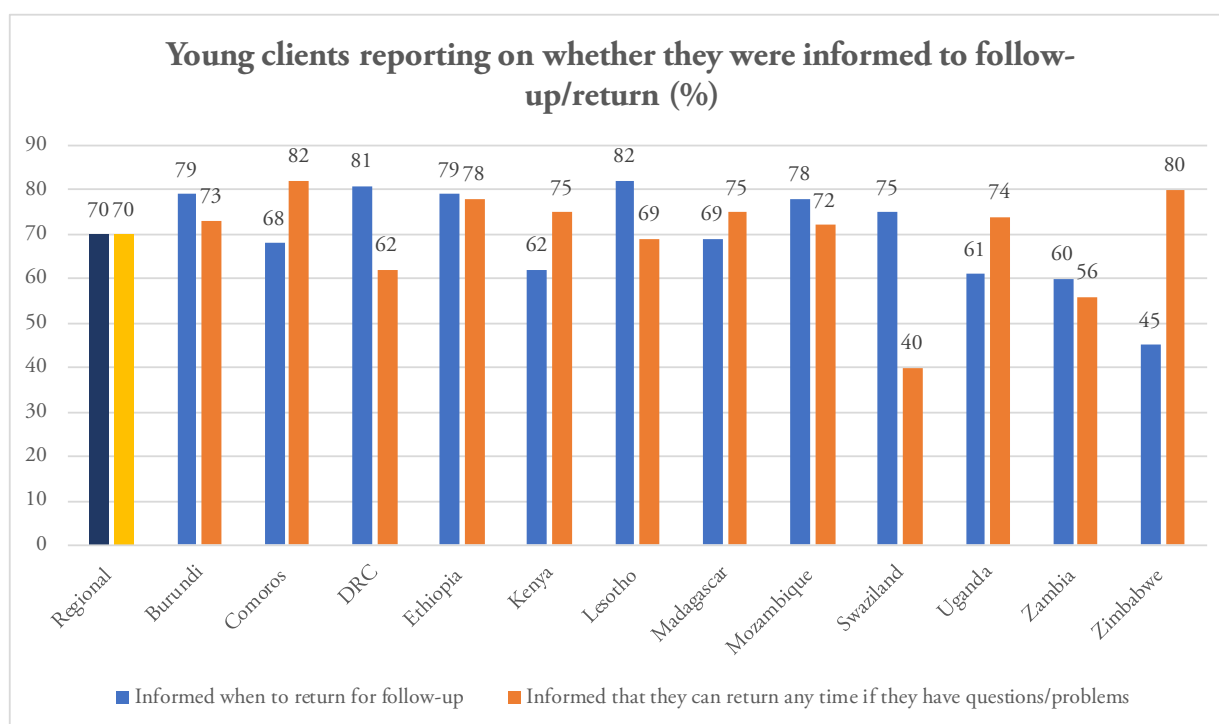
Figure 52:



When asked whether they felt that the health service providers' religious, cultural or other beliefs influenced their interaction with them, 89% of all young clients interviewed reported 'not at all', 5% said 'very much' and 6% said 'somewhat'. The highest percentage of young clients reporting 'very much' were from Burundi and Uganda (13%), followed by Madagascar (9%), and Comoros and Kenya at 7%. In Zambia, some key informants cited not only restrictive policies, but also providers' beliefs as barriers to access for adolescents and young people, "They [policies and guidelines] are still restrictive to age and influenced by service provider attitude, which is often negative." and "...religious and cultural beliefs of service providers hinder objective service provision. There is limited capacity of health workers and teachers to offer SRH information and/ or services in an efficient manner."

Seventy per cent of all the young clients interviewed said that they had been informed about a follow-up visit, and that they could return at any time if they had questions or problems. In Zimbabwe, 45% of the young clients reported being informed of a follow-up visit date and the lowest percentage of clients in Swaziland (at 40%) reported being told to return at any time for questions or problems (see Figure 53).

Figure 53:



Only 8% of young exit clients reported having any problems or difficulties as a result of the services or information received from the health facility in the past. The highest proportion of young clients reporting this was from Kenya at 12%, followed by Swaziland, Uganda and Zambia at 10%. Of the young clients who said they had faced problems as a result of the services, 18% of them said it was because they had not received clear instructions or did not understand the health service provider properly. 16% of them had faced side effects, especially in relation to contraceptives. 11% of them mentioned that they did not get the desired medicines or had to be referred to another health facility. 9% of them said that the health service provider was rough or rude or negligent.

The young people who were not using the health facilities, for example in Swaziland, said, “Accessing health services from traditional healers is five times more expensive than at the facility but young people go there because there are not too many steps and processes for getting treatment and not too many questions,” highlighting young people’s fear of being judged if they went to the health facility to access contraceptives or address other SRH concerns.

Two country Assessment teams (Ethiopia and Zimbabwe) included educational institution-based health facilities in their health facility selection. In Ethiopia, young clients of the university-based health services reported that sometimes health service providers could not allocate sufficient time to listen to their concerns due to large client flow and staff shortage. Waiting times were also noted to be longer in the university-based health facilities (45 minutes to an hour) as compared to other health facilities. In Zimbabwe, it was observed that most of the teaching aids for healthcare providers were not available in the university clinic. In addition, the clinic management expressed that while they offered health services, they were often excluded from meetings and capacity development training sessions by the Ministry of Health since they fell under the purview of the Ministry of Education. The university-based health facilities, while well placed to reach a large number of young people, were not being utilised to their best potential and not receiving the investment due.

Summary and Discussion

For Standard 4, the most consistent findings are from Zimbabwe, where health facilities score high on health facility observation, demonstrate high levels of health service providers reporting training on AYFHS, knowledge on laws and regulations and exposure to national AYFHS policies / guidelines / standards, and had the least percentage of young clients citing any breach of privacy during their consultation, and a high percentage of young clients reporting that they had been informed that they could return any time in case of problems or questions.

While one in two of the health facilities across the ESA region visited had the national AYFHS policies / standards / guidelines available, knowledge of these documents among health service providers was low. This indicates that further efforts to strengthen dissemination of, and training on, the national standards / guidelines is necessary at the health facility level. While all countries have policies or strategies on AYFHS, fewer health service providers are aware of these and their implications on their delivery of health services.

Training specifically on AYFHS has not been rolled out comprehensively in all the countries, despite most of them having national guidelines or training manuals on AYFHS. Therefore, health service providers are not always able to provide quality services to adolescents and young people. This is exemplified by an FGD respondent in Uganda, *“Health workers should be motivated, once this is done, you will have good customer care. Customer care is not basically about being trained. Many people have been trained but do not have that attitude and motivation of helping the youths.”* In Comoros, the lack of adequate training and CDP was highlighted by community workers and peer educators. The vast majority said they did not have a continuing education programme.

With AYFHS integrated into other health facilities, there is the possibility that staff member who has not received AYFHS training is enlisted to provide services to adolescents and young people, as observed by some of the Assessment teams in the bigger hospitals visited in different countries. Hence, ensuring that AYFHS is integrated into pre-service training curricula would help all health service providers be prepared to deal competently with adolescent sexuality followed by continued education for in-service providers and outreach workers. Countries like Ethiopia that have large numbers of community-based health service providers are missing the opportunity to include AYFHS in their trainings.

On the other hand, the high levels of satisfaction with the health services availed, reported by the young clients (92%) during their exit interviews, imply that despite only 64% of health service providers reporting ever being trained on AYFHS, they appear to be doing well when providing services. Only 18% of clients cited that someone entered the room during their consultation, and only 7% reported that the health service provider was interrupted by a phone call, and 9% of providers opined that: a) adolescents and young people should not have sex; or b) they are embarrassed to talk about sexuality issues to adolescents and young people.

However, when it comes to the adolescents and young people who are not accessing the services, there are several gaps. Qualitative data from Swaziland, for example, reveals that potential clients did not like to use health facilities located near them due to concerns of privacy and confidentiality. Similarly, in Zambia, peer educators in FGDs mentioned, *“Adolescents fear adult service providers and sometimes avoid SRH services altogether due to the possibility of their health condition being discussed in the community.”*

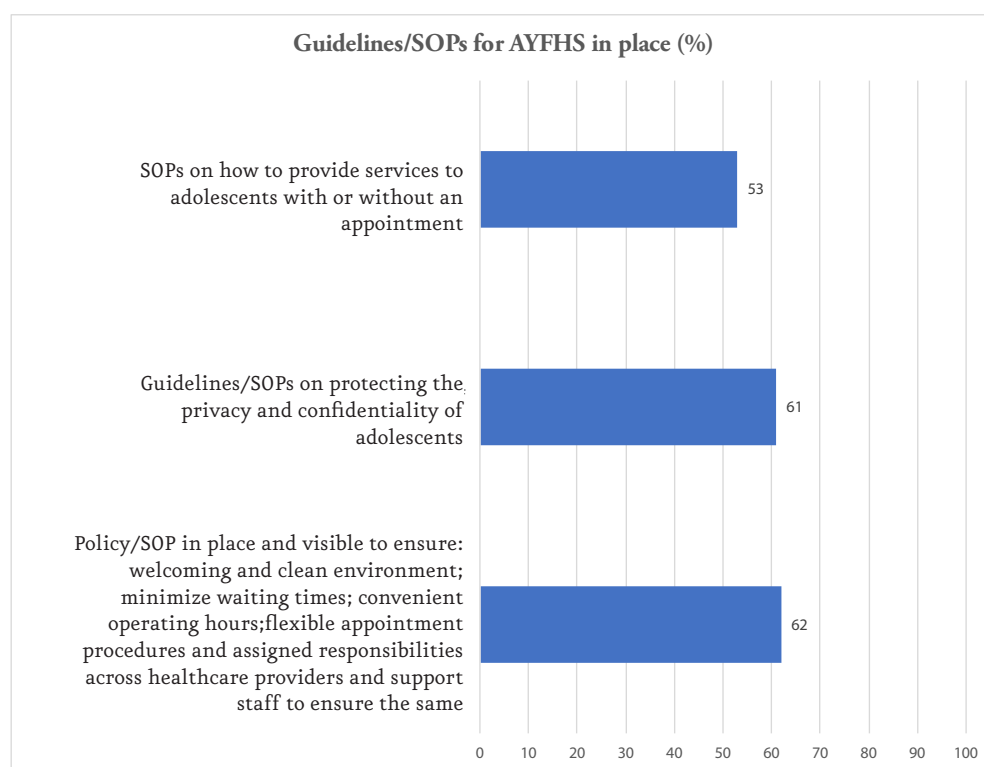
The lack of training registers at the health facilities visited (only 39% of all facilities had them) is symptomatic of the lack of systems at district or national level to track training and to provide supportive supervision and/or mentorship. It could be that the training registers exist at the district or other level, but having them at the health facility level is just as important.

9.6 Standard 5: Facility Characteristics

The Assessment teams observed waiting areas, basic amenities, audio and visual privacy, equipment and supplies, and procurement systems. Health service providers were asked which client rights were being implemented in the health facility and how, while young exit clients were asked about operating hours, distance, comfort and cleanliness at the health facility, as well as interaction with health facility staff.

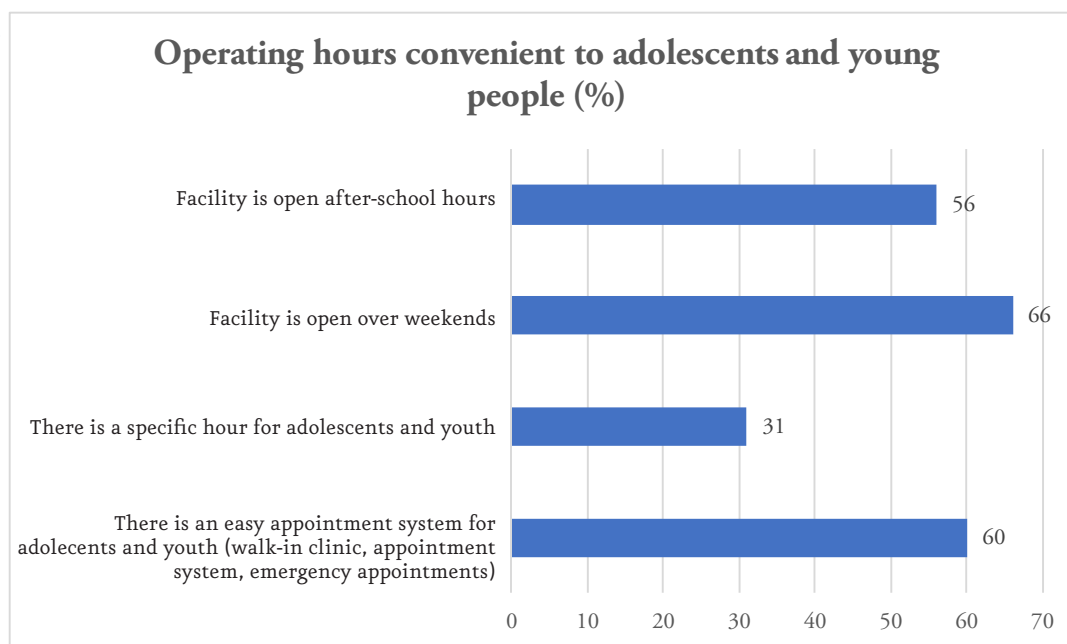
Sixty-two per cent of all the health facilities visited had a policy(ies) or SOP(s) in place and visible to ensure a welcoming and clean environment, minimize waiting times, convenient operating hours, flexible appointment procedures and assigned responsibilities across healthcare providers and support staff to ensure the same (see Figure 54).

Figure 54:



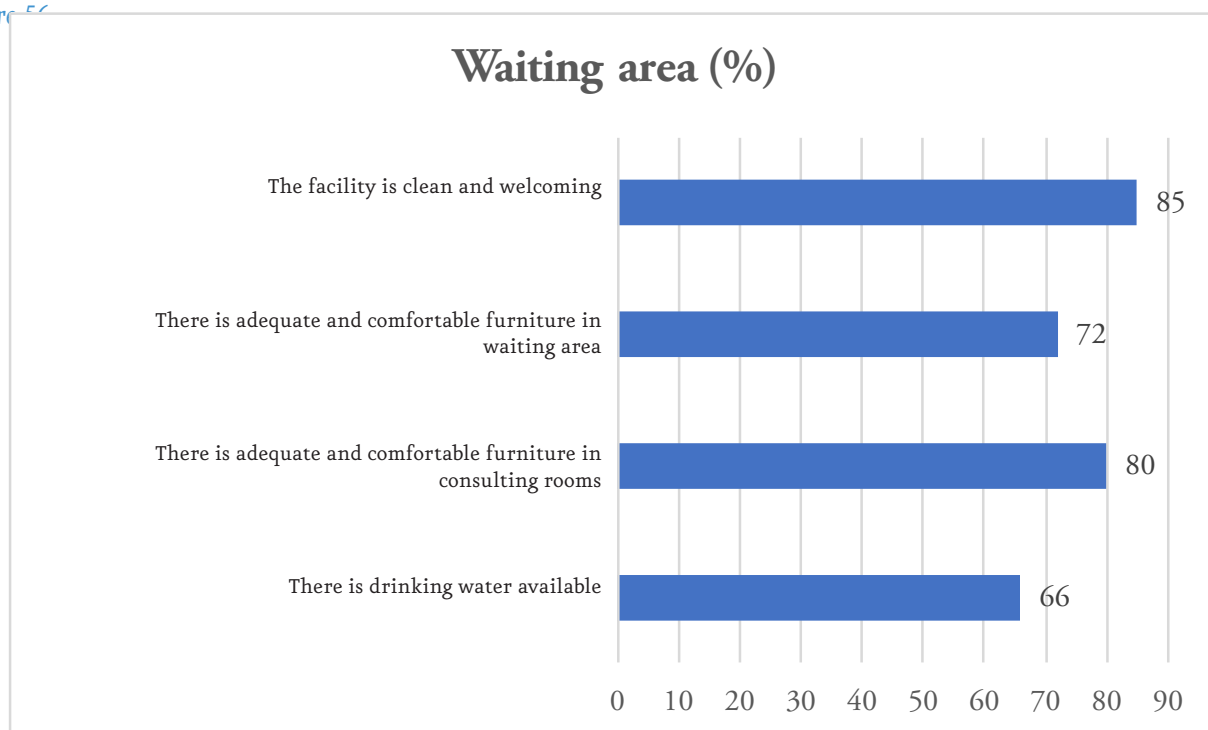
Fifty-three per cent of all health facilities visited had SOPs on how to provide services to adolescents and young people with or without an appointment (see Figure 54), and 60% of the health facilities had an easy appointment system for adolescents and young people (i.e., there was a walk-in system or emergency appointments, etc.) (see Figure 55). Burundi had the highest percentage of health facilities with this at 90% (9 of 10), while Lesotho had the smallest percentage of health facilities at 17% (1 of 6). Similarly, 56% of all health facilities visited were open after school hours and 66% on weekends. Burundi had the highest percentage of health facilities with after-school hours (90% or 9 of 10) and open over weekends (i.e., 100%). Mozambique had the lowest percentage of health facilities with after-school hours (14% or 2 of 14) and none that were open over weekends.

