Royal Tropical Institute

Youth friendly health services in multiple perspectives

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Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AFHS	Adolescent Friendly Health services
ART	Anti-retroviral Treatment
ASRH	Adolescent Sexual and Reproductive Health
AYA	Adolescent and young adult
CEDAW	Convention to Eliminate All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
EC	Emergency contraception
HIV	Human Immunodeficiency Virus
IATT	Inter-Agency Task Team
IDS	Institute of Development Studies
IEC	Information, Education, Communication
FGM	Female Genital Mutilation
IPPF	International Planned Parenthood Federation
FHI360	Family Health International 360
KIT	Royal Tropical Institute
MDG	Millenium Development Goal
PEP	Post-exposure prophylaxis for HIV
SAN!	Stop AIDS Now!
SC	Save the Children
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WPF	World Population Fund (now RutgersWPF)
YFHS	Youth Friendly Health Services

Executive summary

Half of the world's population is under 25 and 1.8 billion is between 10-25 years of age. Enabling young people to attain a good quality of life and health, and especially sexual and reproductive health, is of the utmost priority. Not only is it critical to young people themselves, it is also of vital important in terms of attaining broader development goals related to education, poverty alleviation and gender equity.

This concept note examines existing standards, guidelines and tools for youth friendly health services (YFHS) with a view to assessing the degree of consensus with regard to the features deemed essential in order for a health service to qualify as youth friendly. In addition, the note reviews instruments used to guide the development of youth friendly health services, identifies apparent gaps in current tools and services. Following the analysis of instruments and standards, an intervention logic is provided for the design, delivery and assessment of YFH services.

According to young people the most important aspects of YFHS are:
a) the clinic environment, which includes elements such as location and atmosphere, and services offered, and
b) the respectful, non-judgmental and confidential attitudes of providers.
Involvement of youth in planning and implementation of services leads to wider benefits such as developing competencies and self-esteem, skills and experience as leaders, an improved status of young people in, as well as greater commitment of, communities.

In many settings a taboo rests on talking about matters sexual, particularly when this relates to young women and men. When youth sexuality is engaged with this tends to be in negative terms, i.e. whereby youth sexuality is perceived as a problem paired with the belief that information about sex will lead to sexual experimentation. As a consequence, many young people have insufficient access to information and services to make more informed choices. Given young women and men's continue to be to among the most vulnerable to HIV infection, unintended pregnancies and unsafe abortions, and considering health-related practices during youth are believed to lay the foundation for health status in later life, it is imperative that youth are put at centre stage in the design of global and national health agendas. It is crucial such agendas engage with health in a cross-cutting manner and do not concentrate on one specific disease or issue alone. The intervention logic provided in this concept note provides a tool to assess the extent to which a service - or a health agenda - addresses a comprehensive range of health-related matters.

The first essential element the concept note engages with is the range of health services offered and common gaps in such services (e.g. counseling on healthy sexual development, nutrition, and mental health). A second essential element is facility characteristics, covering elements related to location, design, hours and privacy /confidentiality conditions. The note also discussesaccessibility in relation to questions of gender, stigma, diversity, legal barriers and language, as well as affordability of services. The subsequent element focuses on health providers and the extent to which they are trained to work with young people in

a professional and sensitive manner. While, the quality of providers is often considered the most important condition for establishing youth-friendly services, selection criteria of staff working with young women and men are rarely made explicit in existing instruments.

A fourth element is the involvement of youth and their development. Here a distinction needs to be drawn between youth participation as a means (covered in most programmes and instruments) and participation as an end in and of itself. Only few of the instruments reviewed engage with participation as an end in and of itself, and doing so would require not only training of young women and men but, more importantly, capacity building of providers to work *with* youth rather than *for* youth. Finally, a supportive environment is essential - not only in terms of legal and policy environment (which is addressedin all programmes and instruments) but also from a community perspective, evidence showing that uptake of services is more likely where communities support service provision. None of the programmes reviewed seem to address broader socio-political and cultural setting in which a YFHS might be or was located, and how this might impact on services provided to young women and men and their experiences thereof. As such expectations with regard to age of marriage and childbearing are not discussed, or issues such as gender-based violence, female genital mutilation/cutting, HIV related stigma, or perceptions of the (potential) role of young people in society more generally.

The intervention logic that is based on the review, has as overall outcome "Young people make use of health services that respond to their rights and needs" with five distinct outcome areas covering youth friendly health services, youth friendly facilities, youth friendly service providers, youth involvement and a supportive environment (including laws and policies as well as supportive communities). Each of these outcomes has two levels of outputs and one input level.

While it may not be realistic to expect that all YFH services are able to implement all outcome aspects from the start as a result of financial, organisational and human resource constraints, it is important that there is an understanding of the interlinkages between all outcome areas in order to prioritize the intervention order.

1.   Introduction

Currently, there are more young people in the world than ever before: half of the world's population is under 25 years old and 1.8 billion are between 10-25 years of age (Sawyer, 2012, UNFPA, undated). For two key reasons, enabling young people to attain the universal right to health, especially sexual and reproductive health, is widely regarded to constitute a public health priority for states and other duty-bearers. First, achieving this right to health is of clear importance to young people themselves, and their ability to lead fulfilling lives. Second, attaining young people's right to health is considered critical to efforts to realise a wider set of rights and development goals, such as those relating to education, poverty alleviation and improvements in women's status.

The WHO defines sexual health as "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (WHO, 2006). This also applies to young people and these rights have been laid down in the Convention on the Rights of the Child (CRC) until they reach 18 years of age and for young women in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Despite broad recognition of the centrality of ensuring young people attain the right to health, including in terms of sexual and reproductive health, critical issues remain, particularly in relation to young people's reproductive and sexual health status. While most young people become sexually active before their 20th birthday, both in and outside marriage, in many countries provision of sexual and reproductive health services and/or information is considered inappropriate for unmarried people in this age group. As a result, modern contraceptive use among adolescents is generally low, and has, moreover, been found to decrease with socio-economic status (UNFPA, undated).

Sexual health and well-being and sexuality have been notably absent in the development discourse and is generally only considered in relation to population control, family planning, disease and violence (IDS, 2006), rather than as a source of pleasure, fun, love and intimacy and something that makes people human and an important basis of relationships and social networks. Even in the realm of Sexual and Reproductive Health, sexuality is not taken as a fundamental aspect of programmes and services, which are narrowly focussed on reproductive services and leaving the sexuality aspect and with it its gender, power and violence dimensions out of a more holistic approach (Heinmurger et al., 2008). However, the urgency of responding to the HIV epidemic and the failure of many of the prevention programmes, have resulted in an increased attention for sexuality and sexual rights, rights based approaches and young people as a key vulnerable group.

Adolescent sexual and reproductive health data show that in developing countries, approximately one-third of adolescent girls give birth before they turn 20 years old, childbirth related complications are the number one cause of death among young women aged 15-19 years and 14% of all abortions occur among adolescents under 20 years. The unmet need for contraception among adolescents is 68% in regions such as Sub-Saharan Africa, South Central Asia and Southeast Asia (Guttmacher Institute and IPPF, 2010). Globally, the highest rates of STIs are among youth and young people, with youth between 15 and 24 years accounting for 41% of all new HIV infections in 2009 (WHO fact sheet N°345, 2011; Interagency Youth Working Group, 2011). Every day, 2400 young people are infected with HIV and globally there are more than 5 million young people living with HIV or AIDS. These figures are a clear indication that at present, young people's right to health is not being met (see also WHO, 2009a).

Since the new millennium, a wide range of organizations active in the field of adolescent sexual and reproductive health and rights have developed standards, guidelines and tools for the establishment of what are referred to as youth friendly health (YFH) services. However, during the course of our work in this particular subject area, we identified a number of issues that were, as yet, inadequately addressed in many youth friendly interventions. Among other things, these relate to the integration of an affirmative approach to youth and sexuality as the basis of interventions, responsiveness to youth demands and needs, sexual and reproductive health and rights of adolescents living with HIV, gender based violence and sexual diversity. In order to strengthen the field of youth friendly services, and to do so on the basis of available evidence, we decided to review existing standards, guidelines and tools documents pertaining to YFH services. We did so in order to assess:

- The consensus on essential features of health services to qualify as youth friendly
- The instruments used to guide the design, delivery and evaluation of youth friendly services
- The gaps in essential features and tools, including barriers to youth friendly services and approaches to overcome these

The outcome of this exercise is an intervention logic for youth friendly health services that is based on evidence and integrates the multiple dimensions of such services. This will enable us and our partners to plan and implement interventions in a more holistic manner, that are better aligned to the priorities identified by youth itself.

After an explanation of the methodology used to write this concept note, section 3 analyses different aspects of youth friendly services and covers the definition of youth and adolescence and the rationale for youth friendly services. It also discusses what young people want from services, types of YFH services existing and accessibility of and barriers to YFH services. On the basis of the documents analysed for this section, we present a list of essential elements of YFH services and a short description of these elements in section 4. This is followed by a review of nine instruments/tools that address aspects of the essential elements. Section 6 follows with a discussion on the instruments/tools and the gaps identified to address the essential elements. This results in an intervention logic for YFH services, presented in section 7. The final section presents conclusions and way forward.

This concept paper will be discussed further during an expert meeting that will be organized by Share-net International in July 2014.

2.   Methodology

This paper is based on a review of documentation on YFH services published between 2007 and 2013. Documents were found through a search of the following websites: FHI360, Guttmacher Institute, Horizons, IPPF, loveLife, Pathfinder, Population Council, RutgersWPF, Save the Children, UNAIDS, UNFPA, WHO. Search engines used included Science Direct and Scopus, and key words used were: Youth/adolescent friendly (health) services, in combination with: Conditions, Characteristics, Standards, Guidelines, Tools, Evaluation. Only English-language documents were included.