Figure 55:



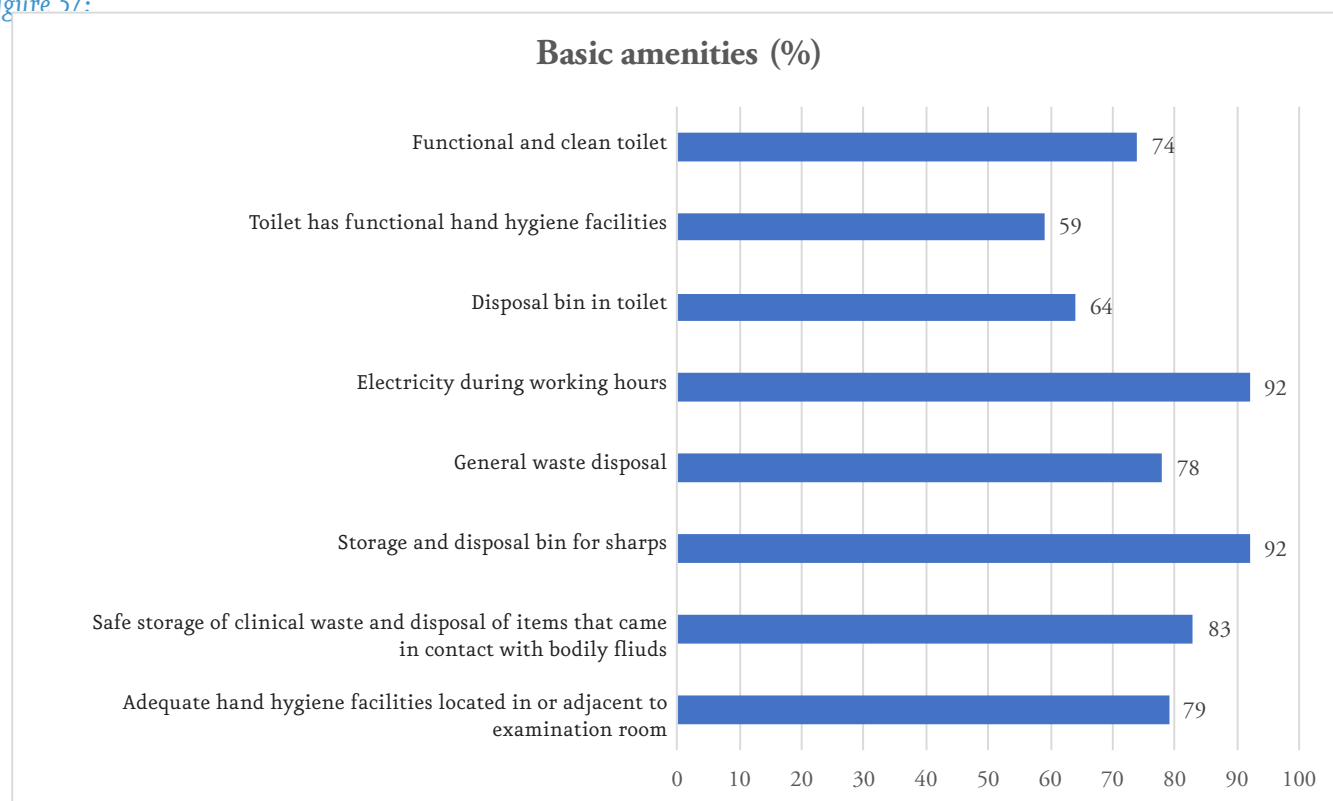
As seen in Figure 56, the waiting areas of most of the health facilities visited were observed to be clean and welcoming (85%) with adequate and comfortable furniture (72%). However, drinking water was only available in 66% of the health facilities. Lack of adequate water supply was observed by the Assessment teams in Ethiopia and Swaziland.

Figure 56:



Other basic amenities were available in most health facilities, except functional hand hygiene health facilities in toilets, which were only there in 59% of all health facilities. Proper disposal of medical waste (83%) and sharps (92%) was observed in the majority of health facilities visited (see Figure 57).

Figure 57:



While policies and procedures on privacy and confidentiality of adolescents and young people were present in 71% of all health facilities visited, they were observed in only 30% of the health facilities in Swaziland. The highest percentage was in Zambia at 100%, followed by Burundi at 90%. Client records were stored securely in 85% of health facilities visited, though in Comoros only 13% of the health facilities were observed to do so. In terms of their implementation, only 69% of health facilities visited could provide private communication between reception staff and visitors, ensuring it could not be overheard in the waiting area. Though many health facilities had consultation areas that were away from public view (84%), and soundproof (70%), only 58% had a separation in the consultation room between consultation and examination areas (see Figure 58), with the lowest percentage in Comoros (38%), followed by Mozambique (50%). Anonymous registration was available to adolescent and young clients only in 55% of the health facilities visited.

Figure 58:

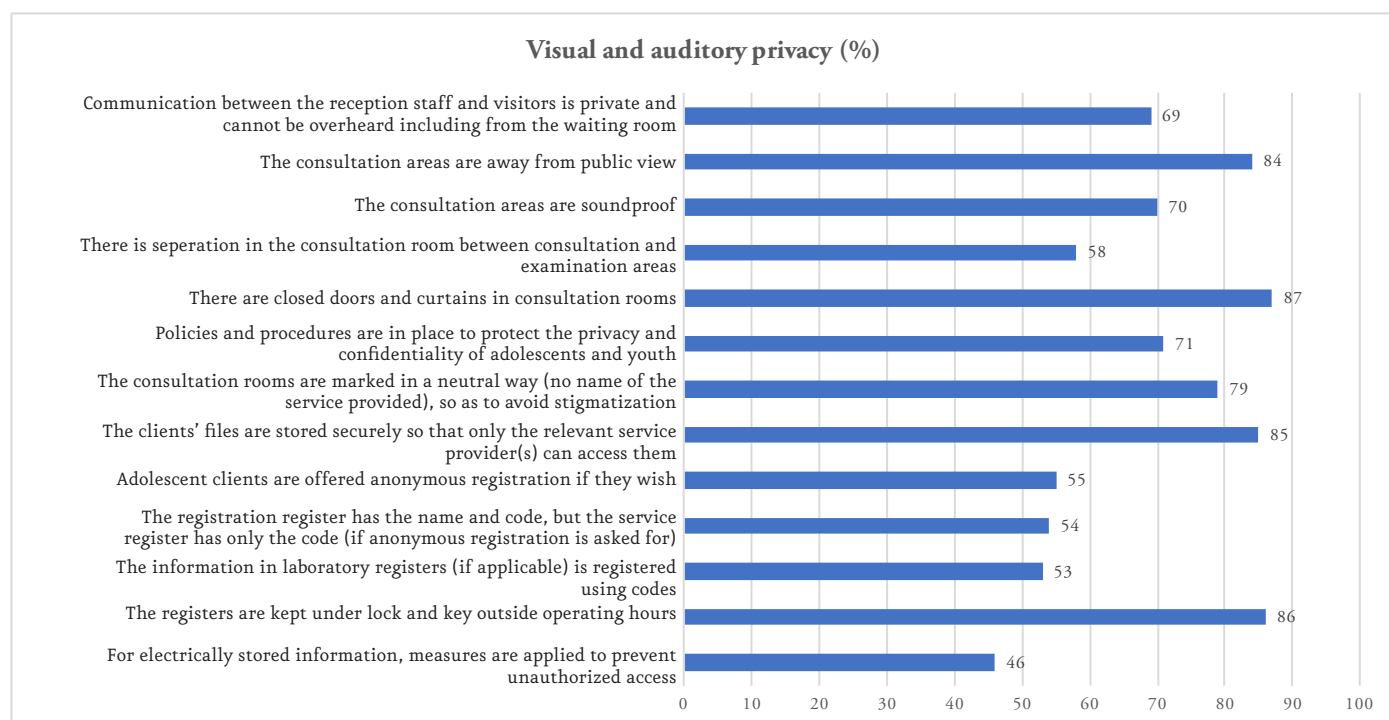
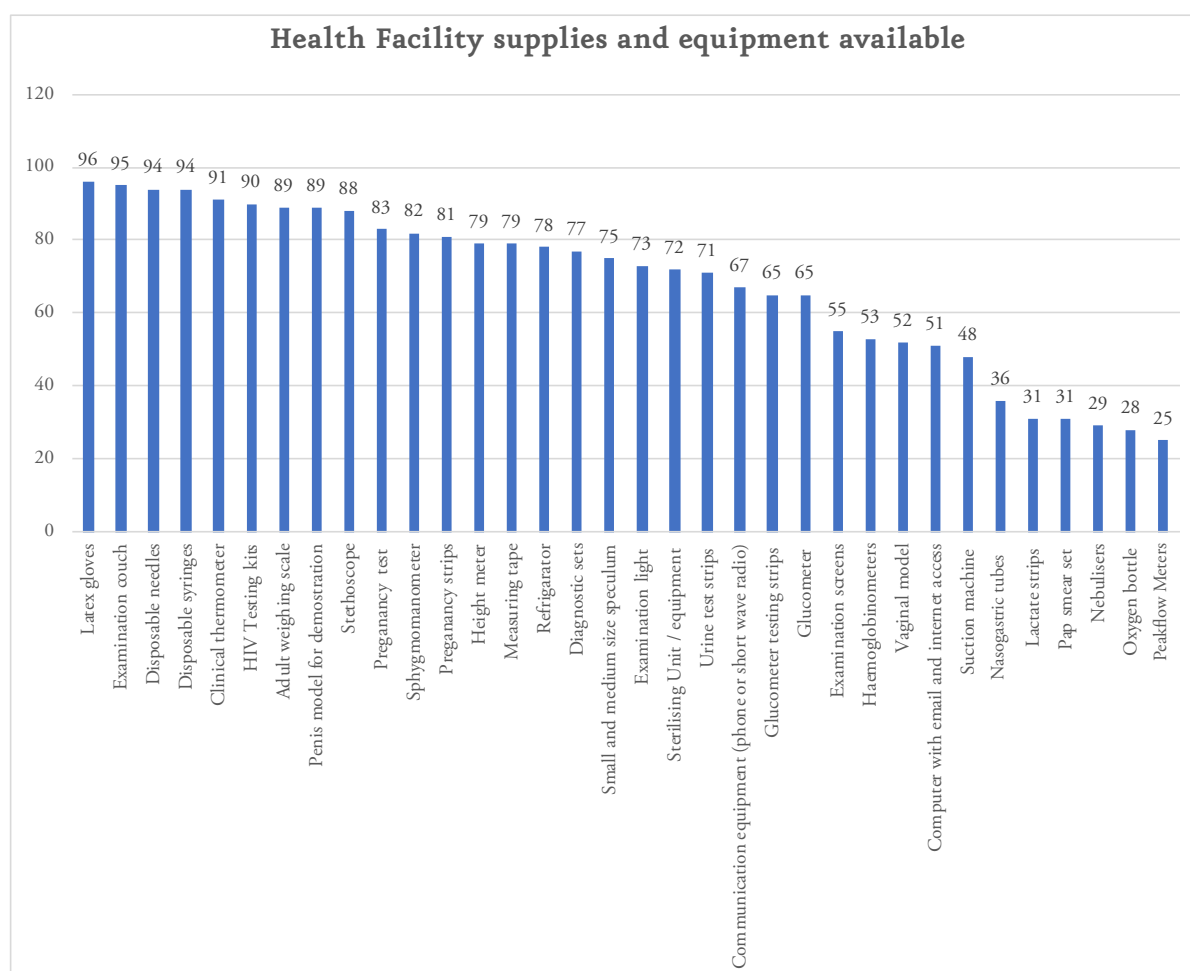


Figure 59



There were visible systems of procurement and stock management of medicines and supplies necessary to deliver the required package of services in 78% of the health facilities visited (see Figure 60). The lowest proportion of health facilities with these systems was in Comoros at 25% and Mozambique at 36%. The system was observed in 67% of health facilities in Madagascar, 71% in DRC and 79% in Uganda. An up-to-date inventory of drugs was observed in 75% of all health facilities visited, with 100% of the health facilities in Zambia and Burundi, 93% of the health facilities in Kenya, 92% of the health facilities in Zimbabwe, and 90% of the health facilities in Swaziland, while the lowest proportion was in Comoros (25%). The storage of supplies in a secure room was observed in 81% of all health facilities visited, with Comoros (25%) and Mozambique (36%) having the lowest number of health facilities demonstrating this. Thus, it can be observed that Comoros is lagging far behind the other countries in terms of streamlining its drug and supplies procurement, supply and storage, while Burundi, Zambia and Zimbabwe have been observed to perform consistently.

Figure 60:

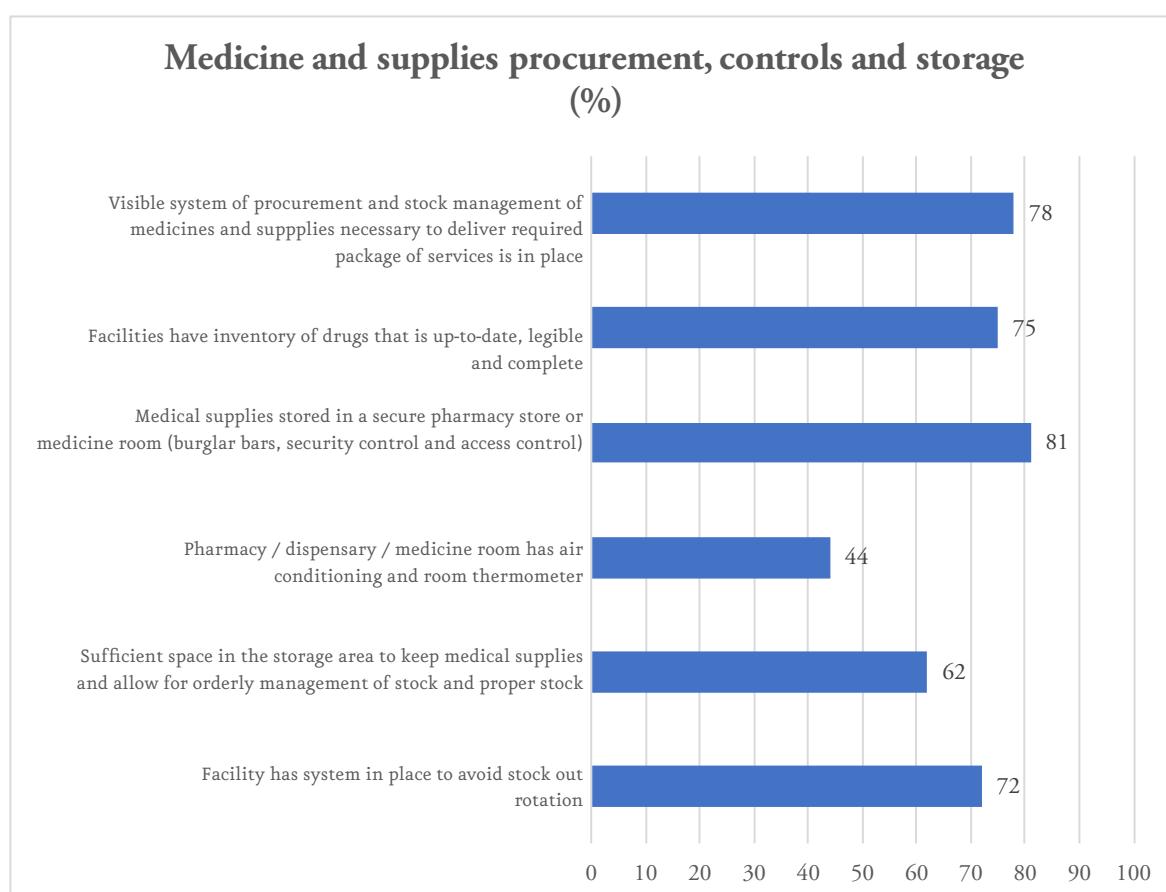
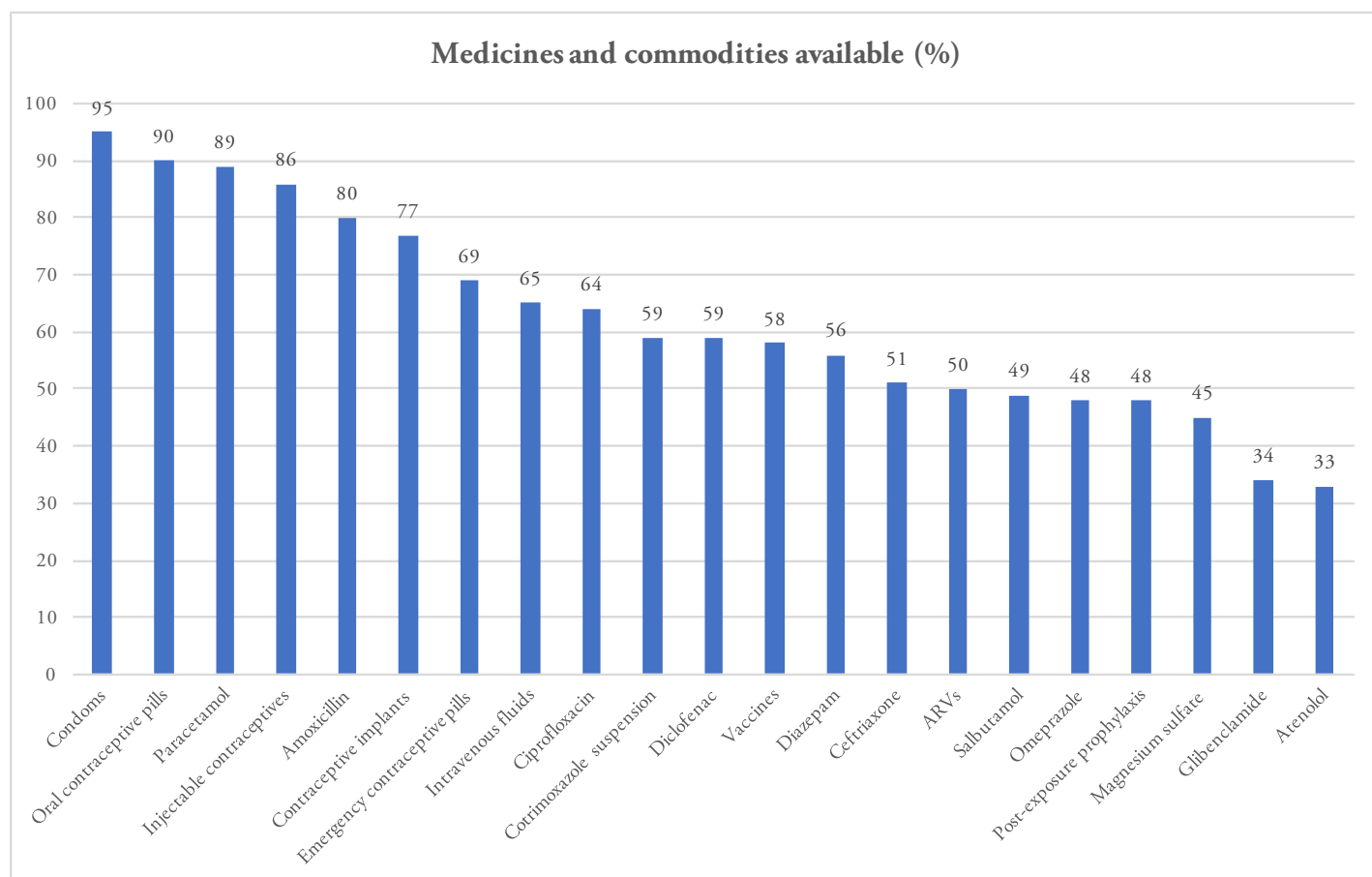


Figure 61 shows the availability of medicines and commodities in the health facilities visited. As evident, condoms, contraceptive pills, paracetamol and injectable contraceptives were available in most of the health facilities. This correlates with the fact that contraceptives were the services provided in most of the health facilities visited (refer to Standard 3). Among the items available in the least number of health facilities were PEP, while ARVs were available in half of all health facilities visited.