On the basis of the documentation review, a list of essential elements of YFH services was developed. This list was subsequently used to review nine existing instruments guiding YFH services in order to assess how instruments were addressing the various the elements and to identify gaps in the coverage of these instruments.

Based on the analysis of essential elements and instruments, an intervention logic was elaborated to guide our work with partners in the field of youth friendly health services.

3.   Definition and rationale

3.1   *What is youth, what is adolescence, what are youth friendly services*
Although the terms 'youth' and 'adolescence' are often used interchangeably, they refer to distinct age groups. The UN defines 'youth' as the period between 15 - 24 years of age. 'Adolescence' on the other hand, generally refers to the period between the onset of puberty and reaching adulthood, which according to the WHO is between 10 and 19 years. By speaking of 'adolescent friendly' services, the organisations thus limit the accessibility to a much narrower age range, and as such possibly exclude young, unmarried adults who may receive less support from adult health care providers. Similarly, youth friendly services exclude those between 10 and 15, who in many parts of the world are already sexually active and in need of information and services. In 2011 'The State of the World's Children', UNICEF discusses the difficulty of defining adolescence at a time when puberty is seen to start increasingly early and where a wide variation exists in terms of national laws regarding age thresholds for participation in activities traditionally considered the preserve of adults.

In line with authors such as Tylee (2007), Sawyer and colleagues (2012) and Viner (2012), as well as key actors in the field such as the Interagency Youth Working Group (2011), in this concept note we use the terms youth and young people to cover young women and men aged 10-24.

The definition of youth friendly health services developed by WHO in 2002 (see annex 1) is generally applicable to what is regarded as rights-based, quality health services**.** The characteristics that are specific tor youth include (i) guarantee privacy and confidentiality and promote autonomy so that

adolescents can consent to their own treatment and care (ii) health care providers who are technically competent in adolescent specific areas, and offer services relevant to each client's maturation and social circumstances, (iii) Community involvement and dialogue to encourage parental and community support (iv) Appropriate and comprehensive services that address each adolescent's physical, social and psychological health and development needs.

3.2 Why are youth friendly sexual and reproductive health services needed?

The focus on youth in sexual and reproductive health is a relatively new phenomenon – historically unmarried youth would be served through children services and married (or pregnant) youth would be served through adult services. There are changes that have rendered this approach outdated. The trend in delaying marriage (including for educational or employment reasons) and in delaying childbirth, have expanded the gap between puberty and marriage and between marriage and childbearing (Bearinger e.a., 2007) and these changes affect all societies in varying degrees and make the adequacy and effectiveness of health services as before no longer appropriate.

A period of changes
Between the ages of 10-24, young people experience a period of changes in terms of physical, psychological, and social development. Not only do their bodies change, but it is also a time of discovering, exploring and experimenting in all aspects of life, often establishing a basis for well-being or ill-being for the rest of their lives. These changes vary between individuals and to an extent, differ between males and females. In important ways, developments taking place during adolescent years are shaped by the social and cultural environment in which they take place, examples include existing norms and values with regard to gender, whether a young person is in or out of school, her/his family relationships and the levels of support received. Important too is whether a young person grows up in an urban or rural setting. Also of great influence are the broader legal and policy environment with regard to access to reproductive health services, information and education, legal minimum age to get married for women and men. The extent to which young people are able to influence the development of policies affecting their age group is also important.

Lack of information
Young people have insufficient access to information and services to make informed choices and this is to a large extent the result of a culture of silence around youth sexuality, the taboo on talking about sexual matters in many cultures, the focus on youth sexuality as a problem and the belief that information about sex will lead to sexual experimenting. In Kenya, young people were found to have little knowledge on sexual matters, although they are sexually active, while the adults are unable to discuss sexual matters with their children (Njoroge et al. 2010). However, the availability of on-line information and social networking sites will change the possibilities to obtain information as is noted in the editorial of Reproductive Health Matters (Berer, 2013): "the introduction of social media has changed the relationship between the source of a message and the audience, where the audience no longer passively consumes media content, but actively engages in creating it. This marks a shift from a one-to-many to a many-to-many model of communication online, which has implications for how young people access information about sex and sexuality

as well as the type of information available". Of course, this may be a source of correct but also of incorrect information.

STI/HIV prevalence
Young people are disproportionately affected by HIV– with 40% of all new infections occurring among those between 15 and 24 years of age (WHO 2011). The prevalence and incidence of curable STIs varies widely between countries, but worldwide it is estimated that the largest prevalence of STIs is among youth (Bearinger, 2007).

Early childbearing
About 16 million adolescent girls between 15 and 19 years of age give birth each year (WHO, 2011). While for some of these young women, pregnancy and childbirth are intended, for many others they are not. In many cases, girls are unlikely to be sufficiently mature – whether in physical, emotional or social terms - to be mothers. Factors contributing to unintended pregnancies include a lack of knowledge of or access to contraception and inability to negotiate safe sexual practices (WHO, 2011). In addition, in many contexts girls are pressurised to both marry and bear children at an early age. Use of antenatal care by young people is poor, and complications during pregnancy and childbearing are leading causes of death for girls aged 15 to 19 in developing countries – they are not only 'two to five times more likely to die from pregnancy or childbirth than women in their twenties', but also 'more adolescent girls die from pregnancy and childbirth-related complications than from any other cause' (WHO, 2009b). For survivors, such complications may lead to a chronic illness or disability, which may bring them life-long suffering, shame, or abandonment.

Unintended pregnancies and abortions
Unintended pregnancy (both unplanned and unwanted) among adolescents is a common public health problem worldwide. It is not only a source of anxiety for (among other people) policy makers in developed countries, it has also become a focal issue in international development programmes. Possibly due to the growing importance of education, whereby pregnancy is regarded as strongly disruptive and the lack of progress in attaining MDG 5, as well as youthful pregnancy upsetting adult notions regarding childhood innocence and the judgemental response to the issue (Arai, 2009; Bhana, 2007 Miedema et al., 2011, Thomson, 1994). Unwanted pregnancies in youth may end in abortions, usually later in pregnancy than for older women, and these are often unsafe for this age group. There were an estimated 3 million unsafe abortions among 15–19 year olds in 2008, oftentimes resulting in permanent injury and death (WHO, 2011).

Basis for health later in life
Finally YFH services are necessary because youth is a time of major changes in health and to a large extent, determines health in later life. Failure to invest in the second decade of life, despite the availability of proven and promising prevention and health promotion strategies, will jeopardise earlier investments in maternal and child health, substantially erode the quality and length of human life, and escalate human suffering, inequity, and social instability. (Resnick et al, 2012). Sawyer et al (2012), present four domains that affect young people's health outcomes: (i) Social determinants of health: economic development, status of women, globalization; (ii) Risk and protective factors:

family, school, neighbourhood, individual; (iii) Puberty and social-role transitions: first sex, marriage, parenthood, education, employment; (iv) Health-related behaviours and states: obesity, substance misuse, sexual health, mental health. These domains not only affect the health of people when they are young, but will have repercussions for their health as adults and even on the health of their children. It is estimated that 70% of premature deaths in adults are caused by determinants and behaviours initiated in youth and that may lead to chronic non-communicable diseases in later life (such as use of tobacco, alcohol, and illicit substances, obesity, lack of physical activity and mental health problems). 'Risky' sexual practices are also often initiated during this period of time (Patton et al. 2012).

3.3   *What do young people want from youth friendly health services?*

As Mathews et al. (2009) reveal in their study of South African YFH services, young people do not necessarily experience treatment at health services defined as 'youth friendly' as more respectful or confidential than 'regular' health care centres. This section discusses a range of studies which have examined young people's views on what constitutes a youth friendly service.

An early study, and one which continues to be drawn on extensively, is that conducted by Senderowitz (1999). Senderowitz observed that individual preferences, cultural differences and reasons for visiting a health centre are likely to shape what it is young people want from the service provided, and that for this reason, it is important to find out from the intended clients of the service what it is they seek from a 'youth friendly' service. According to Senderowitz, in order to qualify as 'youth friendly' health services need to address issues relating to a) the clinic environment (including matters such as location and atmosphere) and services offered, and b) the attitudes of providers; young people attaching particular importance to respectfulness, confidentiality, the extent to which providers are seen to be non-judgmental).

Similar issues are mentioned in the IPPF (2006a) youth friendly health services guidelines. IPPF lists conditions that are either conducive to, or form a barrier to access. In a more recent study focusing on young people in Kwazulu Natal, South Africa, Alice Armstrong (2011) identifies six main thematic categories expressing how young people living with HIV are supported by health services. The young people taking part in the study indicated they a) do not want either HIV or the clinic to take over their life, b) want a separate, safe, youth-friendly clinic environment, c) want to feel respected, d) want honesty with regard to their HIV status, e) want comprehensive information and advice, and f) want to be involved and heard. The most recent study is that of Ambresin and colleagues (2013). In a systematic review of 22 studies measuring young people's perspectives on health care, the authors identify eight domains of adolescent-friendly care. Box 1 summarises the domains of adolescent-friendly care and provides examples of relevant indicators.

Box 1: Summary of eight domains of adolescent-friendly health care

1. Accessibility of health care: location, affordability
2. Staff attitude: respectful, supportive, honest, trustworthy, friendly
3. Communication: clarity and provision of information, active listening, tone of communication
4. Medical competency: technical skills (procedures)
5. Guideline-driven care: confidentiality, autonomy, transition to adult health care services, comprehensive care
6. Age-appropriate environment: Flexibility of appointment times, separate physical

space, teen-oriented health information, clean, waiting time, continuity of care, privacy
7. Involvement in health care
8. Health outcomes: pain management, quality of life
Ambresin et al. (2013), p. 678

Broadly speaking, from young people's perspective confidentiality and respectful attitude appear to be considered fundamental dimensions of truly youth friendly health services, in addition to more 'practical' factors relating to accessibility and availability such as location and cost. All above mentioned findings are confirmed by a study carried out by Tylee et al. (2007).

3.4   Types of YFH services
Youth Friendly Health Services are delivered in different forms around the world. In their article on key forms of youth friendly health provision around the world, Tylee et al. (2007) identify six different models for YFHS provision:
1. Centres specializing in adolescent health set in hospitals,
2. Community based (youth friendly) health centres,
3. School or college based health services,
4. Community based facilities or youth centres that not only provide health services but also e.g. SRH related information and recreational activities,
5. Pharmacies and shops selling health products, and
6. Outreach information and services provision by static health services.

Other studies have found similar categories of YFH service delivery. Homans (2003) points out that in some settings more than one context for service delivery will be used, integrating services in both health and education sectors: for example, providing both outreach for (especially vulnerable) young people as well as 'static' services. In some models - for instance in a school SRH corner - services may be the primary focus, whilst in others - for example in a pharmacy – it may be one of a range of services provided.

3.5 Accessibility of and barriers to YFH services
In spite of the seemingly broad network of YFH services in different parts of the world, the majority of young people do not have access to such services and modern contraceptive use among them is generally low, because of individual, social, cultural and structural barriers, with young women consistently reporting lower contraceptive use than men

Following a review of available evidence, Tylee and colleagues (2007) typified the barriers young people face in accessing YFH services as relating to availability, accessibility, acceptability and equity of health services. As the authors report, services may be unavailable to unmarried young people for example, or if and when available, may be inaccessible due to their prohibitive cost and/or distance. In addition, the generalised fear about lack of confidentiality forms an important barrier. The studies reviewed by Tylee detail young people's concerns about being recognized in waiting rooms or caregivers finding out about a young person's visit to an SRH clinics. Finally, although services may be available, accessible and acceptable to some young people, they may not be equitable, for instance limiting access of particular groups of marginalized young people, such as homosexuals, transgenders or HIV positive youth.

A study on barriers to adolescents' use of reproductive health services, conducted in three Bolivian cities (Belmonte et al, 2000) distinguishes four types of barriers:

- Physical barriers that include physical access in terms of distance, but also in terms of awareness about the existence of such services
- Economic barriers, where costs of services are higher than what young people can afford to pay
- Administrative/process barriers that cover policies, and especially the adherence to policies that support specialised adolescent reproductive health services, special procedures for adolescents as well as staff trained in such services. Also mentioned are the availability and active distribution of IEC materials, equipment and supplies available for use with adolescents. Of crucial importance is the attitude of providers and pharmacy staff who in this study had a much more disapproving attitude towards girls that came for contraceptives than to boys. The quality of care, correctness of information, and professional conduct of health centre staff were also found to form barriers to uptake.
- Psychosocial barriers that include negative feelings about their own sexuality, accompanied by feelings of anxiety, shame and guilt as well as fears of being judged negatively by family and peers. Positive and negative perceptions of contraceptive use as well as incorrect beliefs about contraceptives also form a barrier. Finally, the lack of confidentiality was found to be an underlying reason for not using health services.

4. Essential elements of youth friendly health services

The documents and instruments reviewed for purposes of the current concept paper include those developed by WHO, UNFPA, IPPF, Pathfinder International, PATH, Population Council, FHI360, RutgersWPF and UNAIDS. The current review drew on three additional documents, namely:

a) The WHO and IATT 2006 study on HIV and young people (see annex 2 for further details),

b) The 2009 WHO study on initiatives in developing countries aimed at increasing both demand and support for adolescent sexual and reproductive health (WHO, 2009b), concluding that young people were more likely to use youth-friendly services in communities that demonstrated awareness and acceptance of ASRH services. It also found that uptake of ASRH services was increased by IEC outreach activities, and by active referral between schools and health systems

c) A report of a participatory assessment of the IPPF Danida-funded A+ programme on adolescent sexual and reproductive health and rights. This report (Johnson et al, 2013) describes nine themes that emerged during the assessment:

- Young people and their peers at the centre
- Gender equity
- Spaces for participation
- Working with families to build supportive communities
- Ensuring access to high quality youth-friendly services
- Comprehensive sexuality education
- Advocacy and the broader policy context
  Organisational development: learning for communication and accountability
- Sustainability of youth programming

Table 1 on page 10 lists the essential elements that emerged from the analysis of the above mentioned tools and guidelines. The column to the right of the critical elements offers a short explanation of the various elements.

It is worth noting that the analysis of the above mentioned tools and guidelines revealed a strong degree of consensus as to what are considered essential elements of YFHS and the guiding principles for such services. Common elements agencies tend to refer to seem to originate largely from the 2002 WHO publication on 'adolescent friendly' health services', which was developed following a global consultation on AFH services. The WHO characterized such services as being accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient. In view of the importance of this document, the completed WHO list of characteristics of AFH services is provided in annex 1.

A recently published guide by Guttmacher and IPPF (2013) provides information and measures (indicators) about adolescents and their access to, need for, and use of sexual and reproductive health information and services. It is ultimatelydesigned to provide professionals in the field with information they can use to argue effectively for and design policies and programs to meet young people'sneeds for sexual and reproductive health, education and services, and

information on sexual and reproductive rights (Anderson et al, 2013). The guide discusses many of the essential elements that are covered in table 1

Table 1: Essential elements of youth friendly health services

Clinic Services:	
Information, education, counselling	*Comments*
RH information and education, Contraception/Dual Protection	Counselling on reproductive health, on contraception to make an informed choice, taking into account the nature of the sexual relationship and behaviours in which the individuals are engaged, and the contraceptives available in the country.
STIs, HIV and AIDS	IEC on STIs, HIV and AIDS. This includes pre- and post test counselling and information on HIV and AIDS, risk behaviour and risk assessment. Also this should cover counselling for HIV positive young people on sexual and reproductive health, pregnancies and disclosure.
Nutrition and health behaviour	This includes information and counselling on good nutrition, substance use (tobacco, drugs, alcohol) use, obesity and how to remain healthy as a youth.
Sexual Abuse/Violence	Sexual violence is common. However, as the issue is widely felt to be a source of shame, it is usually not discussed or addressed. In addition to physical injuries, youth may suffer severe mental health problems as a consequence.
Support for healthy sexual development	This covers reproductive health aspects and sexuality for females and males, and includes counselling on male and female sexual and reproductive health concerns, sexuality education, sexual identity, information on body image, genital hygiene, virginity, menstruation, masturbation, wet dreams, etc.
Psychological and mental health	Physical and emotional changes during the period of youth, may lead to mental health problems. It is estimated that around 20% of youth suffer from mental health issues. If unattended, such problems may contribute to low educational achievement, unemployment, substance use, risk-taking behaviours, crime, poor sexual and reproductive health, self-harm and inadequate self-care.
Testing	

STI	If the clinic is not able to provide these testing services, it needs to offer referral services and, where possible, provide follow up counselling and treatment.
VCT/HIV test	
Pregnancy	
Treatment	Where services are not provided in the clinic, it is important that effective working arrangements for referral are developed and the youth friendliness of the referred services ensured.
STI	In line with existing protocols, preferably syndromic treatment as this allows treatment on the first visit.
Abortion related services	In countries where this is legal, this includes (referral to) safe abortion services. Where this is not the case, the service focus should be on post abortion care in line with existing protocols.
Sexual abuse or violence	In addition to physical injury, consequences of sexual abuse or violence may include STIs/HIV and unwanted pregnancy. Providers need to be able to detect and treat injuries due to sexual violence, and preferably provide post-exposure prophylaxis for HIV (PEP), emergency contraception (EC), presumptive treatment for STIs, as well as refer to counselling.
Other Services	
Contraception	Array of contraceptives (including emergency contraceptives) in line with availability in the country. Decisions have to be made on the prices of these commodities.
Antenatal, peri-natal and post natal care	Health providers need to understand the health risks associated with early pregnancy and the importance of providing confidential obstetric services to youth, regardless of their age or marital status. Birth plans can be developed to ensure proper ante-, peri- and post-natal care, with referral to providers that are youth friendly if this is not covered in the clinic.
Primary health care	Simple primary health care services contribute to the holistic vision of youth friendly health services and may facilitate uptake of the other services offered in the clinic.
Availability of equipment and supplies	This includes processes of forecasting and ordering supplies, equipment that is specific for use with youth and procedures for procuring, maintaining and repairing equipment.
Facility characteristics:	

Location	The facility has to be accessible by public transport and to be located in an area near where youth lives, goes to school or work and spends leisure time. It can be located as part of a hospital, part of an adult RH clinic, in school-based clinics, in youth centres, in private clinics.
Environment/design	The setting has to be attractive, waiting rooms provided (if part of general clinic – a separate waiting room for youth), separate space for service provision (counselling and examination) that gives visual and auditory privacy. Welcoming, non-judgemental, attractive for youth of both sexes.
Clinic hours	Afternoons and evenings, timing suitable for youth to visit. This can be as part of general clinic hours, but also providing separate hours for youth.
Privacy and Confidentiality	A very crucial characteristic for youth friendly services. At a minimum, standards and guidelines have to exist to guide providers and ensure safety, confidentiality and privacy and monitoring is done to ensure adherence to these standards and guidelines. These standards are on public display.
Educational activities and materials	Educational materials regarding different aspects of RH need to be available on site such as brochures, posters that describe clients rights, services offered in the clinic, opening hours. If possible, audio-visual or computer based materials. It also includes job aids available for staff such as flipcharts and posters. Activities can include group sessions on RH aspects, life skills and sexuality education.
Administrative procedures	The registration process has to be private, not to be overheard by other clients and should be simple. Preferably allows services without an appointment and is clear on consent requirements (parental or spousal), age requirements and service time allowed per client. This should be on public display.
Fees	The fees for services can be a significant barrier for young clients. A fee schedule needs to be designed for free or affordable services. Sometimes a small fee is preferred to free services as it makes the service more valued.
Promotion of YFH services	YFH services need to be accepted not only by youth, but also by the community. This means that advocacy and mobilization is needed – this can be done through outreach to