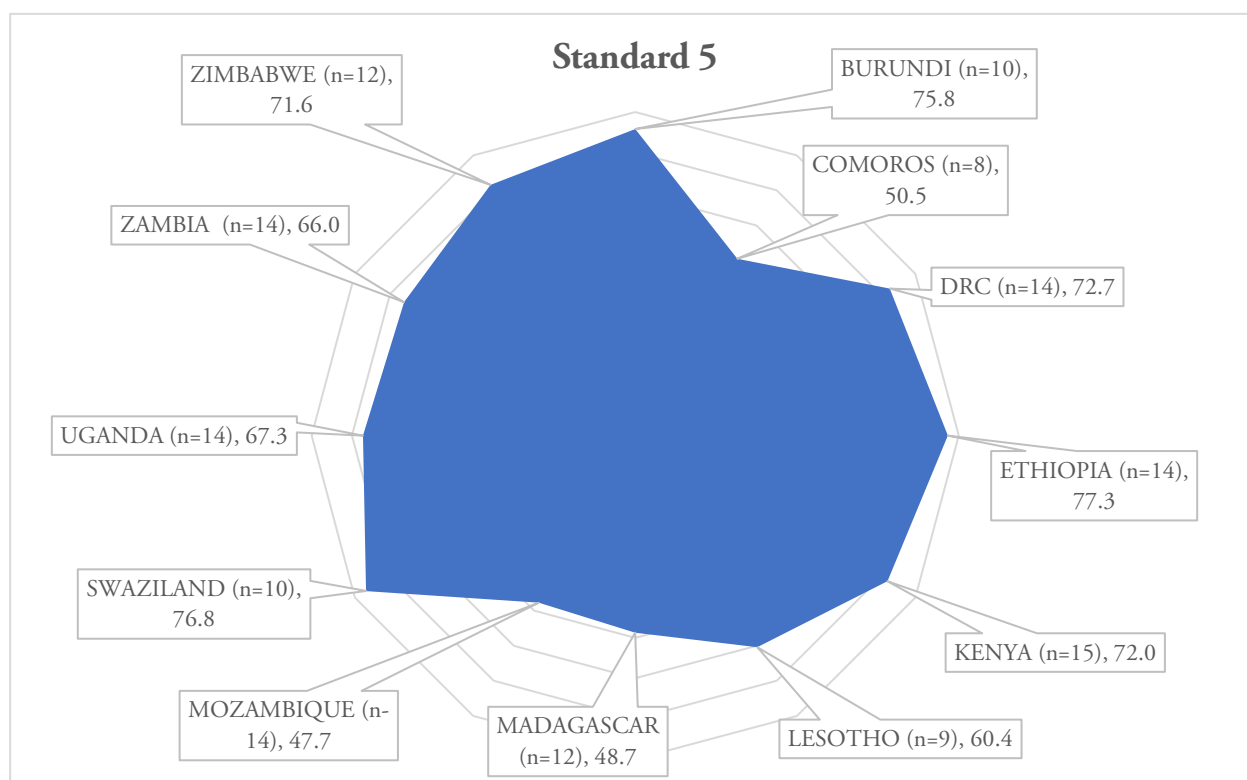
Figure 61:



The low availability of PEP is of concern considering the number of adolescents and young people living with HIV in the ESA region, the low levels of condom use, and high levels of SGBV. This also implies that health services on SRH and HIV are not yet well-integrated, with availability of contraception, maternal health, ARVs, PEP and SGBV services being inconsistent. In absence of the availability of PEP and SGBV related services, clients should be referred to services that do have them.

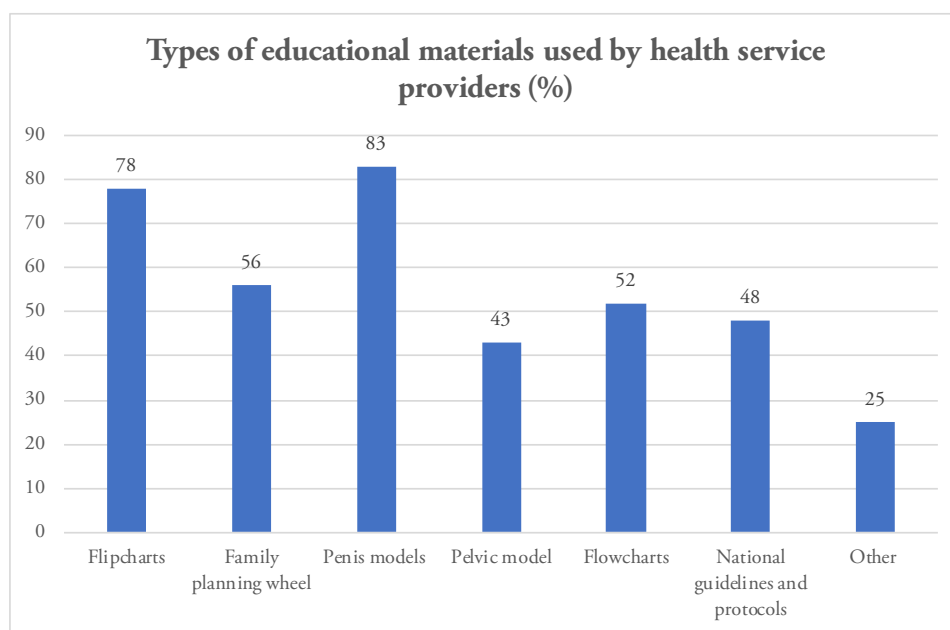
Figure 62, demonstrates how countries compared with each other on Standard 5 when looking at the data from the facility observation tool. Ethiopia had the highest score, followed by Swaziland, Burundi, DRC, Kenya and Zimbabwe. The lowest scoring countries were Mozambique and Madagascar.

Figure 62: Results of Standard 5



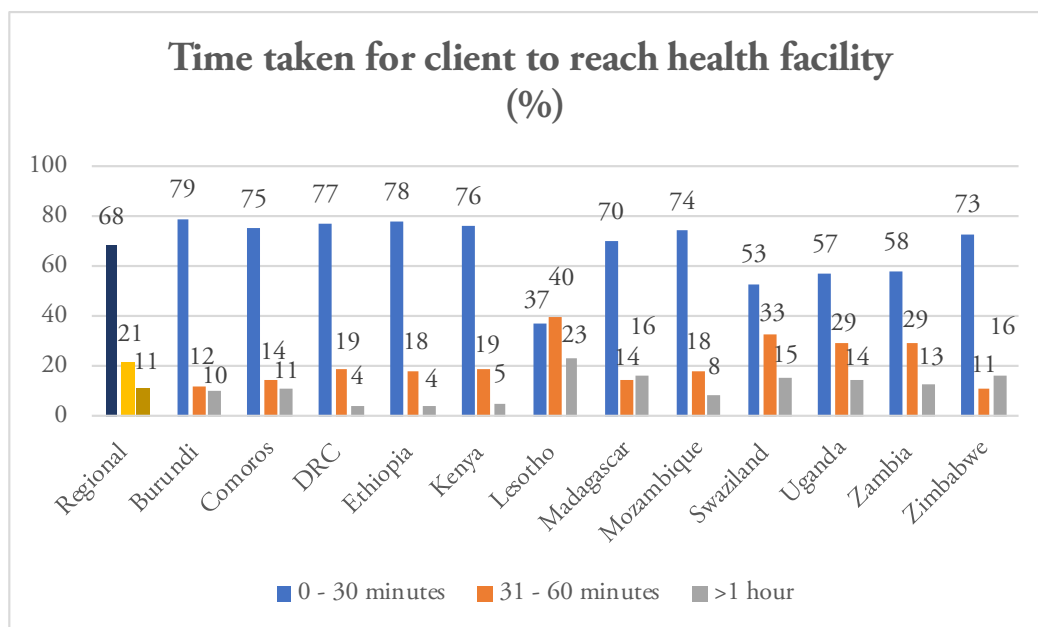
Health service providers who were interviewed were asked whether they used educational materials or gave practical demonstrations while providing services to adolescents and young people. 92% of health service providers interviewed said they did. On being asked about the types of educational materials they used, most said penis models (83%), followed by flipcharts (78%). The least number of health service providers said they used pelvic models (43%), national guidelines and protocols (48%), flowcharts (52%) and the Family Planning Wheel (56%) as shown in Figure 63. This corresponds with the health facility observations on the tools available for health service providers to deliver AYFHS (refer to Standard 4).

Figure 63:



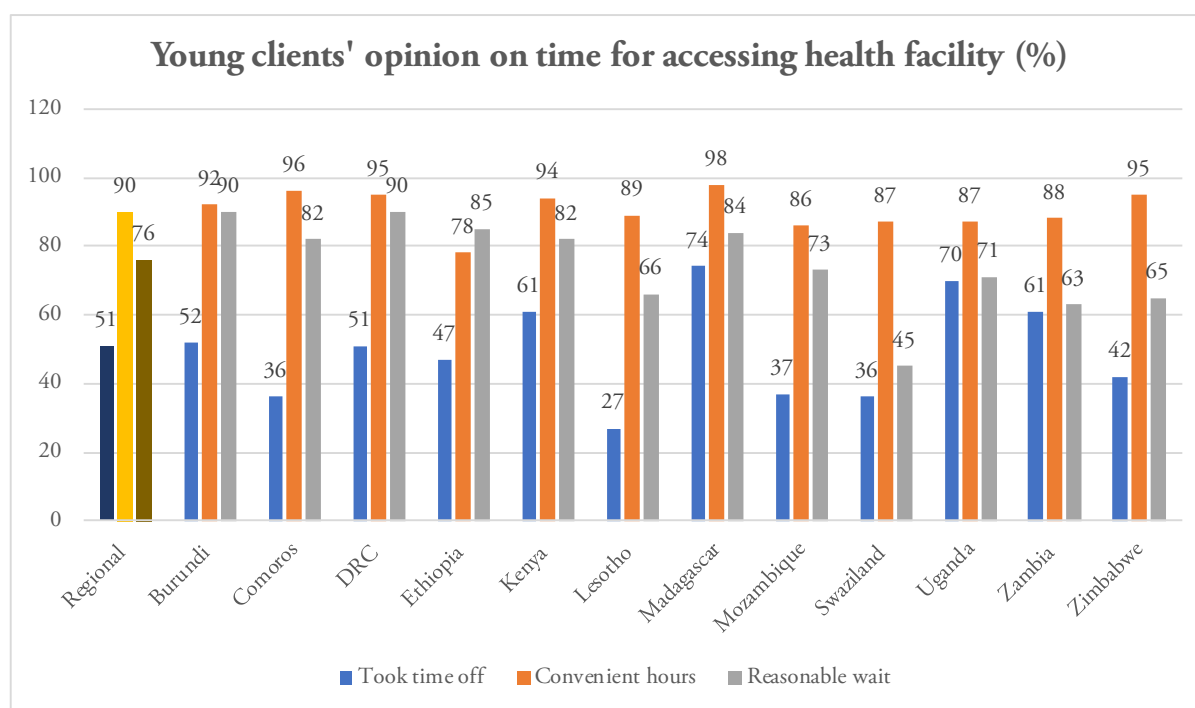
Young exit clients were asked how long it took them to reach the health facility. While 68% of all young clients interviewed said it took them between 0 and 30 minutes, 21% said it took them 31-60 minutes and 11% said it took them over an hour to get to the health facility (see Figure 64). Lesotho had the most clients reporting longer travel times to the health facility.

Figure 64:



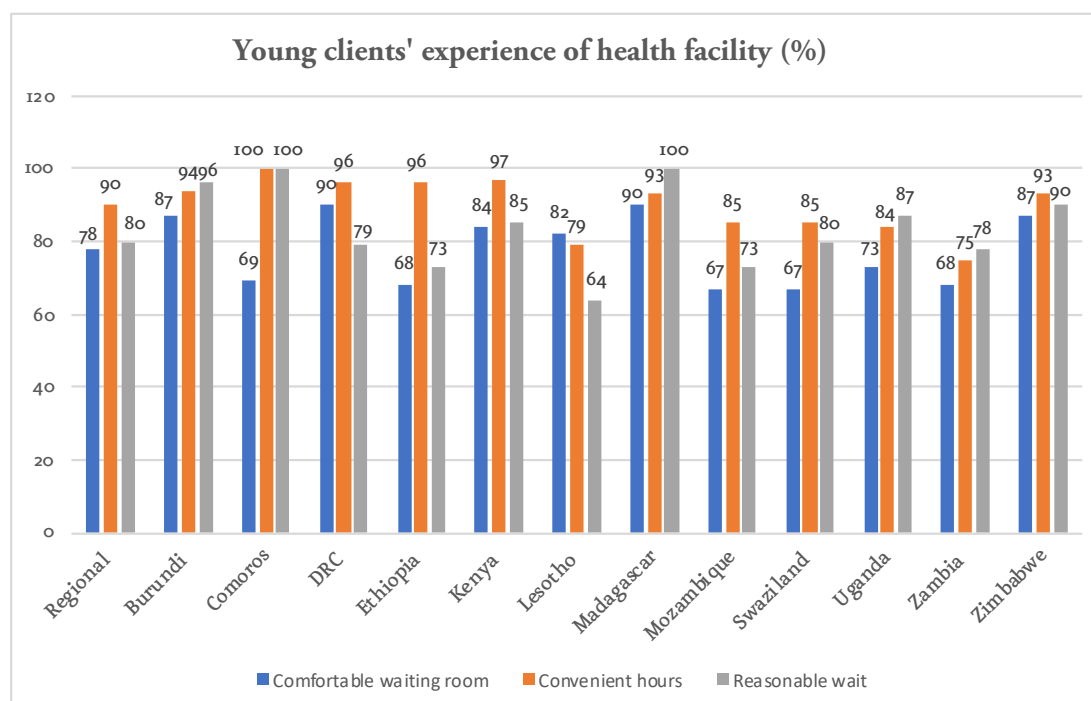
Fifty-one per cent of all the young clients interviewed said that they had to take time off from work, school, or household chores, to visit the health facility. Despite this, 90% of all clients interviewed felt that the health facility had working hours that were convenient for them. 76% of all young clients said they found a reasonably short waiting time at the health facility (see Figure 65). A high percentage of young clients had to take time off to access services in Madagascar (74%) and Uganda (70%). Lesotho had the lowest percentage of young clients who had to take time off at 27%. Swaziland had the least proportion of clients reporting that the waiting time was reasonable at 45%. In the DRC, a consistently high number of young clients found the operating hours convenient (95%) and the waiting time reasonable (90%).

Figure 65:



Young clients were typically positive about their experience of the health facility, which is also consistent with their experience of the health service providers' ability to respond to all their concerns (as seen in Standard 4). As shown in Figure 66, 78% of young clients interviewed thought that the waiting room was comfortable, 90% found the health facility clean, and 41% used the toilet – 80% of whom found it was functional and clean. In Madagascar, a consistently high number of young clients found the waiting room comfortable (90%), the health facility clean (93%), and the toilet clean and functional by those who used it.

Figure 66:



In Mozambique, young potential clients in FGDs said that they did not access the health facilities due to shame since the health facilities were integrated with adult health services. Some also cited inconvenient opening times as the reason for not using the health facilities. Similarly, in Swaziland, several young clients cited discomfort at lengthy waiting times put together with having to wait alongside adults and small children.