	schools (youth, teachers, parents), outreach and activities in the community, local media – radio talkshows, tv and through youth volunteers/peer educators. The key is to have a strategy for the promotion.
Provider characteristics:	
Selection criteria of staff	Because attitude of providers is a key aspects of YFHS, selection of staff is important and should take into account, gender, age, experience in working with young people, having a positive attitude to youth sexuality and diversity and understanding of youth rights to sexual and reproductive health services.
Attitudes	One of the greatest challenges of integrating sexual health into reproductive health services for youth, is the difficulty adults have in accepting youth sexuality (including that of married adolescents). A positive attitude towards this is a key consideration in selection of providers - it also applies to acceptance of diversity in sexuality and the view that sexuality is positive, healthy and pleasurable instead of problematic.
Skills	Skills refer to clinical competencies, counselling and communication skills, skills in dealing with difficult questions and sensitive topics, skills in explaining relevant topics to youth in a way that it is understood. It also includes skills to respond to and deal with new developments such as the coming of age of HIV positive youth and responding to the special needs of this youth.
Knowledge	This includes knowledge and understanding of (male and female) youth concerns and needs, including those of groups with special needs such as HIV positive adolescents and non-heterosexuals. It also implies understanding about gender, stigma, barriers for uptake of services, peer pressure, gender based violence and exploitation. It includes knowledge about clinical aspects of reproductive health, adolescent sexuality and development, various forms of sexual behaviour and different types of contraception.
Provider training and support	Provider training includes: clinical competencies, counselling and communication skills, skills in dealing with difficult questions and sensitive topics, orientation in youth friendly service provision, issues relating to gender, sexuality, and rights. Other important elements are the type and length of the training, refresher training, mentoring approaches,

	assessment of quality of performance and supervision mechanisms and support in place.
Youth involvement and development:	
Rights	Youth rights to sexual and reproductive health have to be the basis for the development of YFH service and have to be part of all services given. Youth have to be informed and explained their rights but also on the corresponding responsibilities. Apart from publicizing the rights in the clinic, also should be publicized how youth can claim their rights and how this can be done through monitoring, client satisfaction forms etc.
Youth participation	Services have to be developed together with youth in all phases of the service/programme cycle: situation analysis (needs and preferences on how to meet these needs), planning, implementation, monitoring and evaluation. The involvement should be such that youth feel ownership of the services provided and are able to suggest and influence changes for improvement.
Target groups	This relates to the need to be clear about which sub-classifications of youth (age, vulnerabilities, in/out of school, other relevant sub classifications) are the target group. If youth is differentiated are services different for the sub-classifications? Are channels used to mobilize youth to access the services also differentiated?
Life skills education	Life skills approaches include the development of psycho-social competencies such as communication, negotiation, problem-solving, decision-making and emotional coping skills, increasing self esteem. They can also incorporate broader livelihood approaches such as the development of employment opportunities.
Sexuality education	Comprehensive sexuality education recognizes that information on sexuality alone is not enough, and therefore seeks to equip young people with the knowledge and skills they need to determine and enjoy their sexuality in all spheres of life. IPPF's Framework for Comprehensive Sexuality Education, address the following essential components/elements: gender, sexual and reproductive health and rights and HIV/AIDS (including information about services and clinics), sexual citizenship, pleasure, violence, diversity and relationships. (IPPF, 2009). This component could also be listed under the heading services offered – it depends on who is facilitating the education – youth or health service providers.

Peer education and counselling	Peer education is an important component of youth sexual and reproductive health because it combines different factors of health promotion such as identification with social and cultural environment of the target group, promotion of positive attitudes and healthy behaviours and involvement of young people in their own programmes. Critical issues are selection criteria, training, turnover, sustaining motivation, financial incentives, IEC materials and monitoring and evaluation. Peers provide education, but may also act as counsellors or condom distributors, they may provide referrals to formal health services, or can be involved in mobilizing youth to access the service through their networks, schools, clubs and other places where youth meets.
Safe and supportive environment:	
Laws and policies	This includes restrictive laws such as prohibiting provision of contraceptives to unmarried young people, or abortion. This realm needs to cover efforts to formulate laws and policies that enable youth to access contraceptives and RH services, obtain safe abortion services and address harmful traditional practices (FGM, early marriage, honour related violence).
Adult community involvement and support	Dealing with youth in isolation does not reflect how youth are embedded in the environment around them and therefore programmes need to involve adults around the youth. Community acceptance of youth health services is important in determining the uptake of these services. Young people are most likely to use youth-friendly services in those communities that demonstrate awareness and approval, so structures to encourage support should be built in from the outset, involving teachers, parents, community leaders and groups, religious communities, youth gatekeepers.
Sustainability	Sustainability can only be ensured by a commitment of governments to provide YFH services and making this part of their health delivery systems and their budget line.

5.   Tools and instruments to provide services addressing the essential elements

This section gives an overview of nine instruments/tools that address (aspects of) the essential elements given in table 1, section 4. The tools and instruments were selected on the basis of the following criteria:
- It is a tool used by one of our partners in YFH services interventions
- It was not reviewed in the WHO (2005) publication 'Integrating sexual health interventions into reproductive health services'
- It is an instrument developed by one of the major players in the field of youth friendly health services (e.g. Pathfinder, Population Council)
- The tools jointly cover the whole array of essential elements as listed in table 1.

The tools are:

Organisation	Purpose
NAFCI / loveLife 2000	(i) to make health services accessible and acceptable to adolescents; (ii) to establish national standards and criteria for adolescent health care in clinics throughout the country, and (iii) to build the capacity of health care workers to provide quality adolescent health services
Pathfinder 2002	Support for the collection of detailed information on the range and quality of services provided to adolescents at a given facility or within a given programme in order to make services more youth-friendly. It guides the assessment of the degree of youth friendliness of the service.
IPPF Provide 2006	Self-assessment tool developed to enable managers, providers and young people to appraise the youth friendliness of its services and prioritise areas for improvement.
IPPF Springboard 2008	This guide focuses on youth friendly centres as opposed to youth friendly health centres. It describes SRH activities as part of a more holistic approach to youth development and is aimed to inspire youth and IPPF staff.
Save the Children 2008	Partnership Defined Quality for Youth (PDQ-Y) is an approach for improving the quality and accessibility of services involving the partnership between youth, health care providers, and other stakeholders working together toward better service quality and availability for young people.
WHO 2009	Support to professionals working in the health sector and health facilities to assess the quality of services provided to young people
UNFPA/Save the Children 2009	Designed to help programme managers to ensure that the sexual and reproductive health needs of adolescents (10-19) are addressed during all emergency situations. The tools are also applicable to non-emergency settings.
Rutgers WPF 2009	The planning and support tool focuses on rights based SRHR education and HIV prevention interventions for young people to encourage people who develop SRHR education to reflect on why certain decisions in programme

	development and implementations were made.
WHO 2011	Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries developed through systematic review of the evidence and technical expertise of policy-makers, programme managers and front-line workers, in partnership with key international organizations working in this field.

Each of the tools/instruments is summarized in annex 3 to give insight on what they cover. The information is condensed in table 2 (in chronological order) which gives an overview of all essential elements and those that are addressed by each tool. It does not give information on the extent to which the tools engage with the elements; some instruments may address a particular issue in great depth, for instance by offering a range of means to assess the quality of training and support provided to staff members of a YFHS, while other instruments might give brief mention of the need to pay attention to such an issue. It is important to note that the various instruments were all designed with a particular purpose and against a particular backdrop. It has not always been possible to fully capture all elements in the table or distinguish between the elements as sometimes definitions may overlap. The table is followed by a discussion of the instruments and the gaps in these instruments.

Table 2: Tools and instruments for essential elements of youth friendly sexual and reproductive health services

Instrument source	NAFCI 2000	Pathfinder 2002	IPPF Provide 2006	IPPF: SB 2008	Save the Children 2008	WHO 2009	UNFPA/SC 2009	Rutgers WPF 2009	WHO 2011
Clinic Services									
Information, education and counseling					Assessment of access to clinical services, identifying quality, gaps, standards, challenges. Focus on the process of working together between health workers and youth, does not give outcomes			Assessment of access to clinical services. Focus on the process of developing interventions, does not give outcomes	
RH information and education, contraception/Dual Protection	√	√	√	√		√	√		√
STIs, HIV and AIDS	√	√		√		√			
Nutrition and health behaviour		√		√					
Sexual Abuse/Violence	√	√	√	√		√	√		√
Support for healthy sexual development			√	√					
Psychological and mental health	√		√				√		
Testing									
STI	√	√	√	√		√	√		
VCT/HIV test	√	√	√	√		√	√		
Pregnancy	√	√	√	√		√	√		√
Treatment									
STI	√	√	√	√		√	√		
Abortion related services	√	√	√	√		√	√		√
Sexual Abuse or Violence	√	√	√			√	√		√
Other Services									
Contraception	√	√	√	√		√	√		√
Antenatal, perinatal and post natal care	√	√				√	√		√
Primary health care				√					√
Availability equipment and supplies	√	√	√			√			
Instrument source	**NAFCI 2000**	**Pathfinder 2002**	**IPPF Provide 2006**	**IPPF: SB 2008**	**Save the Children 2008**	**WHO 2009**	**UNFPA/SC 2009**	**Rutgers WPF 2009**	**WHO 2011**
Facility characteristics									
Location	√	√	√	√	√	√		√	
Environment/design	√	√	√	√	√	√		√	
Clinic hours	√	√	√	√	√	√			
Privacy and Confidentiality	√	√	√	√	√	√	√	√	
Educational activities and materials	√	√				√		√ interactive skills training	
Administrative procedures	√	√	√			√			
Fees	?	√	√	√		√			
Promotion of YFH services	√		√	√		√	√		
Provider characteristics									
Selection criteria of staff	√		√	√	√			√	
Attitudes	√	√	√	√	√	√	√	√	
Skills	√	√	√		√	√		√	
Knowledge	√	√	√			√			
Provider training and support	√	√	√	√	√	√	√	√	
Youth involvement and development									
Rights	√	√	√		√			√	
Youth participation	√	√	√	√	√	√	√	√	
Target groups	√	√	√	√				√	√
Life skills				√				√	√

6.   Discussion on the instruments and the gaps identified

Starting with the **clinic services**, most instruments address a similar range of services, be it in varying levels of detail. The most important aspect of clinic services, and which is mentioned by most instruments, is the existence of standards and protocols to be followed and the support to ensure adherence. None of the instruments, however, describes the range of services in detail, seemingly because it is considered that there are national guidelines that need to be followed. One of the gaps, however, relates to counselling on healthy sexual development. This category should address sexuality from a positive angle, deal with sexual identity and sexual orientation and the problems related to this, as well as female, male and transgender sexual and reproductive health. It is explicitly mentioned in both IPPF instruments and is covered in the questions of Rutgers WPF and SC relating to the assessment of existing services, but not in the other instruments.

Other gaps relate to nutritional and health behaviour, to psychological and mental health counselling and more general primary health services. Most of the instruments reviewed do not address these issues, although WHO (2002) calls for comprehensive services that need to address each adolescent's physical, social and psychological health and development needs. It is during a person's youth that the foundation for her/his physical and mental health are said to be established. For this reason it is arguably important to address these matters in a youth friendly clinic (Sawyer e.a.2012). UNICEF (2011) mentions that mental health problems account for a large proportion of the disease burden among young people and are associated with substance use, poor sexual and reproductive health and risk taking behaviours. The inclusion of general primary health care answers to the need for a 'one stop shop' and could contribute to reducing stigma related to reproductive health services. It is not clear why this is not included in most instruments but may have to do with extra organisational requirements.

With regard to **facility characteristics**, there is a general agreement on the elements relating to location, design, hours and privacy /confidentiality conditions. In the literature, these elements are often combined under the heading accessibility. However, accessibility is also dependent on how issues of gender, stigma, legal barriers and language are dealt with – which is not addressed directly by the instruments, but is often implied. The availability of educational and information materials in waiting rooms or reading rooms is not specifically mentioned by any of the tools, but – again - often implied. The Pathfinder tool, for instance, mentions that: "Some young people prefer to learn about sensitive issues on their own, using written or audiovisual materials, because their discomfort level can be too great to retain information during a face-to-face session. Such learning can occur while clients are waiting to be seen, as with educational videos or computer-based health education". There is not much attention for educational activities carried out by the facility, nor how these are conducted – for instance through interactive group sessions and skills training although this may be covered under youth development and sexuality education which is mentioned by most organisations.

Active promotion of services is the subject of the WHO 2009 review which stresses the link between youth friendly services and other services and networks in the community. The instruments reviewed mention outreach to schools, community organisations and through peer education activities, but do

not elaborate on how such outreach should be done. It is assumed that this will take place, but unless the facility has a plan (and budget) on advocacy and mobilisation of demand it is unlikely to happen.

Cost of services has been found to be a potential important barrier to young clients. According to AYA/Pathfinder (2003) a fee schedule must be designed so that services are free or affordable, but it also needs to be recognized that young people, as do adults, often want to pay something for services or else they will not value what is provided. Most assessment instruments engage with the question as to whether services are perceived to be affordable.

Well-trained, sensitive **providers** are often considered to represent the most important ingredient of a truly youth-friendly service. All publications reviewed here address the issue of providers' skills, attitudes and knowledge, as well as the need for (ongoing) training and support of providers. Apart from the existence of relevant training curricula, it is important that different methods of capacity building are used that go beyond initial training such as for instance refresher training, mentoring support, on the job training and internships.

The Pathfinder, WHO (2009) and UNFPA/Save the Children instruments collect data from a range of sources providing a comprehensive, triangulated picture of (young people's perception of) provider attitudes, skills and knowledge. However, very few tools discuss selection criteria of staff to work with adolescents. IPPF (2006) gives a list of criteria including experience of working with young people, understanding of the principles underlying adolescent sexual and reproductive health rights (pro-choice, non-discrimination, respect etc), positive attitude towards young people's sexuality, age, gender and diversity so that young clients from diverse backgrounds feel comfortable consulting health service providers.

According to the WHO 2006 review, training of service providers (and in some cases, other clinic staff) was the most frequently implemented intervention used to increase service use by young people. Although all tools reviewed refer to the centrality of provider training and support, few comprehensively engage with the issue. The WHO (2009) and IPPF (2008) manual barely pay attention to the issue, and whilst the UNFPA/Save the Children document frequently mentions issues health care providers and peer educators need training on, it provides little in the way of concrete tools to support development of training and/or staff support programmes. The IPPF (2006) guideline is one of the few to include a checklist which poses questions around the provision of YFHS related training. The same applies to Pathfinder that gives an extensive list on subjects that providers should be trained on. Training manuals for providers do exist (for instance the excellent module of Pathfinder (2004) and the new guide for trainers (SAN! and RutgersWPF (2014), but fall outside the scope of the review done for this concept note.

When talking about **youth involvement and development**, a distinction needs to be made between youth participation as a means and participation as an end. In the first participation is needed for effective project implementation, necessary for needs assessment and determination of services offered, setting up the clinic according to priorities of youth, using youth for peer education and outreach and promotion of services. Such participation is covered in all instruments. In the second type, participation is seen as a means to empower youth and has a developmental objective beyond YFH services, aiming to

increase self esteem and taking responsibility, building capacities for decision making, programming and planning and negotiation – and crucially, giving youth a explicit role in the monitoring of the services. In the instruments this is covered by RutgersWPF and Save the Children (SC) that give guidelines on how to build this capacity not only in youth, but also with the providers who need to change their traditional way of working for youth to working with youth. Though both approaches to youth participation require training, the capacity building for the second option is much more extensive and implies on the job training in governance for both.

A number of the instruments base the whole youth friendly services intervention on the process of involving youth and strengthening of dialogue between service providers and youth (WPF and SC), while others (IPPF, 2006) base the intervention on the rights of clients (youth) and the rights of providers in youth friendly services. Youth rights are implied by all instruments, but apart from those mentioned above, this does not go much beyond the need to have policies that support the rights of youth.

Target groups are rarely defined in the instruments beyond 'youth' in the sense that they are explicit about certain services and activities with certain sub-groups of youth. Only IPPF Springboard discusses explicitly the need to define who a youth centre is meant for, indicating that it is impossible to serve all sub classifications. Admittedly this instrument deals with youth friendly centres, where this may be more of an issue than for exclusive reproductive health services. However, we feel that by just talking about boys and girls as is done in many instruments, there is a possibility that sub-groups will feel excluded such as certain age groups, non-heterosexual youth and youth living with HIV. WHO (2002) explicitly mentions that youth friendly services should "not restrict the provision of health services on grounds of gender, disability, ethnic origin, religion or (unless strictly appropriate) age".

Life skills education as part of the services is not a common feature for the instruments dealing with YFH services. We consider this to be a missed opportunity as life skills may provide youth with a number of competencies that can shape their (reproductive) health behaviour. It may be a matter of definition of the concepts of life skills and sexuality education whereby life skills are seen to prepare youth for employment and sexuality education would include dealing with peer pressure, negotiation, norms and values, coping skills. It does not matter where those are covered as long as it is covered in the programme. Sexuality education is addressed by most instruments in varying degrees of detail.

Peer education is an important element in most youth friendly services covered in the many reviews on which this concept note is based. The instruments all mention peer education, but do not go into details on how this should be done (including training, incentives, retention). Again, many peer education manuals exist, but are not included in the scope of this concept note as this would have required rather different searches. What is essential for peer education strategies to work, is (i) the selection process of peer educators; (ii) training and re-training of peer educators on many subjects, ranging from general health, sexual and reproductive health and rights information, testing and treatment - basically on the services offered in the clinic - but also on communication, behaviour change approaches, life skills and sexuality education. Even if the peers do not facilitate activities on these subjects themselves, they have to be

able to explain what the subjects are and why it is useful to follow these sessions. The same applies to counselling. The third (iii) essential aspect of peer education is the availability of brochures, booklets or other IEC items to support the outreach, and also condoms to demonstrate and hand-out. Finally supervision and feedback are important to ensure that peer education is done according to plan and give the educators the possibility to discuss issues.

Creating a **supportive environment requires** inputs from two very different systems: the legal and policy system and the community. The legal and policy environment deals with laws that either support or obstruct young people's access to reproductive health services. While these are very important, they are beyond the (direct) control of clinics or programmes. Most instruments mention the importance of the laws and policies and the need for the providers to have clear legal guidelines. A few instruments mention that clinics can be actively involved in advocacy for changing or adapting laws where they endanger the reproductive health and rights of youth. That this can be successful is evidenced by the "*December 2013 Ministerial Commitment on comprehensive education and sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa",* where ministers from 20 countries commit to review and where necessary amend existing laws and policies on age of consent, child protection and teachers codes of conduct and to integrate and scale up youth friendly HIV and SRH services (Ministerial commitment, 2013).
The WHO (2011) instrument is the most vocal on which policies should be addressed and in place to reduce adolescent pregnancy and poor reproductive outcomes. The UNFPA/Save the Children manual explicitly addresses the legal setting of YFH services in emergency settings, alerting service providers to the fact that national laws with regard to adolescents' rights may clash with international law. The manual recommends that at all times providers are able to resolve issues in the best interest of the child or adolescent.