In Ethiopia, a key informant from a hospital mentioned that the absence of separate rooms and convenient service hours posed a big challenge to the effective delivery of AYFHS at the health facility. Young potential clients in Uganda said that seeing long queues of waiting clients deterred them from seeking health services, especially if they were not ‘feeling ill’ (i.e., not in pain). In the DRC, one potential young client said, *“A friend of mine who had attended this centre said that the healthcare providers are not nice, they have not welcomed her and their toilets are not clean. This really discouraged me, I won’t go there, I will go elsewhere.”*

In Lesotho, several peer educators mentioned stock-outs and shortage of medication in several health facilities, during FGDs. However, there were other health facilities that did not face this, thereby demonstrating a lack of equity in allocation of commodities for the provision of AYFHS across the country.

Summary and Discussion

Despite the fact that only 62% of health facilities had policies or SOPs in place to ensure clean and welcoming environments, minimal waiting time, and convenient operating hours, among others, a majority of the young exit clients were satisfied with these aspects of the health facilities. However, when speaking to young people who are not yet accessing the health services (i.e., potential clients), it was clear that the operating hours and waiting times constituted barriers to their access. Specifically, in the case of Mozambique, Swaziland and Uganda, where young clients and young people who do not use the health facilities have both cited problems related to waiting time, operating hours, and lack of privacy when waiting for services. In Uganda, for example, young clients cited absenteeism and late coming among the health facility staff as contributing to the long waiting hours.

In addition, while basic amenities seem provided for, infrastructural issues of privacy and confidentiality are not as well catered to, including for example, anonymous registration. Even though this does not appear to affect the level of satisfaction expressed by young clients, it remains a barrier for those adolescents and young people who are not accessing the services. Adolescents’ and young people’s low knowledge of their rights as clients may explain the fact that they are not demanding better services and better health facilities, including enhanced privacy and confidentiality.

Some health service providers across many of the countries cited lack of adequate medicines, supplies, equipment or specialists as barriers to providing services to adolescents and young people. In Ethiopia, for example, the Assessment team was unable to find specific budget allocations for AYFHS in the government health facilities, while in comparison, the NGO health facilities tended to provide separate and/or exclusive services to adolescents and young people. The issue of inadequate resources was also raised by key informants, as well as lack of drugs at the health facilities by FGD respondents in Uganda.

As evident, resource allocation and implementation of the standards set on basic health facility characteristics is necessary. However, this is necessary not only for adolescents and young people, but in fact for all clients to be able to access health services. Therefore, adopting a health systems strengthening approach and making the system more client-oriented would be a more effective utilisation of scarce resources. For example, investing in reducing waiting times would be a more effective investment of resources than on improving the waiting areas.

The majority of young clients needed less than 30 minutes to reach the clinic, and this in itself might be a bias

with regard to the young clients accessing health services. However, this also contradicts what some potential young clients have said about wanting to go further to access services rather than using the neighbourhood clinic due to concerns around privacy. As discussed earlier, this indicates that the profile of the young clients accessing the services is different from that of those who are not (i.e., they have support from family and community to access services). It seems this support is more important than the actual distance from services to facilitate adolescents’ and young people’s access to services.

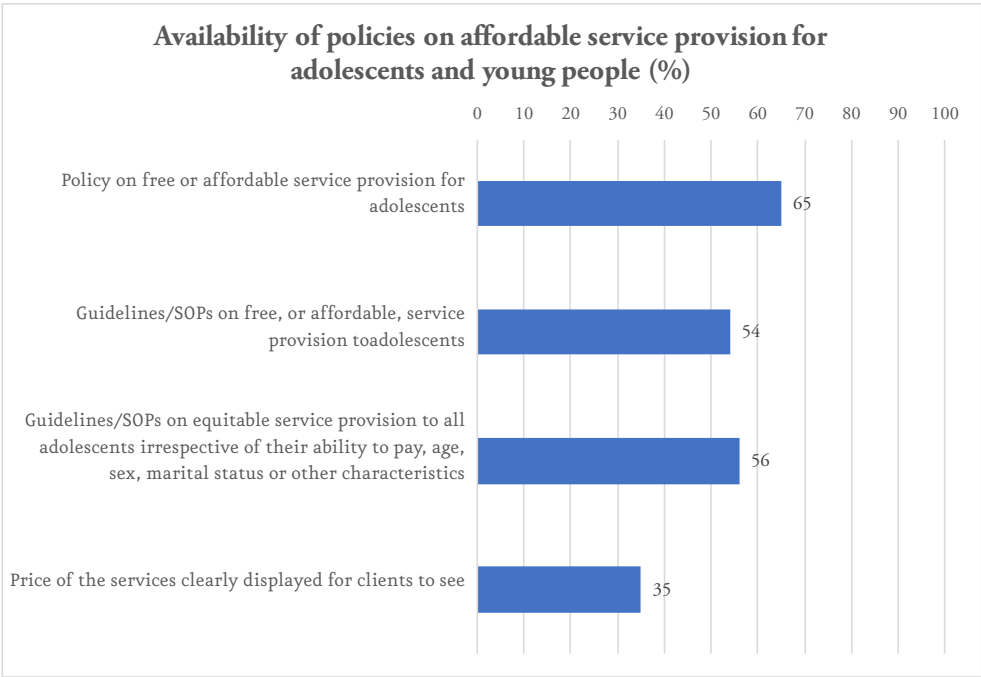
Similarly, most young clients found the opening hours of the health facilities convenient, even though less than half had specific hours for adolescents and young people, and just over half were open after-school hours or on weekends. Since most of the health facilities were integrated rather than stand-alone health facilities for adolescents and young people, it may imply that separate or special opening hours for adolescents and young people may not be necessary. However, what is convenient for these young people who are accessing the services may not be convenient for the adolescents and young people who are not accessing them. This could be due to their being unable to leave work, school or household chores to visit the health facility. Thus, the context of the health facility is an important deciding factor for such things as opening hours, location, etc. For example, when trying to provide health facilities to marginalised, excluded and vulnerable groups of adolescents and young people, there may be the need for a stand-alone health facility or separate timings.

9.7 Standard 6: Equity and Non-Discrimination

Under this standard, health facilities were observed for existence of policies on free or affordable services for adolescents and young people, as well as on child protection, and health service providers were asked about the types of clients they provided services to, for example married or not, in or out of school, LGBT, YPLHIV, sex workers, or young people who use drugs, among others. Young clients were interviewed about their impressions of staff at the health facility, including biases or discriminatory attitudes.

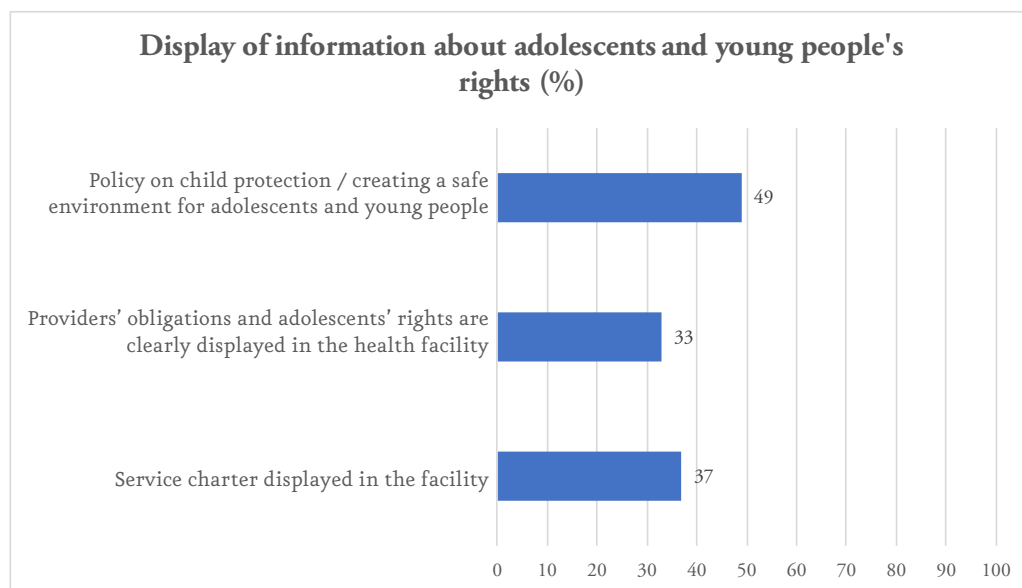
Only 65% of all health facilities visited had a policy on free or affordable service provision for adolescents and young people, and less (54%) had guidelines or SOPs on the same. Similarly, only 56% health facilities had guidelines or SOPs on equitable service provision to all adolescents and young people regardless of their ability to pay, age, sex, marital status or other characteristics, and only 35% had prices clearly displayed for all clients to see (see Figure 67).

Figure 67



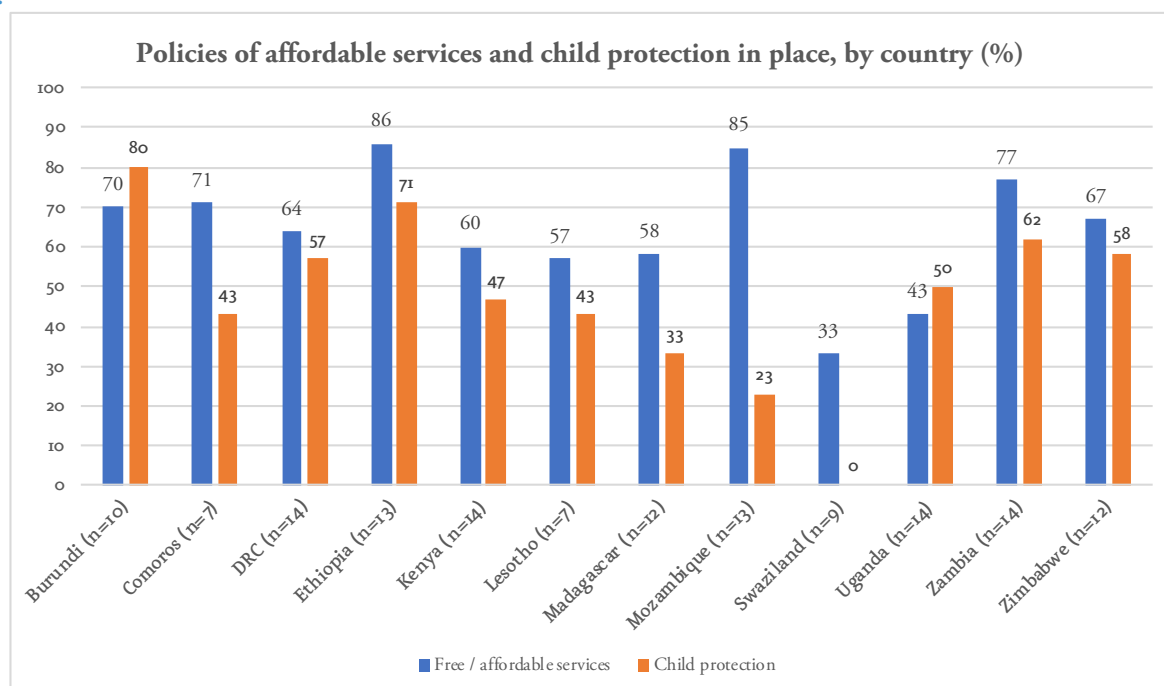
Only 49% of all health facilities visited had a policy on child protection or creating a safe environment for adolescents and young people, and fewer health facilities had clear displays of health service providers' obligations and adolescents' and young people's rights (33%) and/or the service charter on SRH rights (37%) (See Figure 68).

Figure 68:



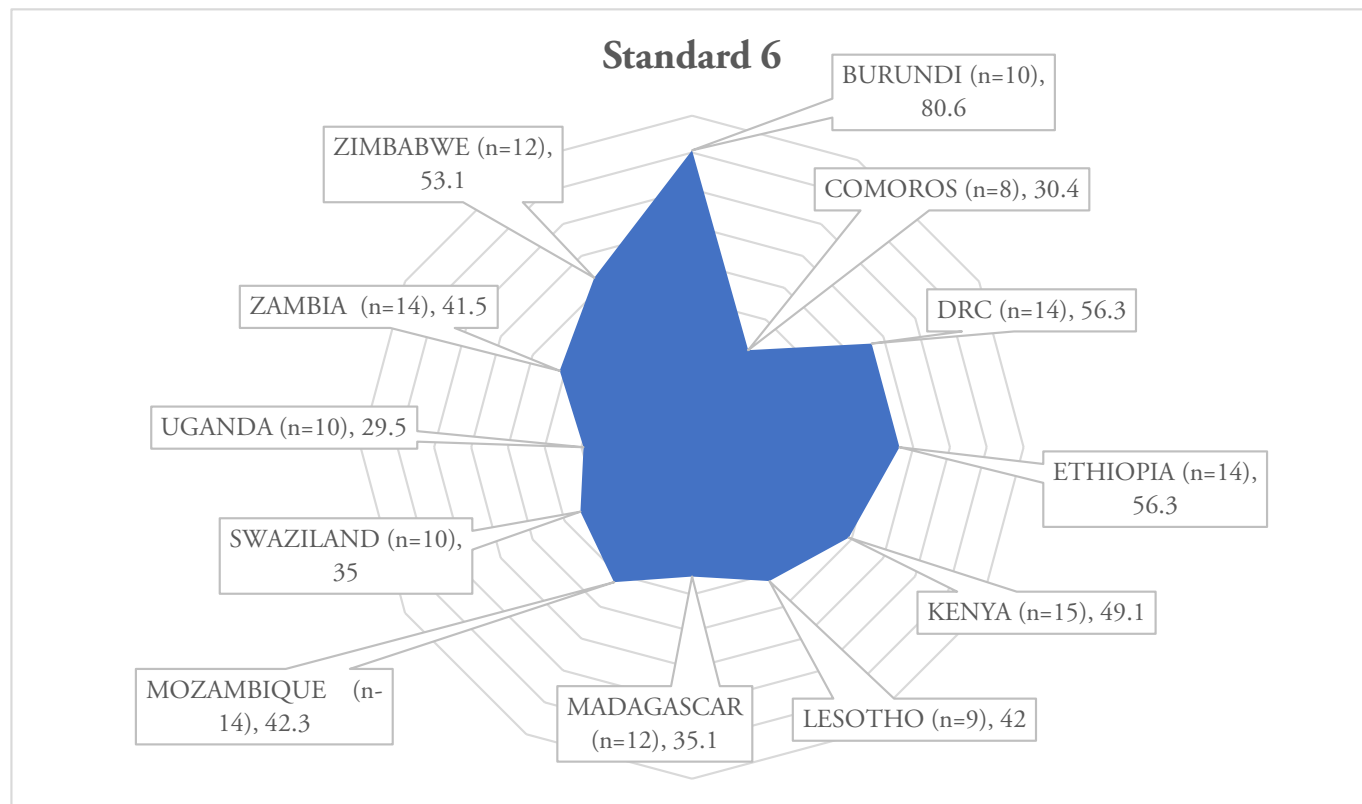
As demonstrated in Figure 69, Swaziland (33% or 3 of 9) and Uganda (43% or 6 of 14) had the least percentage of health facilities with policies on providing free / affordable services to adolescents and young people in place, while Ethiopia (86% or 12 of 14) and Mozambique (85% or 11 of 13) had the highest percentage of health facilities with this. The highest percentage of health facilities having child protection policies (or policies for creating a safe environment for adolescents and young people) in place was Burundi (80% or 8 of 10). The smallest percentage of health facilities with child protection policies, or policies for creating a safe environment for adolescents and young people, were in Mozambique (23% or 3 of 13) and Madagascar (33% or 4 of 12). There were none in Swaziland.

Figure 69:



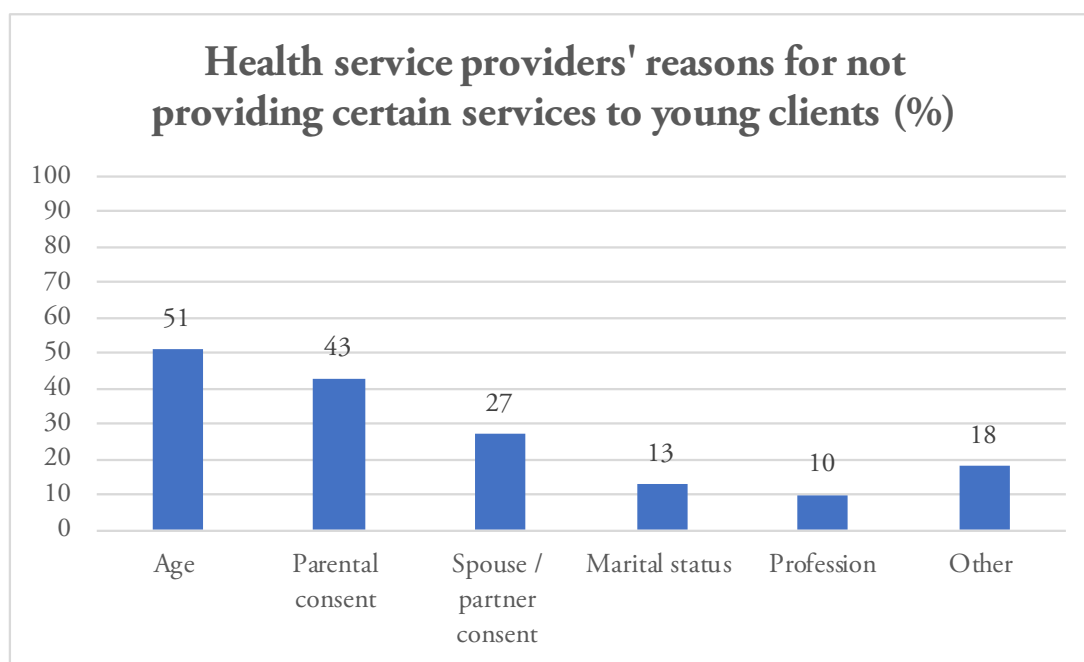
As can be seen in Figure 70, the overall scores based on the facility observation tool for Standard 6 were low across all countries. Burundi stood out with the highest score, while the rest of the countries were significantly lower. Uganda being the lowest, followed by Comoros, Swaziland, Madagascar, Zambia, Lesotho and Mozambique.

Figure 70: Results for Standard 6



Health service providers were asked whether there were any services that could not be provided to adolescents and young people due to age, need for parental, spousal or partner consent, marital status, profession or other reasons. 51% of all health service providers interviewed said that there were some services that could not be provided to adolescents and young people due to age, 43% said due to requirement of parental consent, 27% due to spouse or partner's consent, and 13% due to marital status (see Figure 71).

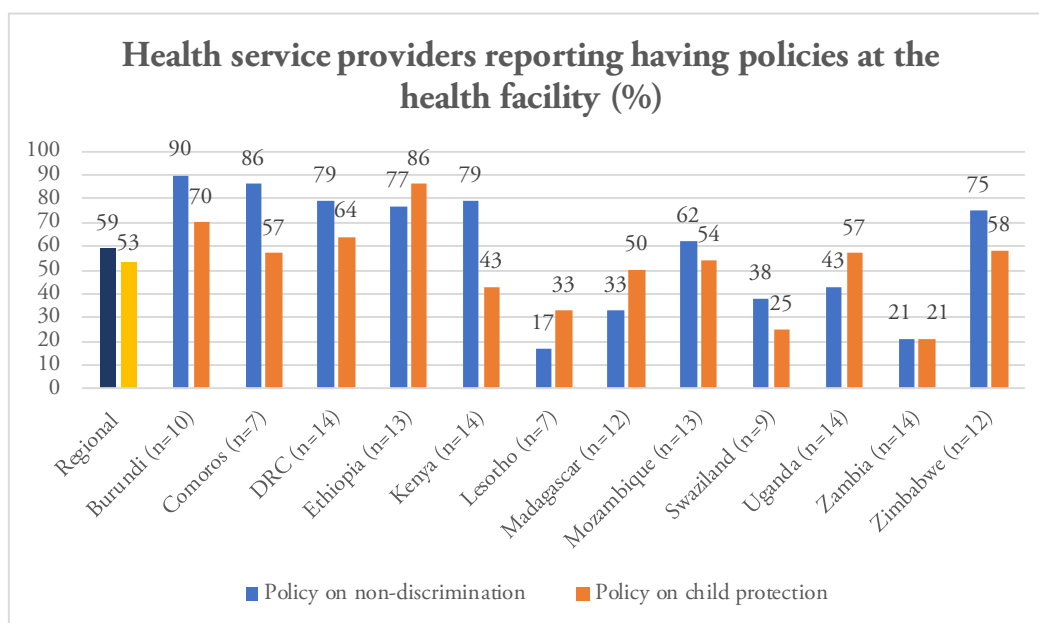
Figure 71:



About 62% of those saying that services could not be provided based on age, referred to contraceptive methods, especially long-acting methods as not being provided to adolescents and young people. Other services not provided due to age were HIV testing and cervical cancer screening. Similarly, 52% of those saying that parental consent was required for adolescents and young people referred to their accessing contraceptive services, especially long-acting or permanent methods, 36% referred to HIV testing services, and the rest to abortion and male circumcision. 59% of those who said that spouse or partner consent was required to access services also referred to contraceptive services, especially long-acting ones, while the rest referred to HIV and other STI related services and abortion. This was similar for services linked with marital status. Services denied on the basis of clients' profession (e.g., sex workers) included gynaecological services, mental health services, among others. Those who answered 'other' mostly referred to contraindications for services, while two of the 23 who said other referred to religion as a reason for denying services to adolescents and young people, three said abortion, and one said that management of sexual violence was not possible due to lack of kits.

Health service providers were also asked about the policies they had in place at the health facility on non-discrimination and child protection. Only 59% of all health service providers interviewed said they had a policy on non-discrimination, and 53% said there was a policy on child protection (see Figure 72). This was not vastly different from the results of the facility observation tool reported above.

Figure 72:



More health service providers in Madagascar, Mozambique and Swaziland reported having child protection policies in place than were observed through the facility observation tool. Especially in Swaziland, none were found to have child protection policies in place by the Assessment team, but 25% of the health service providers said they had them. In Zambia however, less numbers of health service providers said there were child protection policies compared with the findings from the facility observation tool.

98% of all health service providers interviewed affirmed that all adolescents and young people have the right to access health services, especially SRH (the least percentage of health service providers affirming this was in Comoros at 86% or 6 of 7). Equally, 94% of all health service providers interviewed said that they were aware of client rights (Lesotho had the least health service providers affirming this at 83% or 5 of 6). In terms of the diversity of young clients who were provided with health services, the health service providers interviewed reported that the following types of clients were served by their health facility (see Table 8).

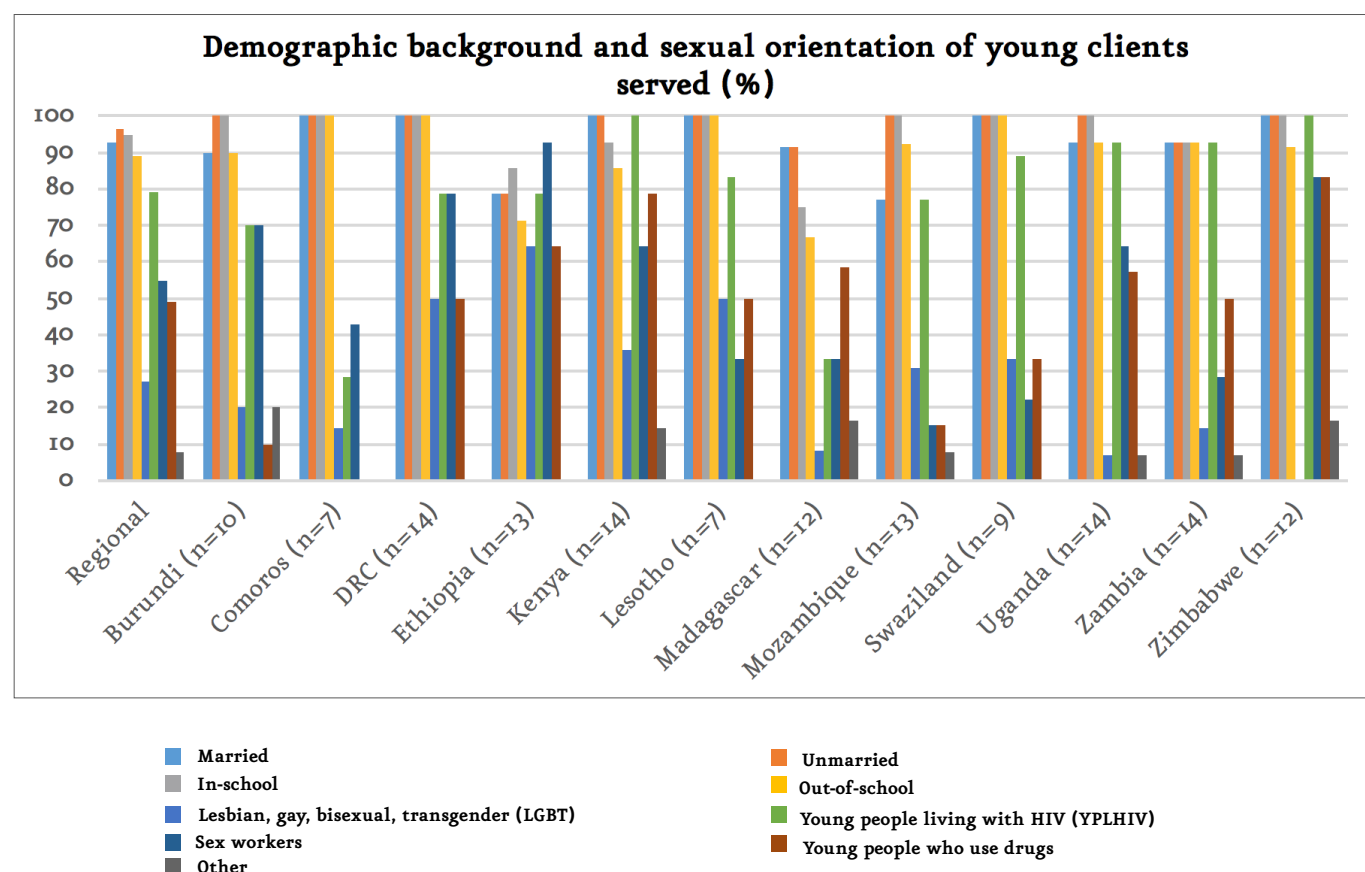
Table 8: Type of Clients Served by Health Facilities

Married	Unmarried	In-school	Out-of-school	Lesbian, gay, bisexual, transgender (LGBT)	Young people living with HIV (YPLHIV)	Sex workers	Young people who use drugs	Other
93%	96%	95%	89%	27%	79%	55%	49%	8%

The young clients most served as reported by health services providers were adolescents or young people who were married, unmarried, in-school, out-of-school and living with HIV (see Figure 73). The lowest percentage of health service providers reporting service provision to married young people was in Mozambique at 77% (10 of 13); on the other hand, a 100% of health service providers in Mozambique reported providing services to in-school young people. The lowest percentage of health service providers that reported serving YPLHIV was in Comoros at only 29% (2 of 7) and in Madagascar at 33% (4 of 12).

All countries had a much lower percentage of health service providers reporting service provision to LGBT adolescents and young people, with Ethiopia (64% or 9 of 14), and the DRC and Lesotho (both at 50% or 7 of 14, and 3 of 6 respectively) having the highest percentages of health service providers reporting service provision. In Zimbabwe, none of the health service providers reported serving LGBT adolescents and young people, while in Uganda it was 7% (1 of 14) and 8% Madagascar (1 of 12). Ethiopia (93% or 13 of 14) and Zimbabwe (83% or 10 of 12) had the highest percentages of health service providers reporting service provision to young sex workers, while only 15% (2 of 13) in Mozambique and 22% (2 of 9) in Swaziland. Also in Zimbabwe (83% or 10 of 12) health service providers reported serving adolescents and young people who use drugs, followed by Kenya at 79% (11 of 14), while Burundi (10% or 1 of 10) and Mozambique (15% or 2 of 13) had the lowest percentage of health service providers reporting this and Comoros had none. Among those who said 'other', they included fisher folk, domestic workers, young people with disabilities, young prisoners and orphans.

Figure 73:



In the DRC, the peer educators said that they reached all categories of adolescents and young people without discrimination. One said, *“During my youth awareness activities, I encounter all categories of young people: the educated, the out-of-school, the married, the unmarried, young people living with HIV, young people living on the street, lesbians, homosexuals, etc. I do not judge them, on the contrary I get closer to them to convey to them the messages about their health.”*

In Ethiopia, two of the health facilities that were visited had specific outreach programmes to reach sex workers. However, health service providers in Ethiopia admitted that there were instances of services not being provided to adolescents and young people due to their sexual orientation. In addition, young outreach workers in Ethiopia revealed that marginalised and vulnerable adolescents and young people do not feel comfortable accessing services due to the conservative culture in the community. There is no specific standard addressing equity and non-discrimination in Ethiopia.

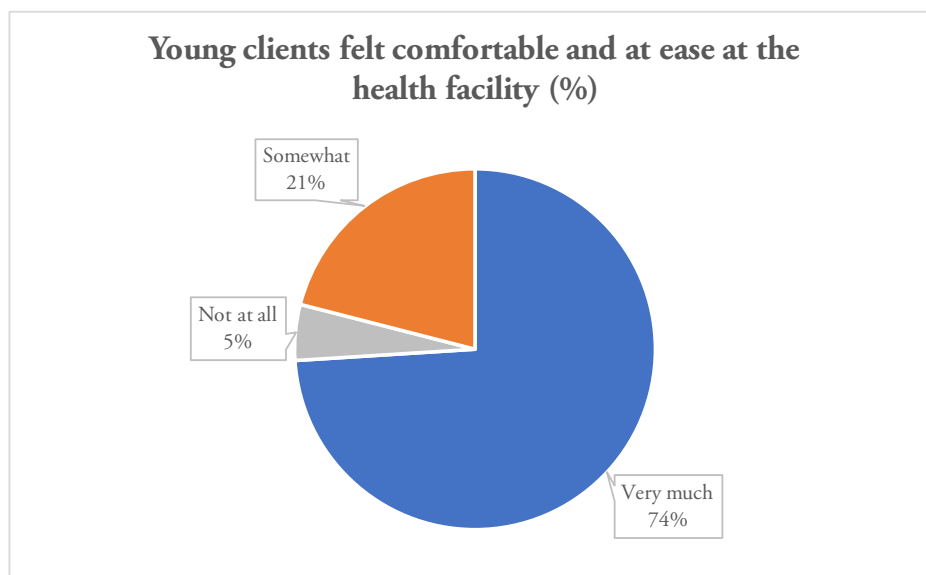
FGDs with peer educators and potential young clients in Zimbabwe revealed that young mothers with children did not feel that youth centres were meant for them and they feared abuse. One young mother said this about nurses, *“...they have an attitude to me as a 16-year-old mother,”* implying a lack of respect from the nurses. In Uganda, health service providers stated marital status and/or spousal consent as a key requirement for offering long-acting or permanent contraception. In Lesotho, despite policy documents specifying groups to be served (including those physically challenged), there were gaps as highlighted by peer educators in the FGDs, *“Those visually impaired can’t access written information. We do not serve this group as efficiently as expected.”* Another peer educator said, *“Health service providers may not be comfortable to work with drug abusers because they are just like mad people,”* thus demonstrating the lack of positive attitudes towards diverse groups of young people.

The questions on ‘who is being served’ at the health facility were intended to reflect the attitude and ability of the health service providers on diverse groups of adolescents and young people. The assumption being that if the health service provider is skilled and competent with an open and non-judgemental attitude, they would be able to get a clear case history of the client, including sexual practices and preferences (where relevant), occupational hazards, and/or other risky behaviours. Thus, they would be able to address adolescents’ and young people’s health issues in a holistic manner, and be able to assert that they did indeed serve young clients who used substances, were sex workers, and/or had diverse sexual orientations, among other diversities, and addressed their needs accordingly. For outreach, this would mean putting in place intensified and special measures that attract marginalised and vulnerable adolescents and young people, and invite them into the clinic, rather than simply stating that the services were ‘open to all’.

Forty-eight per cent of all the young clients interviewed said that they had had contact with support staff (i.e., receptionist, cleaning staff, security staff, etc.), 96% of whom said that they felt the staff were friendly and treated them with respect. The 19 young clients who said that the staff were not friendly or did not treat them with respect, were from Burundi (1), the DRC (1), Ethiopia (3), Lesotho (1), Mozambique (1), Swaziland (2), Uganda (1), Zambia (8) and Zimbabwe (1). Of these 19, 5 young clients said that the staff had been rude or harsh, and 4 said they did not know why the staff had acted in the way they did.

As seen in Figure 74, a majority of the young exit clients felt very comfortable and at ease at the health facility, except in Ethiopia (48%), and were of the view that the staff understood adolescents' and young people's concerns on sexuality and sexual relationships, except in Ethiopia (51%) and Uganda (63%). This corresponds with the findings in Standard 4 where 92% of young clients in all countries reported that the health service provider they had seen had responded to all their concerns satisfactorily (including Ethiopia and Uganda with 86% of young clients reporting satisfaction).

Figure 74:



Of those who said they were not at all comfortable at the health facility (i.e., 50 clients of 964), 28% said this was because the staff were rude or harsh, 16% said it was due to the long waiting hours, 14% felt uncomfortable with the presence of adults in the same facility, 9% said they did not get the services they came for, and a further 9% said they did not find the health facility clean or comfortable.

In Swaziland, peer educators in FGDs reported receiving negative feedback from young clients about support staff being rude and unwelcoming. They also cited frequent cases of nurses lacking respect and inflicting physical violence on adolescents and young people who go to health facilities to give birth. In other instances, the peer educators said the young clients are scolded for being sexually active at their age. Similarly, in Burundi, young people said that they did not use services because “providers do not care for patients, they even insult patients.” In Uganda, one peer educator said that “I would like to give my opinion but listening to it is what I see as an impossibility. This is so because, even those that are above me have always presented their opinion without response for example the VHTs,” thus exemplifying the lack of voice adolescents and young people have in health facility feedback and decision-making.

The young clients were also asked whether they knew what they could do if they did not feel safe at the health facility or were unhappy with the visit. Only 37% said they would know what to do, and of these many said they would go to another health facility, and others said they would register a complaint or use the suggestion box. A few said they would simply go home.

Sixty-six per cent of all young clients interviewed felt that all staff understood adolescents' and young people's concerns on sexuality and sexual relationships (93% in Comoros, but only 31% in Ethiopia). Only 42% of young clients interviewed had seen a display which mentioned that services would be provided to all adolescents and young people without discrimination (only 19% in Lesotho). Therefore, despite 98% of health

service providers interviewed affirming that all adolescents and young people have the right to access services, there remains a consistent lack of effort to educate adolescents and young people, including young clients at the health facilities, on their rights.