The second system is the supportive environment provided by the community. When communities in which the services are offered are supportive, evidence shows that uptake of services by youth is more likely (WHO, 2006). As with youth participation there are two approaches to this involvement. One – and the most common – is the ensuring support for the clinic or programme by involving gatekeepers (community, women, youth leaders, religious communities, schools, parents etc.) in the planning phase and possibly in implementation as facilitators. This is mentioned in all instruments signifying that the need for community support is recognized and that lessons have been learned from the failure of programmes that did not include the community. The second approach is much broader and aims to influence community norms and values that impact on YFH services, such as ages to marry and bear children, gender based violence, female genital mutilation/cutting, HIV related stigma, the taboo on adolescent sexuality and talking about this and the right of youth to become full-fledged partners in community development. Very few instruments engage with this kind of broader approach.

As we can see from the table, only two instruments address the issue of **sustainability.** This is probably because it is linked to the sustainability of the health system as a whole and YFH services are considered to be part of that. However, it is necessary to take into account how and where YFH services are placed within the broader setting of the (national) health sector. It would then be useful to address issues relating to (i) health-sector reform influencing cost recovery and cost sharing; (ii) policies to include vulnerable populations,

including youth; (iii) impacts of health-sector reform on staffing and quality of services.

The need to have low fees or no fees in order to promote uptake of YFH services by youth basically prevents a discussion on financial sustainability of such services. Sustainability can only be ensured by a commitment of governments to provide YFH services and making this part of their budget line. WHO (2004) states that 'Since there is no single definition or perspective on how to sustain programmes, it may be more useful to consider possible elements that contribute to the sustained delivery of programme benefits and impact in the target populations'.

The analysis of the instruments and gaps that we have identified, have led us to the formulation of an intervention logic for YFH services. This is presented in the next section and will be discussed in the Expert Meeting on youth friendly health services organised by Share-Net International in July 2014.

7. Intervention logic for YFH services

The intervention logic presented below is based on the review described in the previous pages. The overall outcome of the intervention logic is: "Young people make use of health services that respond to their rights and needs". It has five distinct outcome areas covering youth friendly health services, youth friendly facilities, youth friendly service providers, youth involvement and a supportive environment covering laws and policies, but also supportive communities. Each of these outcomes has two levels of outputs and one input level. It reads from bottom to top.

While it may not be realistic to expect that all YFH services are able to implement all outcome aspects from the start as a result of financial, organisational and human resource constraints, it is important that there is an understanding of the interlinkages between all outcome areas in order to prioritize intervention order.

Table 3: Intervention logic for YFH services

Impact: **Reduced incidence of unwanted pregnancies, STIs, HIV, abortions, sexual violence, maternal morbidity and mortality, substance abuse and mental health problems in youth**				
Outcome: **Young people make use of health services that respond to their rights and needs**				
Outcome 1: **Clinic services** are youth friendly and offer quality comprehensive health and sexual and reproductive health services including information, education, counseling, testing, treatment and (referral to) other relevant services. They adhere to youth friendly policies and standards.	Outcome 2: **Facilities** where YFH services are provided are accessible for youth, confidential, offer educational activities and materials, have youth friendly inclusive (administrative) procedures, have affordable fees and are known in communities.	Outcome 3: **Providers** are selected based on criteria, with the required attitudes, skills and knowledge and have received training and continuing support on youth friendly service provision.	Outcome 4: **Youth** is fully involved in decision making in all phases of the programme cycle: situation assessment, planning, implementation (as peer educators) and monitoring and has the capacity for this.	Outcome 5: **Laws and policies** required for comprehensive YFH services are adapted or being addressed with advocacy. **Communities** are supportive to YFH services and norms and values support the rights of youth.
Output 1b: Youth friendly	Output 2b: Adaptation for	Output 3b: Selection	Output 4b: Selection	Output 5b: Gaps in laws

policies and procedures exist for all services listed in the essential package. Referral systems are established. Equipment and supplies are present and processes for procedures for procuring, maintaining and repairing equipment exist.	accessibility (location, design, hours) done, and fees, procedures on confidentiality and administration established, IEC materials, equipment and activities available as well as a plan for clinic promotion in the community.	criteria of providers established; trainings on youth friendly service provision are held; supervision, mentoring and refresher procedures established	criteria for youth partners established; youth trained on governance aspects, planning, monitoring and communication with providers. Peer educators trained on life skills, sexuality education, counseling, BCC and outreach. Plan for incentives, retention, supervision and monitoring established.	and policies required for comprehensive YFH identified and advocacy plan established. Community mobilization and information activities are implemented and follow-up activities are taking place.
Output 1a: Assessments are done and gaps are identified. Plans for overcoming the gaps are agreed	Output 2a: Assessments are done and gaps are identified. Plans for overcoming the gaps are agreed between providers and youth. Relevant IEC materials are developed or obtained as are equipment and design of activities. Target groups established.	Output 3a: Assessment on providers criteria and training needs done. Training materials and facilitators identified, training dates and plan agreed. Requirements for supervision, mentoring assessed and agreed.	Output 4 a: Assessment on youth selection criteria and training needs done. Training materials and facilitators identified, training dates and plan agreed. Target groups established.	Output 5a: Assessment of laws and policies required for comprehensive YFH services done. Assessment on community support and barriers to YFSRH services done and plan for community mobilization developed.
Input: 1 Guidelines for clinical assessment of YFH services are identified and agreed upon; Selection of assessing team agreed and done	Input 2: Assessment checklist developed, assessment team trained and selected (involving youth, managers, providers).	Input 3: Guidelines for provider assessment are identified and agreed upon; Selection of assessing team agreed and done (involving	Input 4: Assessment guidelines for youth KAP, SRH behaviour, priority needs, barriers for uptake identified or developed. Selection of assessing team	Input 5: Identification of laws and policies required for comprehensive YFH services. Assessment guidelines for community support identified and

(involving youth, managers, providers) Training for assessment is carried out.		managers, providers), training for assessment carried out.	agreed and done (involving youth, providers, community gatekeepers); Training for assessment is carried out.	agreed upon: Selection of assessing team agreed and done (involving youth, providers, community gatekeepers); Training for assessment is carried out

8.   Conclusions and way forward

The review of documentation and instruments related to YFH services has led to the identification of an array of elements that are deemed to be essential to such services. None of the documents and instruments cover all elements that are highlighted in this concept note. There is a fair amount of consensus on a number of main elements, the clinical services, the facility characteristics and the provider characteristics. There is less agreement on issues regarding youth development and the extent to which the broader setting is supportive. We consider these aspects to be equally critical, not only from a rights perspective, but also for reasons relating to broader and longer-term development and sustainability. Only if youth and the community in which they live feel a responsibility towards the services, are they likely to be effectively used. This requires substantive inputs from both sides in the development of the service in all phases of the programme cycle.

The element of supportive laws and policies is also crucial to the sustainability of services, but is commonly viewed to be beyond the influence of the YFH services. Yet without supporting laws, it will be difficult to establish these services in the public realm and often even in the domain of civil society. It may be useful to provide all services that are permitted under the law and put efforts into advocating for those that are presently not allowed.

The review also shows that for all essential elements identified here, various standards, procedures and guidelines are available that can be used by programme designers and evaluators. The review also shows the importance of an inclusive process of planning, implementation and monitoring. Here again, guidelines exist to support such processes and ensure all relevant stakeholders are meaningfully engaged.

While it may not be realistic to expect that all YFH services are able to fully realise all essential elements from the very start, we are of the opinion that it is important that there is an understanding of all essential elements and that this will help to decide on priorities and to develop plans as to how to progressively address all elements of a truly YFH service.

We feel it would be useful if this concept note were to be substantiated with on the ground experience. In particular, it may be instructive to assess which elements are incorporated by YFH services and how this is done. Such a review should also analyse why other elements are not included and what (if anything) has been done to overcome barriers to their inclusion.

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Annex 1: Adolescent friendly health services (WHO, 2002)

Adolescent friendly policies that
* fulfil the rights of adolescents as outlined in the UN Convention on the Rights of the Child and other instruments and declarations,
* take into account the special needs of different sectors of the population, including vulnerable and under-served groups,
* do not restrict the provision of health services on grounds of gender, disability, ethnic origin, religion or (unless strictly appropriate) age,
* pay special attention to gender factors,
* guarantee privacy and confidentiality and promote autonomy so that adolescents can consent to their own treatment and care,
* ensure that services are either free or affordable by adolescents.

Adolescent friendly procedures to facilitate
* easy and confidential registration of patients, and retrieval and storage of records,
* short waiting times and (where necessary) swift referral,
* consultation with or without an appointment.

Adolescent friendly health care providers who
* are technically competent in adolescent specific areas, and offer health promotion, prevention, treatment and care relevant to each client's maturation and social circumstances,
* have interpersonal and communication skills,
* are motivated and supported,
* are non-judgmental and considerate, easy to relate to and trustworthy,
* devote adequate time to clients or patients,
* act in the best interests of their clients,
* treat all clients with equal care and

Adolescent friendly health facilities that
* provide a safe environment at a convenient location with an appealing ambience,
* have convenient working hours,
* offer privacy and avoid stigma,
* provide information and education material.

Adolescent involvement, so that they are
* well informed about services and their rights,
* encouraged to respect the rights of others,
* involved in service assessment and provision.

Community involvement and dialogue to
* promote the value of health services, and
* encourage parental and community support.

Community based, outreach and peer-to-peer services to increase coverage and accessibility.

Appropriate and comprehensive services that
* address each adolescent's physical, social and psychological health and development needs,
* provide a comprehensive package of health care and referral to other relevant services,
* do not carry out unnecessary procedures.

Effective health services for adolescents
* that are guided by evidence-based protocols and guidelines,
* having equipment, supplies and basic services necessary to deliver the essential care package,
* having a process of quality improvement to create and maintain a culture of staff support.

Efficient services which have
* a management information system including information on the cost of resources,
* a system to make use of this information.

Adolescent friendly support staff who are
* understanding and considerate, treating each adolescent client with equal care and respect,
* competent, motivated and well supported.

respect, * provide information and support to enable each adolescent to make the right free choices for his or her unique needs.	

Annex 2: WHO (2006) Preventing HIV/AIDS in young people; a systematic review of the evidence from developing countries.

The UNAIDS Interagency Task Team (IATT) for young people supported a review of the effectiveness of prevention programmes among young people in developing countries. The resulting document is titled 'Preventing HIV/AIDS in young people; a systematic review of the evidence from developing countries' (WHO 2006). When doing the study, a standard methodology[1] was used to review evidence from a range of studies of interventions delivered through the major settings that reach young people, such as schools, health services and mass media.

Health services were among the three recommended interventions to prevent HIV among young people in developing countries (the other two being curriculum based interventions in schools and mass media). Six types of health service interventions were defined on the basis of whether they included some of more of the following characteristics:

- Training for service provides / clinic staff
- Making efforts to improve the quality of the facilities
- Implementing community activities to generate demand and support for the activities, and
- Involving other sectors (schools and the media).

- Below an outline is given of some more specific findings of the review:Training of service providers (and in some cases other clinic staff) was the most frequently implemented intervention used to increase service use by young people. Supervision of health workers to reinforce the skills and knowledge gained during training was mentioned in five studies.

Though descriptions of training were limited, the most frequently mentioned topics for training were:
- Counselling and communication skills
- Clinical knowledge and skills related to STIs
- Clinical knowledge and skills related to contraception
- Health workers' attitudes (in relation to working with young people and ensuring confidentiality).

One of the studies reviewed had explored the relationship between service use, aspects of quality in the facility and actions in the community. This study found that service use was more strongly associated with levels of community acceptance than with the 'youth friendliness' of the services (p.

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[1] The reviews were done following seven steps: 1). Define the key interventions that policy makers need to choose between in the setting under consideration; 2). Define the strength of evidence that would be needed to justify widespread implementation of the intervention; 3). Develop explicit inclusion and exclusion criteria for identifying the studies to be included in the review; 4). Critically review all eligible studies and their findings, by intervention type; 5). Summarize the strength of the evidence on the effectiveness of each type of intervention; 6). Compare the strength of the evidence provided by the studies against the threshold of evidence needed to recommend widespread implementation; 7). From this comparison, derive evidence-based recommendations related to the implementation of each type of intervention in the setting or population group.

188).
Most of the interventions reflected current thinking that a <u>combination of interventions in different settings</u> is likely to have the greatest impact on young people's behaviour.

Studies including <u>actions taken in health facilities mentioned</u>: reducing fees, subsidizing commodities, and making changes to the physical environment to improve privacy and/or make the surroundings more attractive for young people.

Initiatives in South Africa, Madagascar and Mongolia included the <u>setting up of (national) standards</u> along which facilities were assessed.
- o Monitoring data were available for some interventions and included information gathered through <u>facility observations, surveys of clients and service providers, costs of interventions</u>.
- o With regard to research on intervention costs, few conclusions could be derived. The authors indicate there is a <u>need for better costing data</u>.
- o There is a <u>need for more analytical case descriptions</u> to clarify and document lessons learnt and for operations research to specify and explain the content of the interventions and to help explain some of the 'how?' questions . According t<u>o the review there is also an ongoing need for research to tease out the relative importance of the various components of interventions</u> in terms of their contribution to increasing the use of services by young people.

None of the studies in the review addre<u>ssed the issue of the need for services in relation to the overall population of young people, the</u> catchment area and/or other age groups served by the same facilities.

Annex 3: Summaries of instruments and tools

1.   loveLife: National Adolescent Friendly Clinic Initiative (NAFCI)
NB: most of the description below is based on Ashton et al. 2006

Background
LoveLife is a national adolescent reproductive health programme aimed to reduce high-risk behaviour among people between 15 - 24 years in South Africa. One of its components is the National Adolescent Friendly Clinic Initiative (NAFCI), which was introduced in 1999 as a nationwide quality improvement programme with the aim to improve the quality of adolescent health services at the primary-care level and to strengthen the public sector's ability to respond appropriately to adolescent health needs. Key objectives are (i) to make health services accessible and acceptable to adolescents; (ii) to establish national standards and criteria for adolescent health care in clinics throughout the country, and (iii) to build the capacity of health care workers to provide quality adolescent health services. NAFCI was conceptualized and implemented by the Reproductive Health Research Unit at the University of Witwatersrand between 1999–2005. Thereafter, NAFCI has been directly implemented by the loveLife Trust.

Description of the NAFCI services and assessment standards
The NAFCI programme was developed within the (policy) framework of the South African government's Youth and Adolescent Health Guidelines, the development of which coincided with the NAFCI development process. NAFCI clinics are expected to provide an essential service package which includes: Information and education on sexual and reproductive health; Information, counselling and referral for violence/abuse and mental health problems; Contraceptive information and counselling, and provision of methods including oral conceptive pills, emergency contraception, injectables and condoms; Pregnancy testing and counselling, antenatal and postnatal care; Pre- and post-termination of pregnancy counselling and referral; Sexually transmitted infections (STIs) information, including information on the effective prevention of STIs and HIV, diagnosis and syndromic management of STIs. NAFCI clinics can be located in Government run primary health centres, Private clinics, Youth centers with clinics and School based clinics.

The NAFCI is designed around four main elements of quality improvement: (i) focus on the client; (ii) effective systems/processes; (iii) use of data, and (iv) a team approach. NAFCI standards were designed to define what adolescent friendly services are, tools were developed to measure the quality of services, and quality improvement methods were introduced to assist in overcoming barriers to providing quality services. As a result of the consultation process with young people, (other) national and international stakeholders and resource persons, the following ten key standards were developed to define the quality of services for adolescents.

NAFCI standards

1. Management systems are in place to support the effective provision of adolescent-friendly services.
2. The Clinic has policies and processes that support the rights of adolescents.
3. Clinic services appropriate to the needs of adolescents are available and accessible.
4. The clinic has a physical environment conducive to the provision of adolescent health services.
5. The clinic has drugs, supplies and equipment to provide the essential service package for adolescent-friendly services.
6. Information, education, and communication (IEC) consistent with the essential service package is provided.
7. Systems are in place to train staff to provide adolescent-friendly services.
8. Adolescents receive an accurate psychosocial and physical assessment.
9. Adolescents receive individualized care based on standard service delivery guidelines.
10. The clinic provides continuity of care for adolescents

Methodology

Clinics assessed according to NAFCI standards and criteria are awarded bronze, silver, or gold (good, better, and best, respectively) depending on how well they meet the standards. The accreditation process consists of four main 'phases'. The first step is the self-appraisal by the clinic. The self-appraisal is intended to help staff determine which standards and criteria they meet and those they don't meet. Unmet criteria/standards form the object for the quality improvement process in which clinics themselves determine how to make their services more youth-friendly. Once staff feels confident they meet the standards, an external assessment is done and accreditation is awarded on the basis of the number of standards met.

Eight assessment tools were developed to gather necessary information for the external assessment. These are: 1). Interview with clinic manager; 2). Document review; 3). Inventory of the clinic and immediate surroundings; 4). Health Care Provider interview; 5). Non-clinical support staff interview; 6). Client-provider interaction observations and simulations; 7). Adolescent client exit interviews; and 8). Key informant interviews.

Note:

It should be noted that standards, questions outlining the standards and assessment tools are not available on the internet.

2.   Pathfinder International (2002). Clinic Assessment of Youth Friendly Services; A Tool for Assessing and Improving Reproductive Health Services for Youth

Background

This tool is designed by Pathfinder to support the collection of detailed information on the range and quality of services provided to adolescents at a given facility or within a given programme in order to make services more youth-friendly. It guides the assessment of the degree of youth friendliness of the service.

Description

The assessment form covers general background information about the facility and addresses questions relating to client volume, the range of services

provided (including the schedule of available services), personnel (specifically on type of training received by staff) and supervision (frequency, type, monitoring, processes). It then poses questions dealing with twelve characteristics of youth-friendliness (location, facility hours, facility environment, staff preparedness, services provided, peer education/counselling program, educational activities, youth involvement, supportive policies, administrative procedures, publicity/recruitment, fees). An explanation on each of these characteristics is also given.

Methodology
According to the authors, a critical preparatory step is to review the characteristics of a youth-friendly programme listed in the tool and reach consensus among the assessment team on the standard for each characteristic. These standards will then be used as the benchmark to determine when improvements are needed.

Beside each question on the assessment form, there is a notation on the suggested methods to evaluate that particular aspect of youth-friendly services, such as: review of clinic records; interviews with clinic managers and staff; examination of the clinic layout and environment; interviews with clients; observations of provider-client interaction; and review of clinic policies and procedures.

Note: A useful tool to assess or set up YFHS, although it does not give directions on how to set up the services. Missing is the link to broader community activities or involvement of parents. It also does not include legal environment, diversity, stigma. RH services are not integrated with other health services.

3.   IPPF: Provide: strengthening youth friendly services (2006)
Background
The publication is part of the IPPF *Inspire* series, a resource pack providing self-assessment tools, guidelines, framework and standardized capacity building tools. IPPF developed this self-assessment tool to enable managers, providers and young people to appraise the youth friendliness of its services and prioritise areas for improvement. While the organization believes that 'services provided need to be appropriate to each Member Association's setting', certain minimum standards for adolescent services can be established. These minimum standards should be based on principles of quality and rights.

Description of the IPPF tool
The tool developed by IPPF aims to apply a rights based approach to youth friendly services, as the notion of rights is closely associated with the principle of empowerment. It is organized according to two main themes: client rights and provider needs. It provides a range of questions in relation to eight specific client rights and nine provider needs. The questions can be used as a guideline to assess the youth friendliness of the services, it is very detailed and also provides information on resources for youth friendly services. The rights and needs covered are outlined in the boxes below.