Summary and Discussion

The fact that much needs to be done on equity and non-discrimination is exemplified by this quote from a key informant in Kenya, *“There is no equity. I would imagine equity to mean more resources where there is more need. That will mean we put more resources in areas for example places which are marginalised but that is not the case as we have invested more in Nairobi than in Turkana or in Mandera which are Kenya’s marginalised areas.”* This inequity is symptomatic of all the countries, not only in terms of where and how resources have been invested, but also in terms of who is (not) being reached by the health services. In addition, while many health service providers across the ESA region said they served YPLHIV, it was seen under Standard 3, that only half of the health facilities visited had ARVs.

As explained above, there are certain groups in each country that are typically left out of service access, the common ones across the board being LGBT adolescents and young people and young people who use drugs. Added to this is the lack of adequate policies and guidelines on issues of equity and non-discrimination. The claim of the health system, or health facilities, or health service providers being ‘open to all’ cannot be used to hide behind the fact that marginalised and excluded, and vulnerable groups of young people are not being reached specifically.

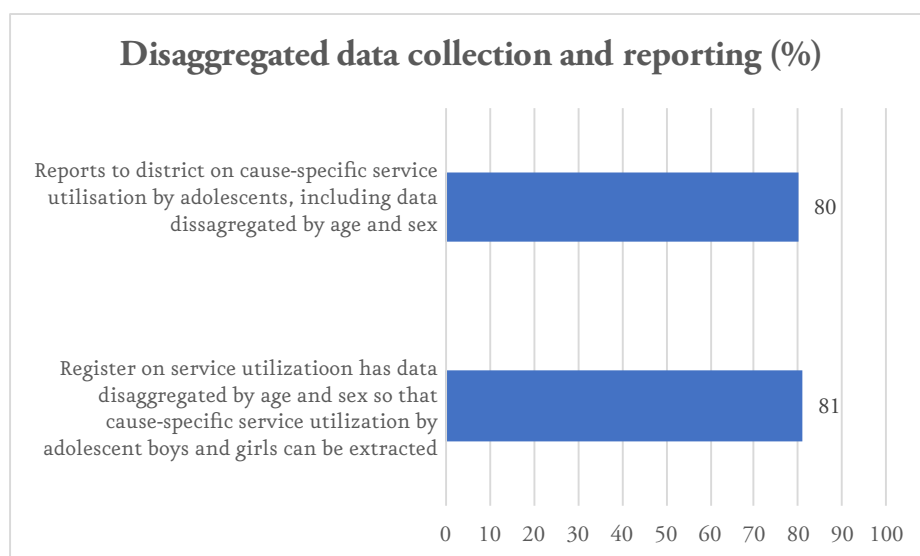
The issue of rights is not being adequately dealt with – neither in the display and delivery of information to adolescents and young people on their rights, nor in the adoption or dissemination of policies that respect, protect, fulfil adolescents’ and young people’s rights. Most health service providers confirmed having the knowledge of clients’ rights (refer to Standard 4) and the analysis of the data on training they report having received reveals that 70% of health service providers interviewed had been trained on, ‘providing effective health services that respect, protect and fulfil adolescents’ and ‘youth’s rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect’ and 55% of them had been trained on, ‘human rights-based approach to adolescent and youth healthcare.’ While this is a positive finding, the lack of focus on educating adolescents and young people about their rights results in them not being able to demand their rights to access health services in an equitable manner.

9.8 Standard 7: Data and Quality Improvement

This standard examined the data collection, analysis and reporting at the health facility level, as well as looking at tools and mechanisms for supportive supervision, self-monitoring, rewards and recognition. Data disaggregation by age, sex and type of health service provided was investigated as was the supervisory support given to health service providers.

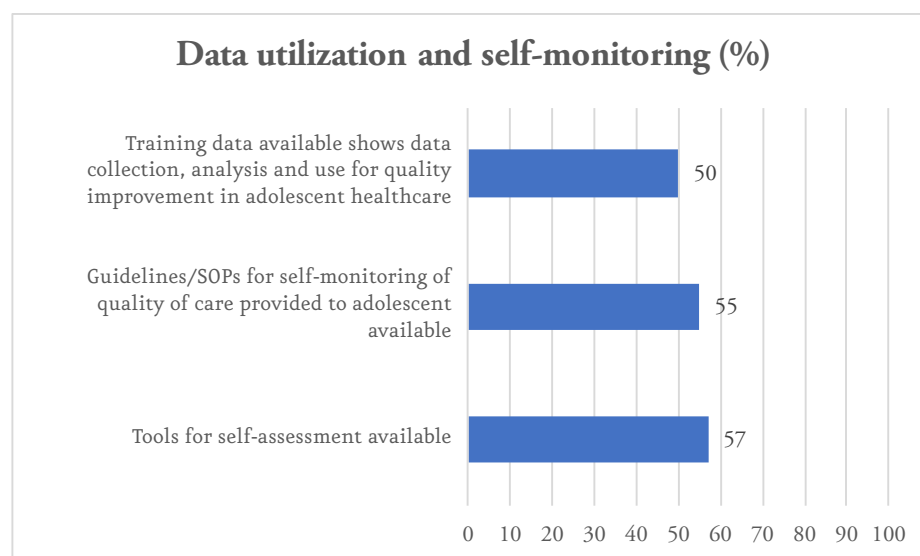
Findings from the facility observation tool reveal that a considerable number of the health facilities visited were reporting to their districts on cause-specific service utilisation by adolescents and young people (80%). In addition, 81% of the health facilities had data disaggregated by age and sex on their service utilisation registers (see Figure 75). This is an interesting finding, as only Swaziland has guidelines specifying on age disaggregation.

Figure 75:



On the other hand, evidence of data utilisation for self-monitoring was seen in fewer health facilities, with 55% of health facilities having guidelines or SOPs for self-monitoring of quality of care provided to adolescents (see Figure 76). Only half of health facilities had data that showed that staff had been trained on data collection, analysis and use for quality improvement in adolescent healthcare.

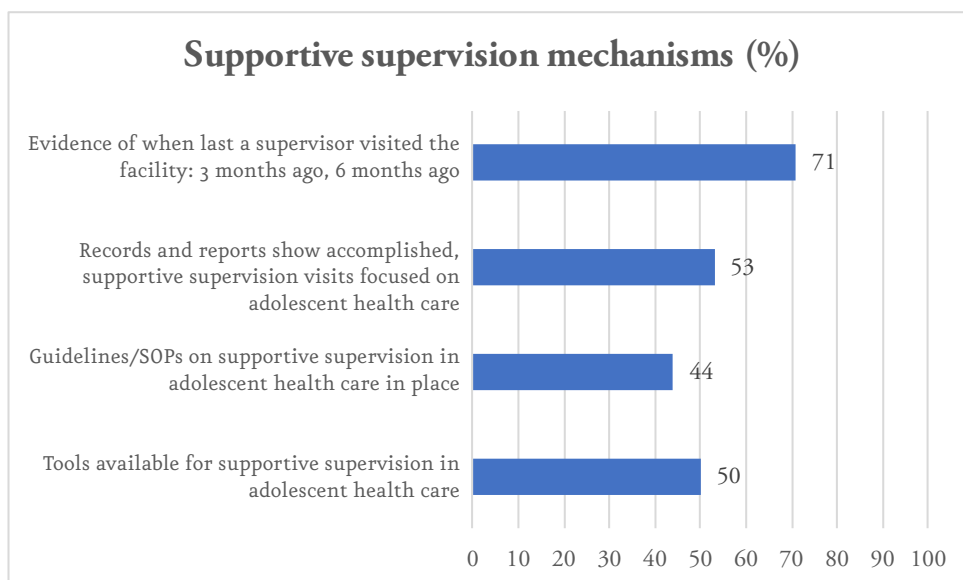
Figure 76:



Ethiopia (86%) had the highest percentage of health facilities where guidelines on self-monitoring of quality of care for adolescents and young people were observed, followed by Burundi at 80% and Zimbabwe at 75%, and with Madagascar (25%) and Lesotho (29%) having the lowest percentage of health facilities with these guidelines. The tools for self-assessment were only observed in 50% of the health facilities in Zimbabwe. The lowest percentage of health facilities to have the tools were in Lesotho and Uganda (14% each).

While there was evidence of a supervisor visit in the last 3 to 6 months in 71% of health facilities visited, only 53% of the health facilities had records to show that supportive supervision visits focused on adolescent healthcare had taken place (see Figure 77). As with self-monitoring, guidelines or SOPs on supportive supervision in adolescent health were only in place in 44% of all health facilities visited.

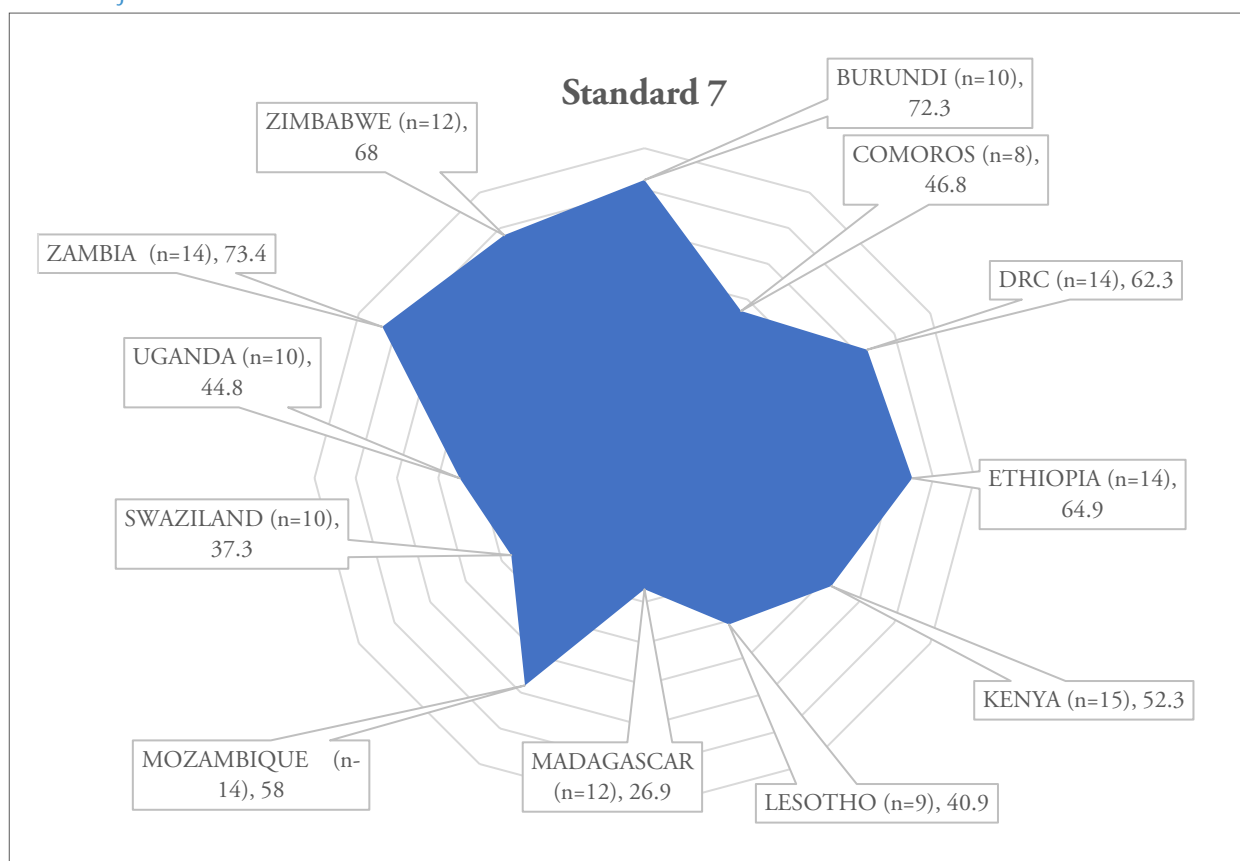
Figure 77:



Guidelines on reward and recognition for high performing staff were observed in only 28% of health facilities visited. The highest percentage of health facilities observed to have these were in Ethiopia at 79%. There were none in Lesotho, and only 7% and 8% in Uganda and Zimbabwe respectively.

Figure 78, demonstrates how countries compared with each other on Standard 7 when looking at the data from the facility observation tool. Zambia and Burundi had the highest scores, with Madagascar and Swaziland being the lowest.

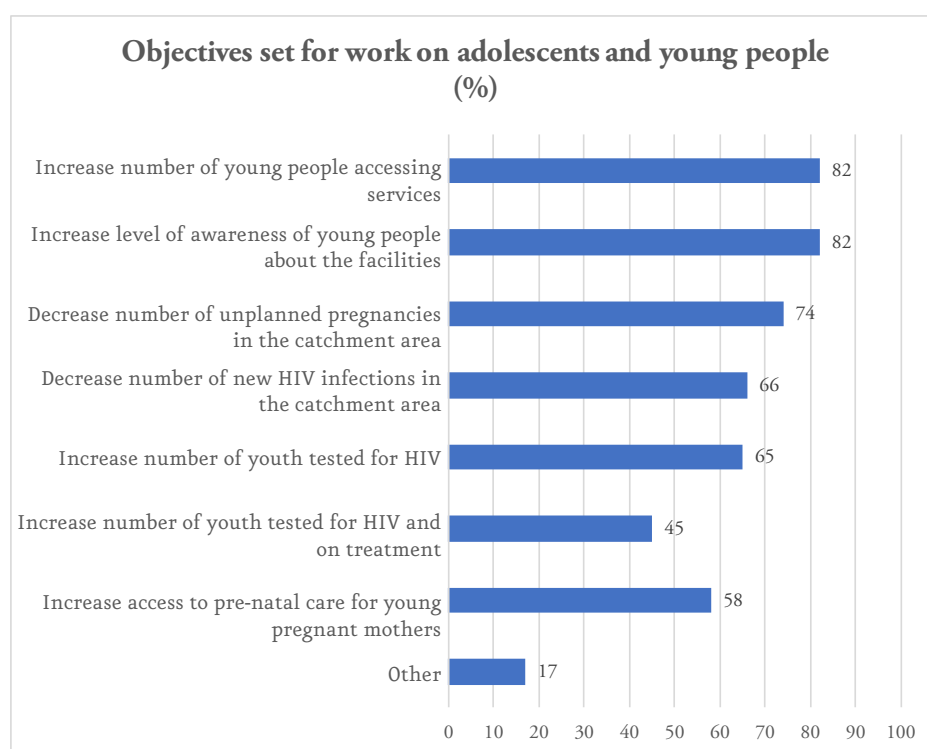
Figure 78: Results for Standard 7



Health service providers were asked whether they set objectives for the work on adolescents and young people, and 72% of health service providers interviewed said that they did so. Whereas in Zimbabwe, 100% of health service providers reported that their health facility had set objectives for their work on AYFHS, Lesotho and Uganda (50% or 3 of 6, and 7 of 14, respectively) had the lowest percentages of health service providers reporting setting objectives for working with adolescents and young people.

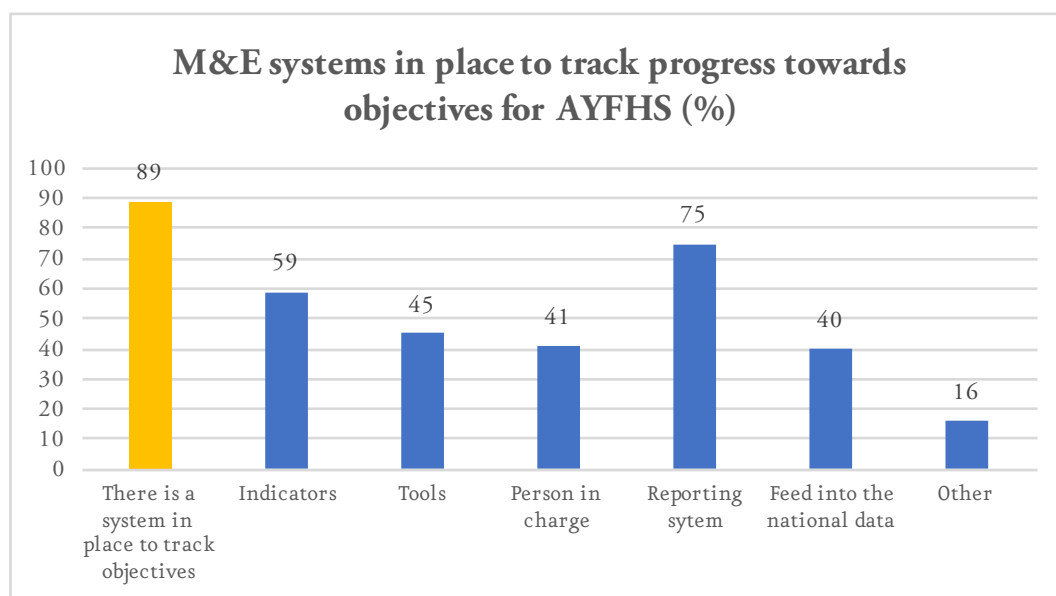
Most of the health service providers mentioned increasing the number of adolescents and young people accessing health services and increasing the level of awareness of adolescents and young people about the health facilities (82%). Those who were setting objectives were not focusing on the epidemiological concerns of the region as demonstrated in Figure 79. Only 45% said they had set objectives to increase the number of adolescents and young people tested for HIV and on treatment. Considering that only 50% of the health facilities visited had ARVs, this is understandable even though it does not respond to the HIV prevalence among adolescents and young people in these countries. In effect, the objectives listed should be the drivers for the policies and workplans of the health facilities. It is therefore surprising that 25% of the health service providers said they do not have objectives to decrease unintended pregnancies, and 34% said that they do not have objectives to decrease new HIV infections.

Figure 79:



When asked whether there were systems in place to track these objectives, 89% of the 72% who enumerated the objectives said there were, and 75% of these health service providers mentioned a reporting system being in place (see Figure 80).

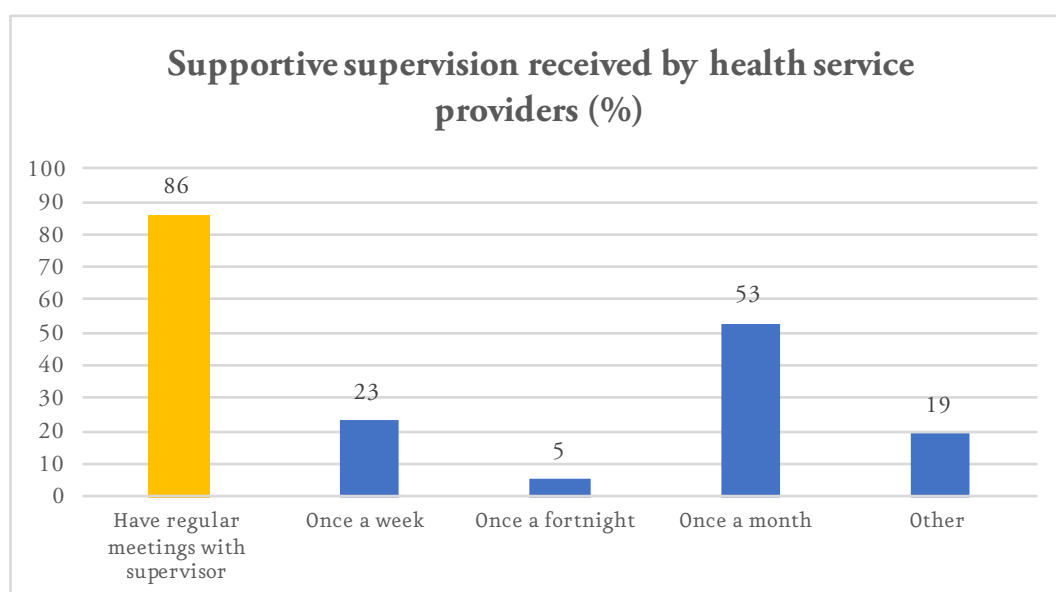
Figure 80:



Eighty-eight per cent of health service providers interviewed confirmed that they recorded client data disaggregated by age, sex and type of health service provided. Madagascar was the country with the lowest percentage of health service providers confirming this (55%) (i.e., 7 of 11 said they disaggregate by age, 6 of 11 said they disaggregate by sex, and 5 of 11 said they disaggregate by type of service). 86% of health service providers interviewed said that they used this data to inform service delivery, outreach strategy, or to improve services at the health facility. Burundi and Swaziland, at 56%, had the lowest percentage of health service providers (5 of 9 in both countries) saying that they used the data in this way.

In terms of supportive supervision, while 86% of health service providers interviewed said that they had regular meetings with the immediate supervisor to give and receive feedback, for around half of these health service providers, this happened once a month (see Figure 81). And only for 23% of those who have regular meetings did these take place once a week.

Figure 81:



While there appears to be a wealth of disaggregated data being captured at the health facility level, its utilisation, both at the health facility and at the national level to inform policies and programmes remains ineffective and inconsistent. For example, a key informant from the national government in Kenya said, *“When it comes to the entering of the data especially for family planning, we don’t have anywhere where we segregate by age. For HIV it is well segregated but for family planning it is not.”* Another key informant from Lesotho said, *“The MOH is supposed to collect monitoring data but the health management and information (HMIS) system does not capture data of 10-14 year old clients, and the demographic health survey (DHS) is interested in the ages 15 to 49 years.”* Similarly, the national HMIS in Ethiopia, Zimbabwe and DRC were reported to have no room for collecting comprehensive, age-disaggregated data on AYFHS users. A key informant from the DRC said, *“Data on the health of young people in the DRC are not only poorly collected but are also unreliable because there is a real problem of completeness, promptness and transmission of these data. Much remains to be done in this area.”*

Summary and Discussion

Despite the recording of data, and regular supervisory meetings to some extent, qualitative data captured in this Assessment has revealed that the data collected is rarely used to inform decision-making at the health facility. Half the health service providers reporting regular supportive supervision said this happens once a month. In addition, outreach or extension health workers and peer educators often do not have effective or standardised systems for quality assessment or M&E. This, combined with the low percentages of health facilities having guidelines and/or tools on self-monitoring quality of care to adolescents and young people, means that M&E specific to AYFHS is weak across all countries. As seen, supervisory visits in the last 3 to 6 months were seen in 71% of health facilities visited, but those focused on adolescent healthcare were only seen in 53% of health facilities. Despite this, 86% of the health service providers said that they had regular meetings with a supervisor. While it is difficult to determine one interval for supportive supervision visits across all countries, it is important to set and implement feasible national standards nevertheless.

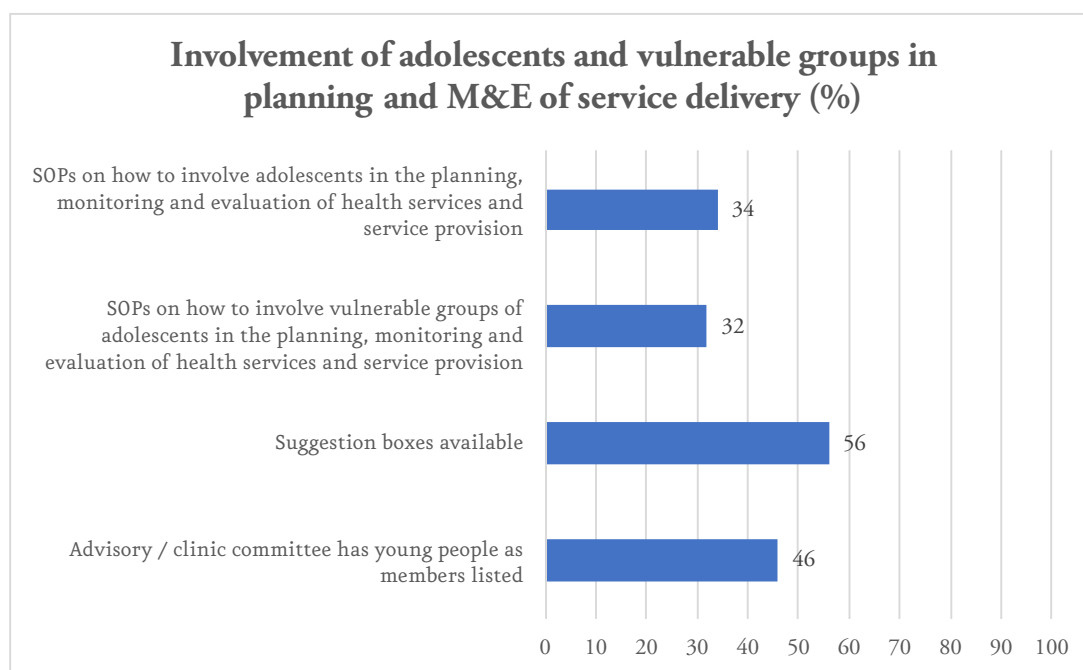
9.9 Standard 8: Adolescent Participation

Adolescents’ and young people’s opportunity to provide feedback, and to participate in service provision were among the aspects examined under this standard. Health service providers’ awareness on laws and regulations on informed consent, and SOPs on involvement of vulnerable adolescents and young people were also part of the assessment for this standard.

The involvement of adolescents and young people in various aspects of service delivery and health facility management, from planning and implementation to M&E was found to be quite varied. Many of the Assessment teams reported that adolescents’ and young people’s participation was better in NGO-run health facilities than in government-run health facilities. In addition, those health facilities that were dedicated to AYFHS (as opposed to having AYFHS integrated into health facilities for the general population) or were stand-alone youth centres, tended to have more avenues for adolescents’ and young people’s participation.

SOPs related to involvement of adolescent and young people and/or vulnerable groups of adolescents and young people were found in about a third of the health facilities visited as shown in Figure 82. Only Burundi had 60% of health facilities reporting having these guidelines, though it does not have a specific national standard on adolescent participation.

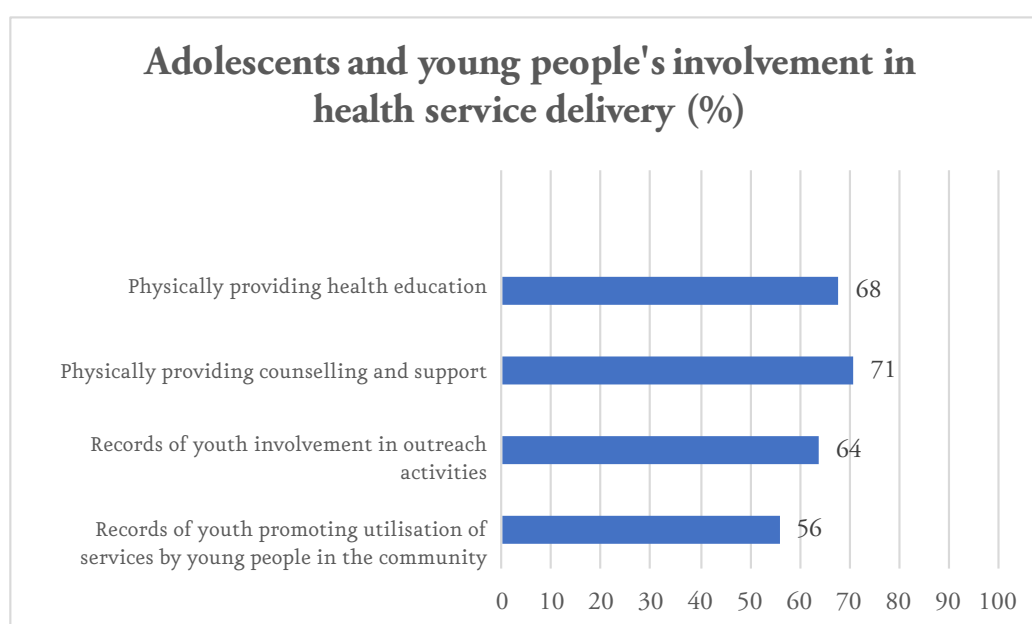
Figure 82:



Though suggestion boxes were found in 56% of the health facilities visited, qualitative data revealed that these were used or opened infrequently, and were thus not an effective method of receiving feedback from young clients. Only 46% of health facilities visited had adolescents and young people on their facility advisory committees, with the highest percentage of health facilities in Burundi (80%) and Zambia (79%). Mozambique had none and Swaziland had only 10% of health facilities with adolescents and young people on facility advisory committees.

The Assessment teams' observations of adolescents and young people physically providing health education (68%) and physically providing counselling and support (71%) were seen in a substantial number of health facilities visited (see Figure 83).

Figure 83:

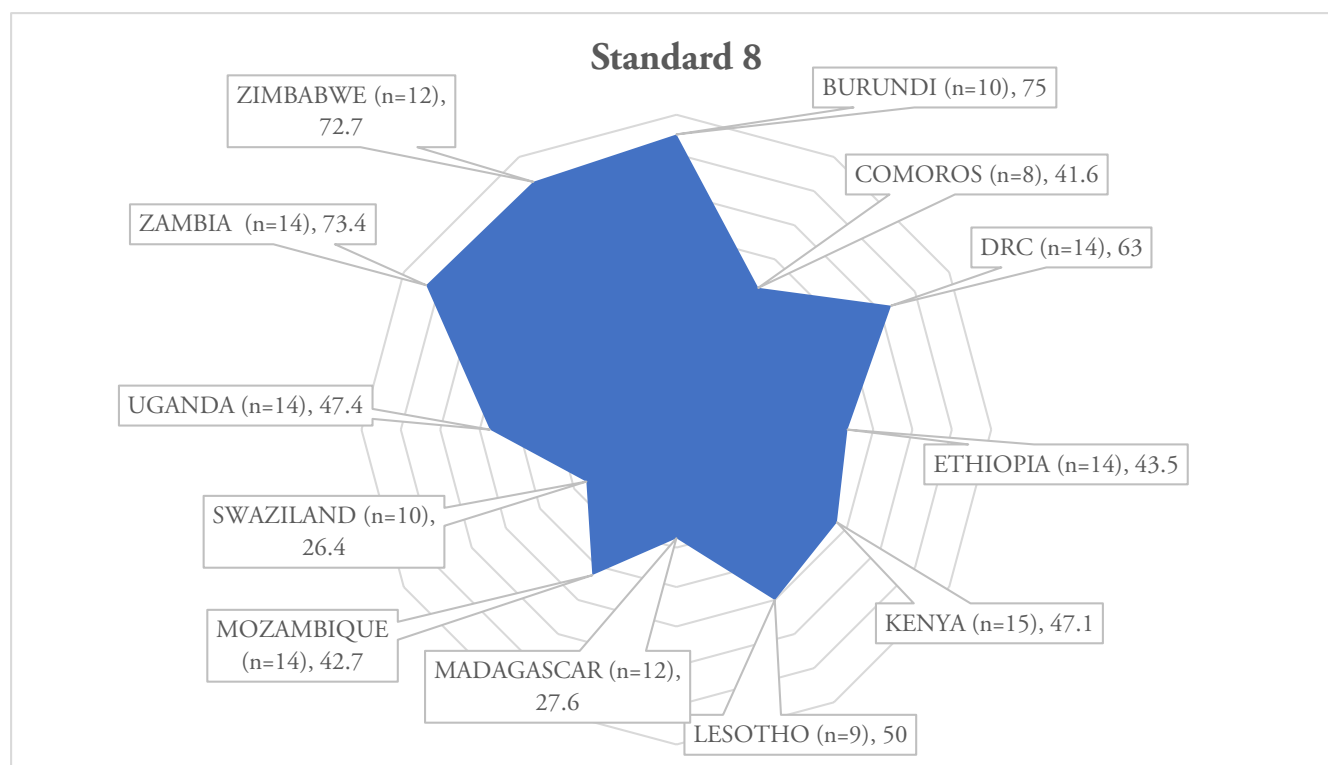


Records of adolescents' and young people's involvement in outreach was observed in 64% of health facilities visited, with Zambia at 87% and the DRC at 85%, while Swaziland (20%) had the lowest percentage.

Guidelines on informed consent were observed to be available in half of all health facilities visited, with 79% in Zambia, 78% in Lesotho and 71% in Mozambique, while Comoros was the lowest at 13%.

Figure 84 demonstrates how countries compared with each other on Standard 8 when looking at the data from the facility observation tool. Burundi, Zambia and Zimbabwe had the highest scores, while Swaziland and Madagascar had the lowest.

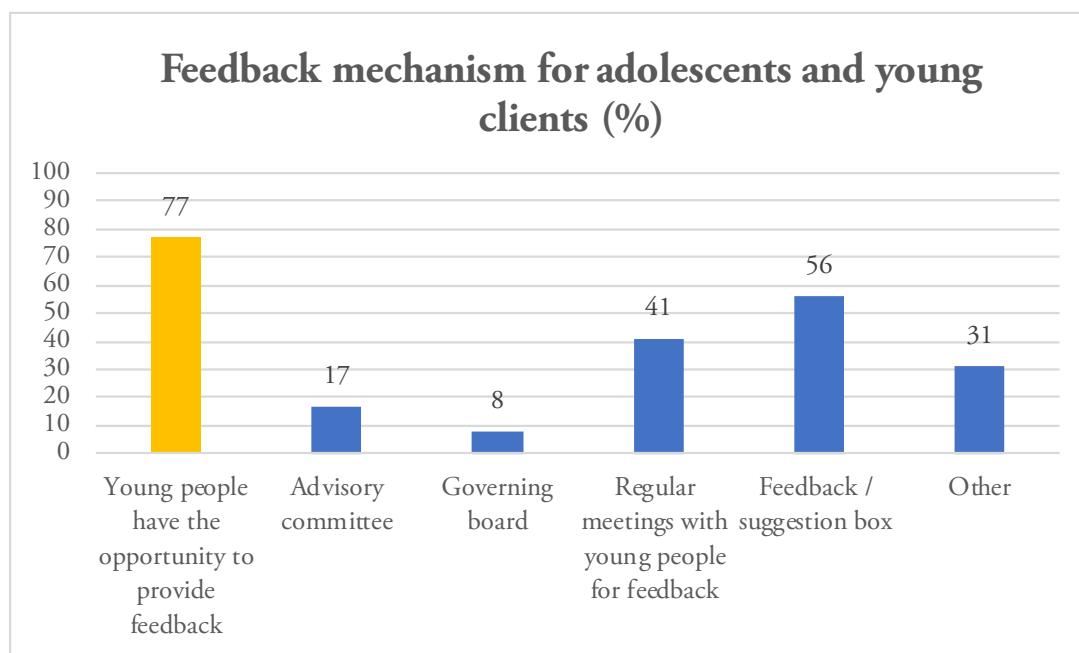
Figure 84: Results of Standard 8



Health service providers were asked whether adolescents and young people (i.e., clients or peer educators), had the opportunity to provide feedback to the health facility. 77% of health service providers interviewed affirmed this, with most of them enumerating the suggestion box as the avenue for feedback (56%), which corresponds with the findings from the facility observation tool (see Figure 85). On the other hand, while the facility observation tool revealed that adolescents and young people were listed as members of the advisory board or clinic committees in 46% of health facilities visited, only 17% of the health service providers said that adolescents and young people could provide feedback through advisory committees, and 8% said they could do so through the governing board.

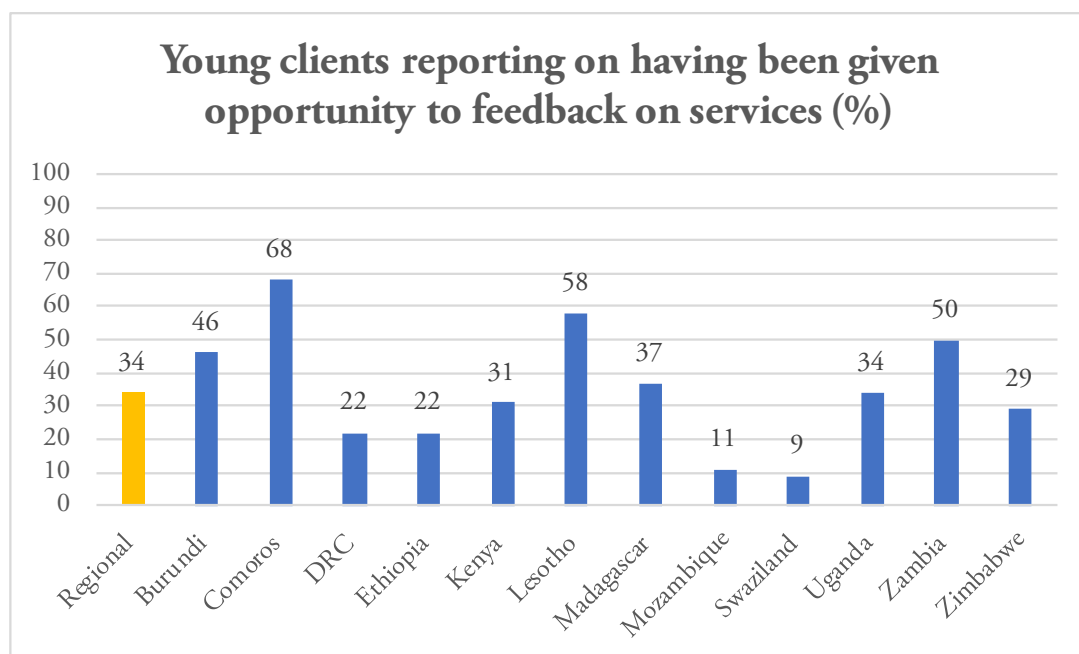
Qualitative data from the DRC revealed that the majority of the adult community health workers reported involving peer educators in planning activities in the community, and implementation and monitoring of these activities. One such adult workers said, "I often work with peer educators. We regularly hold meetings with them to plan and see what we can do together to help adolescents and young people."

Figure 85:



Young clients were also asked if they had the opportunity to express their opinions on the services provided, and as shown in Figure 86, only 34% said that such an opportunity was available to them (the lowest being Swaziland at 9% and Mozambique at 11%). Comoros (68%) and Lesotho (58%) had the highest number of young exit clients who said that they had such opportunities.

Figure 86:



Summary and Discussion

Adolescents' and young people's participation in governance, planning, decision-making and M&E remains low across all countries. Though several peer educators in Lesotho, for example, said that they were involved in planning meetings, across the other countries, it was mainly NGOs that were making the effort to meaningfully involve adolescents and young people, while the involvement seemed sporadic in government health facilities. The most common means of involving adolescents and young people is in relation to implementation (i.e., as peer educators, peer counsellors, community mobilisation, etc.). Qualitative data from the young peer educators revealed that there were very few opportunities for them to provide feedback to health facility management, other than routine reporting. As mentioned by a group of peer educators in Swaziland, "Youth are not involved in any planning or decision making they are just told what to do." Typically, these adolescents and young people involved in health promotion and delivery are inadequately informed about government policies and guidelines, as well as about adolescents' and young people's rights. In Zambia, a peer educator categorically said, "Young people are not given an opportunity to fully participate in planning for implementation of youth activities. Such a proposal or thought has never been considered."

The lack of meaningful youth engagement in AYFHS and its importance is best described by this key informant from a county government in Kenya, "I think young people should be at the table. I think one mistake we make is plan for young people and we are not young people. So we need to get them at the table."

9.10 Compliance with Standards

After analysing the data from the facility observation tool of each health facility visited, Table 9 depicts the average country adherence to each standard.

Table 9: Average Country Adherence to Each Standard

STANDARD								
	1	2	3	4	5	6	7	8
Burundi	74.4%	71.9%	78.8%	72.0	75.8%	80.6%	72.3%	75.0%
Comoros	49.8%	33.0%	39.1%	42.6	50.5%	30.4%	46.8%	41.6%
DRC	55.5%	55.8%	67.2%	60.6	72.7%	56.3%	62.3%	63.0%
Ethiopia	59.4%	56.3%	71.6%	66.9	77.3%	56.3%	64.9%	43.5%
Kenya	52.0%	62.9%	70.4%	56.2	72.0%	49.1%	52.3%	47.1%
Lesotho	35.5%	42.9%	66.2%	61.6	60.4%	42.0%	40.9%	50.0%
Madagascar	41.3%	31.7%	50.5%	44.6	48.7%	35.1%	26.9%	27.6%
Mozambique	43.5%	45.7%	49.9%	53.5	47.7%	42.3%	58.0%	42.7%
Swaziland	38.3%	45.0%	75.1%	75.0	76.8%	35.0%	37.3%	26.4%
Uganda	50.4%	62.5%	67.6%	51.5	67.3%	29.5%	44.8%	47.4%
Zambia	51.6%	75.9%	74.8%	30.3	66.0%	41.5%	73.4%	73.4%
Zimbabwe	64.5%	77.6%	77.2%	77.9	71.6%	53.1%	68.2%	72.7%

Burundi has consistent scoring across all standards, scoring highest on Standard 6 and lowest on Standard 2, with a difference of 8.7 percentage points. Compared to the other countries, Burundi had the highest scores for Standards 1, 3, 6 and 8. Mozambique also has more or less consistent scoring across standards, but on a low level. Swaziland demonstrates the maximum variance in its scores across the different standards, with a 50.4 percentage point difference between its highest score (Standard 5) and its lowest score (Standard 8). Compared to other countries, Swaziland had the lowest score for Standard 8. Five countries (Comoros, DRC, Ethiopia, Kenya and Swaziland) score higher for Standard 5 than they do for any of the other standards. Four countries (Comoros, Mozambique, Uganda and Zimbabwe) score lower for Standard 6 than they do for any of the other standards.

10. Conclusion and Recommendations

A 2006 literature review on universal access to services and SRHR in ESA highlighted the key factors affecting SRH policy and access to services, including:

- The socio-cultural taboos around sex and sexuality, harmful traditional practices, and stigma against non-conforming individuals, including those that do not conform to gender norms.
- Lack of political will to implement international commitments, repressive laws and policies, and a lack of accountability mechanisms.
- Under-investment in health services, leading to weakened health systems and poor infrastructure.

Despite the large number of adolescents and young people and the heavy burden of maternal mortality, high HIV prevalence, limited access to contraception and high rates of unsafe abortion that are disproportionately affecting adolescents and young people in the ESA region, the present Assessment shows that many of these factors described above remain as challenges. Although progress has been made on several fronts, not least in revising and updating policies, standards and guidelines against regional and global standards, and in scaling up AYFHS and reaffirming political commitment towards increasing access to AYFHS as evidenced through the ESA Commitment, increased investment is needed in the region to fulfil the rights to health and well-being of the present and future generations of adolescents and young people.

This Assessment shows examples of progressive policies in the ESA region, including policies that adopt a rights-based framework in at least 14 countries (i.e., Angola, Burundi, Comoros, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Rwanda, South Africa, South Sudan, Swaziland, Uganda and Zimbabwe), as discussed in Chapter 8. Some of the countries with older policies have a pressing need to revise and review their policies, especially in light of the SDGs in effect from 2016. For example, Madagascar's National Policy on Adolescent and Youth Health is from 2002 and the Norms and Procedures on Reproductive Health are from 2006. While the newer policies, strategies and standards in the region are comprehensive and addressing adolescents' and young people's rights, their implementation must be strengthened by: building ownership among programme managers, health facility managers, health service providers and outreach workers; allocating adequate funding for the implementation of the specified package of services, competency requirements and M&E; and incorporating supportive and participatory supervision and monitoring methods in the health system.

In addition, there is a need to reduce the legal and policy barriers to adolescents' and young people's access to health services (e.g., requirements for parental or spousal consent, marital status, age of consent to uptake

services, and to sexual activity, among others). Policies and guidelines on issues of equity and non-discrimination need to be adopted or strengthened.

These in-country assessments in 12 countries have revealed a wealth of information on the way AYFHS are provided, the key challenges that adolescents and young people face in accessing these health services, and the possible path to improve health services, leading to the following recommendations;

Adolescents' health literacy: Greater focus is required on making adolescents and young people aware about the existence of AYFHS. In addition, potential young clients need to be assured about privacy and confidentiality, including through the adoption and display of policies and including this in awareness raising about AYFHS.

It is important for young clients to be reached *before* they require health services to enable not only awareness, but also trust-building. Involvement of adolescents and young people in the design of the outreach methods, materials and content would ensure that issues relevant to adolescents and young people are addressed, and that they reach the intended audience. Since leaflets and other reading materials were not a popular source of information, either before the clients reached the health facility or within the health facility itself, it may be worth examining the content and appropriateness of language for those leaflets that are available. It would also be important to check whether they are appealing to those who are not literate or marginalised by using an equity lens to design the methods and materials for awareness raising and information dissemination on AYFHS.

Using social media and smartphones to target adolescents and young people is a strategy that should be explored for different contexts. Referrals to hotlines is another important source of information, as well as trust-building measures that should be available in all health facilities visited.

Continuous investment in the training and supervision of adult outreach workers and peer educators is necessary to ensure their confidence in addressing adolescent sexuality. Countries may need to put in place a minimum training package for peer educators, standardise the knowledge and skills that are expected to be in place, implement strategies for quality assurance and deal with peer educators aging out or leaving the programme, and provide guidelines for their meaningful involvement in the delivery of information and services. If the lack of training, transition systems, mentorship, and supportive supervision are addressed, and systems are put in place that clearly link peer educators or outreach workers to the health facilities, peer education and outreach may deliver more effective results.

Since many countries are moving towards an integrated approach to delivering AYFHS, and a creation of adolescent responsive healthcare systems, more comprehensive materials need to be made available (e.g., on issues like mental health, GBV, chronic diseases, etc.), which were available across different health facilities in this Assessment. Adolescent health literacy should also include policy literacy so that adolescents and young people are aware of their rights and entitlements with respect to the public health system.

Community support: It appears that referral from the community and outreach services is either inadequate, and/or not being recorded. Strategies are required for putting in place referral and feedback mechanisms that are appropriate and address the specific needs of adolescents and young people in a particular catchment area.

Linkages between schools, parent-child communication, CSE, and the health facilities or health service providers, should also be well established. When training teachers for school health programmes at the school and district level, the linkages between the school health programme and the health facilities ought to be made. In addition, there should be systems for follow through. Outreach records should show who they addressed, for how long, the interaction / discussions had, etc.

With suggestion boxes being the most common platform for parent/guardian engagement, it is important to ask whether this is an adequate mechanism. An example from Senegal is that of combining suggestion boxes with periodic meetings between young clients, parents and management, and discussing issues that adolescents and young people are facing with regard to access to services. Quality of care issues are brought up and addressed at such forums, as are any questions there may be in the box. This has resulted in improved quality and access to health services.

The plans for outreach and community engagement in AYFHS require adequate funding, including for training.

Appropriate package of services: The countries assessed have specified different health service packages, some according to the level of the health facility (i.e., primary, secondary and tertiary) however, the Assessment reveals that several gaps in the availability of different types of services remain, and more efforts are therefore needed to ensure that the service packages are rolled out as specified in the guidelines and standards. This, again, requires fund allocations to ensure that the relevant equipment and supplies are available in the health facilities, trained and competent health service providers are hired and retained at the health facilities, adolescents and young people are informed about the health services available to them. Of key importance are the health services that are not currently in place, and the need for strengthened referral mechanisms including for counselling in relation to mental health, drug and alcohol use and GBV, as well as to non-clinical services including schools, social protection and other support programmes, especially for key populations and marginalised groups.

Providers' competencies: Implementation of AYFHS standards and guidelines, including training materials requires greater commitment and investment in the strengthening of existing and new cadres of health workers by the ministries of health. This Assessment recommends that such efforts are undertaken in close partnership with NGOs and other providers of AYFHS to ensure that the nationally adopted guidelines and materials for competency-based trainings are systematically implemented in accredited in-service trainings and CPD programmes for all healthcare providers dealing with adolescents and young people. Additionally, ensuring that adolescent health and the principles of AYFHS are integrated into the pre-service training curricula would help create a critical mass of health service providers that possess the necessary competencies and skills to deal with adolescent sexuality. Both pre-service and in-service training should focus on value clarification and building positive attitudes towards adolescent sexuality, for example, on the issue of contraceptive methods for adolescents and young people; as seen in the findings of this Assessment, health service providers reported refusing access to long-acting methods for adolescents and young people based on their age, need for parental or spousal consent, or marital status.

Facility characteristics: Young clients need to be made aware of their rights, and these discussions need to be included in adolescent health literacy curricula. The issues of long waiting hours, health service provider absenteeism, and lack of privacy when waiting for health services also need to be addressed. This Assessment identifies a range of context specific factors that contribute to client satisfaction, including appropriateness of opening hours, travel time, space for privacy and models for service delivery (i.e., integrated versus stand-alone health facilities for adolescents and young people). This highlights the importance of an in-depth analysis of the context and the involvement of adolescents and young people in the design of health facilities. Each context is different that there may be some places where young clients would rather have a health facility that is close to them, while in other places or communities they may prefer to access health services from a health facility that is further away and no one is likely to know them. Additionally, innovative solutions for effective outreach (e.g., through mobile clinics), that can be implemented in resource-poor settings and among underserved populations are also needed to address the barriers and misconceptions among adolescents and young people who are not interested in using or unable to access the health services.

Equity, non-discrimination: In general, this Assessment finds that policies and guidelines on issues of equity and non-discrimination are inadequate and need greater attention, especially for countries where AYFHS policies, guidelines and standards are due to being revised. This includes reducing legal and policy barriers to adolescents' and young people's access to health services (e.g., requirements for parental or spousal consent, marital status, etc.). Additionally, strategies for inclusiveness of adolescents and young people need to be in place. It is not enough to only reach out to the 'low hanging fruit' among the cohorts of adolescents and young people reached. As evidenced by the level of satisfaction among the young clients interviewed, it is clear that community, peers' and parents' support serve as protective factors and enablers for uptake of services. On the other hand, the FGDs with the potential young clients revealed exactly the opposite situation (i.e., lack of information and service access, lack of supportive family or community in accessing health services, etc.). Effective and diverse approaches for outreach to adolescents and young people who have more 'risk factors' and less 'protective factors' are therefore needed to increase the access to, and uptake of, health services among those who are not being served at the health facility. Efforts are needed to reach young key populations with AYFHS, not only with HIV related information and services (i.e., young people who use drugs, young people in sex work, young people who identify as LGBT, etc.), as well as young people living with disabilities, among other marginalised and vulnerable groups.

Data and quality improvement: Disaggregated data and its effective utilisation, both at health facility and national levels, to inform policies and programmes is important to ensure that quality of care for adolescents and young people is constantly improving. There is a need for standardised systems by country on the use of data recorded at the health facility level. Explore the use of new technologies, for example, encouraging health service providers to take a photo of the daily register and upload it to a centralised system. The national HMIS needs to be disaggregated by age as per WHO guidelines where this is not so.

Supportive supervision that enables health service providers, adult outreach workers and peer educators to strengthen their delivery of information and services is needed on a more systematic basis. At the same time, enabling health facilities to use tools on self-monitoring quality of care to adolescents and young people is likely to encourage health service providers to work on self-improvement. This, combined with the meaningful involvement of adolescents and young people in M&E and feedback on services, would enable much better access to services for adolescents and young people.

Despite the fact that many of the adolescent health/ASRHR policies, strategies and/or AYFHS standards and guidelines lay out M&E frameworks with objectives and indicators, these are not being implemented effectively at the health facility level. This, as iterated earlier, requires budget allocations for adequate and ongoing training, user-friendly tool development and dissemination, regular supportive supervision visits, and actual utilisation of health facility level data to inform programming.

Meaningful participation of adolescents and young people: While involvement of adolescents and young people in policy making at the national level seems to be better implemented, adolescents' and young people's meaningful involvement at all levels of AYFHS programming at the health facility level needs to be reinforced, (e.g., to resolve issues of proximity of the health facility to the young clients versus their perception of privacy and confidentiality at such a health facility), support training on client rights, and ensuring that adolescents and young people get a sense of ownership over the health facility. This is a process and involves capacity building and sensitisation for both adults, as for adolescents and young people to be able to work in partnership.

With the ESA Commitment being operationalised through this, and other studies, it is hoped that the status of AYFHS will become clearer in the region and the in-country Assessments and follow-up discussions on their findings will provide recommendations that can help strengthen the demand for scale and quality of services through implementation of effective strategies that match the on-ground realities as perceived by health service providers and young clients. These recommendations can further be used to support the countries that are in the process of reviewing or drafting their policies, guidelines, and/or training materials, and will also inform the development of a regional guidance for strengthening adolescent health, including ASRHR, AYFHS, and pre-service and in-service training for health service providers.

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