Client rights (to):

Information	Privacy and confidentiality
Access	Dignity and comfort
Choice	Opinion
Safety	Continuity of Services

Provider needs (with regard to):

Selection and recruitment	Need for guidance and back up
Need for training	Need for respect and encouragement
Need for information	Need for feedback
Need for infrastructure	Need to express opinion
Need for supplies	

For a more comprehensive appraisal of the services provided, the authors recommend further assessments:

- Assess management, using the IPPF 'Quality of Care: Improvement process manual for service providers and managers', and
- Client exit interview to gain insight into service provision and client satisfaction, using the appendixes (3 and 4) included in the tool and the IPPF 'Your comments count' checklist.

Note:
This is a very useful tool to make an assessment of existing services, but also good to decide how to set up new youth friendly health services. Because this tool is concerned about the health services, it does not really include questions about youth empowerment and supportive environment. These aspects are covered in other IPPF tools.

4.   IPPF (2008). Springboard; A hands-on guide to developing effective youth friendly centres

Background:
The Springboard publication is also part of the IPPF *Inspire* series, and this guide focuses on youth friendly centres as opposed to youth friendly health centres. Aside from providing SRH related activities (as described in the IPPF guide: Provide), it also covers recreational initiatives, career development activities, training in life skills and vocational skills, internet access. It describes SRH activities as part of a more holistic approach to youth development and is aimed to inspire youth and IPPF staff.

Description:
The guidelines offer a set of practical suggestions related to programme activities, staffing, programmatic and policy issues that need to be addressed, IEC activities and the linking of the youth centre to other activities for young people and the community at large – the youth centre is seen as a catalyst for change. It stresses that young people should have ownership over the centre and should be involved at all levels of decision making, implementation and monitoring activities

Methodology
The guide starts discussing strategic planning and deciding on target group, needs, and ability of the organization to establish a youth centre and resources available. It discusses the youth centre as catalyst for change at micro (youth), mezzo (community) and macro (national) level. It gives action points on sub themes and discusses overcoming limitations. It stresses that youth centres cannot be successful or sustainable without a strong commitment from the community and that it is vital that any organization seeking to establish a youth centre focuses its energies not only on young people, but on the community in

which they live. It gives tips for building up community participation and support and a checklist of do's and don'ts to identify and involve key stakeholders.

An overview is given of elements to address in service delivery: tips on location and organization of the centre lay-out, staff selection and training, age groups. While the need for integration of SRH activities with recreational activities is noted, the guide stresses that the provision of SRH information and services is the key aim of the centre and this should not be compromised by too much attention to the other activities.

A number of sections in the guide address overcoming barriers to access and give do's and don'ts, emphasizing the need to be clear on target group(s), hours, accessibility. Gender equity is considered a crucial component and the guide gives tips on how to attract both boys and girls, how to overcome traditional gender stereotypes (f.e. specific activities for different groups at different times) in order to avoid the situation that boys only use the recreational activities and girls the SRH services. Mobilisation of youth is advised through outreach and peer education, linking to schools and hospitals and other community based services. The guide stresses the importance of youth empowerment and gives tips to ensure that youth participation is integrated in all phases and needs to be emphasized in decision making and monitoring in order to be contributing to empowerment and promotion of possibilities for employment at a later stage. This applies to the different target groups of the youth centre.

The guide explicitly states that youth centres cannot cater for all young people as what may attract one group to the centre, may put another one off. Considering youth centres are designed as multi-purpose centres however, and not 'simply' to provide SRH related services, the recommendation to carefully decide on and cater to a particular target group is understandable.

Interestingly, the guide stresses the need to 'set aside time to treat male clients and employ male medical staff', suggesting a sensitivity to barriers (young) men face in accessing and using health services (Courtenay, 2000). The guide furthermore addresses barriers faced by young women, such as parental support for girls wanting to attend youth centre activities. It also notes a possible demand of young couples for information and services in making decisions as a couple on contraception and childbearing.

Note: This guide does not give any tools or instruments on how to implement the services, it confines itself to action points and do's and don'ts that are useful in the planning phase.

5.   Save the Children/US (2008). Partnership defined quality for youth. A process manual for improving reproductive health services through youth-provider collaboration
 (www.savethechildren.org)

Background
Partnership Defined Quality for Youth (PDQ-Y) is an approach for improving the quality and accessibility of services whereby young people are involved in defining, implementing, and monitoring the quality improvement process. The process involves the partnership between youth, health care providers, and

other stakeholders working together toward better service quality and availability for young people. The focus is on ensuring that the views and experiences of youth, health care providers and other community stakeholders are understood by each and that gaps and differences are overcome together.

Description
The manual offers tools that can be used in the different phases of the PDQ process, these include session outlines, activity descriptions, key points, exercises, discussion guides, checklists and facilitation tips. The PDQ process steps are: (i) planning and design considerations; (ii) phase 1: building support; (iii) phase 2 exploring quality; (iv) phase 3: bridging the gap; (v) phase 4: working in partnership and (vi) evaluating the process and outcomes. Alongside the tools, examples are given from different countries where PDQ has been carried out.

Methodology
The first pre-process element is the planning and design of the PDQ process including: Identifying needed skills and resources, defining goals, identifying the level of service to improve and address, understanding youth and their role, mapping by youth and health service providers of existing health, community and youth structures and their interface, planning for participation and representation of different stakeholders, identifying other quality insurance initiatives or partners.

Phase 1 Building support involves presenting the process and obtaining commitment for participation from youth, key members of the community and the health system. This includes advocacy with MoH, community groups and churches, (non)formal health providers, parents, NGOs and gives some advocacy guidelines.

In phase 2: Exploring quality, the perceptions of quality of services by adolescents and health care providers are assessed providing the opportunity to understand different perspectives: health worker defined quality, youth defined quality with rights and responsibilities of both.

In phase 3: bridging the gap the partnership necessary for subsequent activities in quality improvement is initiated, starting off with a presentation of the quality perceptions of each. This is followed by sessions on team building, developing a shared vision, defining youth friendly health services, problem identification, developing an action plan, selecting QI teams and keeping youth involved and interested, peer education training.

In phase 4: working in partnership the groups have agreed on a common vision of quality and challenges they face. They now need to determine causes, solutions, and action plans. This requires a creative team working together in cooperation and respect. Components in this phase are: Establishing youth-adult partnerships; The QI Action Cycle; Tools for Program Analysis; Tools for Self Management; Team Effectiveness Evaluation; Facilitation Exercises; Mobilizing Resources; Representation.

The process manual ends with a section on evaluation of the process and outcomes and components for which tools are given are: Determining the baseline, Monitoring the process, How do we measure success in PDQ-Y and Taking PDQ-Y to scale

Note:
This is the only tool included in this document that really provides an in depth guide on working with youth in partnership to improve not only access to SRH services, but also contributing to youth development in a way that goes far

beyond these services. The process will ensure an increased understanding and value clarification for health service providers and youth alike, while other stakeholders are involved where this is necessary for improved services and their uptake.

6. WHO (2009) Quality Assessment Guidebook; a guide to assessing health services for adolescent clients

Background
This detailed guidebook was developed to support professionals working in the health sector and health facilities to assess the quality of services provided to young people.

Description
The guidebook includes a range of data collection tools to assess client satisfaction. It is based on five main features/elements for adolescent friendly health services: equitable, accessible, acceptable, appropriate and effective. These main elements are subdivided in characteristics. The guidebook gives interview guides that cover interviews with adolescent client, health care provider, support staff, facility manager, outreach worker, community member, adolescent in community and observation guide.

Methodology
Below is an overview of the main features and the characteristics of adolescent youth friendly health services, combined with the suggested data collection tools by respondent and observation.

Characteristic of AFHS	AC	HP	SS	M	OW	CM	AinC	OG
EQUITABLE: All adolescents, not just certain groups, are able to obtain the health services they need								
Policies and procedures are in place that do not restrict the provision of health services on any terms.	√	√		√			√	
Health-care providers treat all adolescent clients with equal care and respect, regardless of status.	√	√					√	
Support staff treat all adolescent clients with equal care and respect, regardless of status.	√		√				√	
ACCESSIBLE: Adolescents are able to obtain the health services that are provided								
Policies and procedures are in place that ensure that health services are either free or affordable to adolescents.	√			√			√	
The point of health service delivery has convenient hours of operation.	√			√			√	
Adolescents are well-informed about the range of available	√						√	

	1	2	3	4	5	6	7	8
reproductive health services and how to obtain them.								
Community members understand the benefits that adolescents will gain by obtaining the health services they need, and support their provision.	√	√				√	√	
Some health services and health-related commodities are provided to adolescents in the community by selected community members, outreach workers and adolescents themselves.	√			√	√		√	

ACCEPTABLE: Health services are provided in ways that meet the expectations of adolescent clients

	1	2	3	4	5	6	7	8
Policies and procedures are in place that guarantee client confidentiality.	√	√		√				√
The point of health service delivery ensures privacy.	√	√		√				√
Health-care providers are non-judgmental, considerate, and easy to relate to.	√							√
The point of health service delivery ensures consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral.	√	√	√					√
The point of health service delivery has an appealing and clean environment.	√							√
The point of health service delivery provides information and education through a variety of channels.	√			√				√
Adolescents are actively involved in designing, assessing and providing health services.	√			√				

APPROPRIATE: The health services that adolescents need are provided

	1	2	3	4	5	6	7	8
The required package of health care is provided to fulfill the needs of all adolescents either at the point of health service delivery or through referral linkages.	√	√		√				

EFFECTIVE: The right health services are provided in the right way and make a positive contribution to the health of adolescents

	1	2	3	4	5	6	7	8
Health-care providers have the required competencies to work	√	√		√				√

with adolescents and to provide them with the required health services.								
Health-care providers use evidence-based protocols and guidelines to provide health services.		√		√				√
Health-care providers are able to dedicate sufficient time to work effectively with their adolescent clients.	√	√						
The point of health service delivery has the required equipment, supplies, and basic services necessary to deliver the required health services.	√	√		√				√

Key: AC = adolescent client tool; HP = health-care provider tool; SS = support staff tool; M = health facility manager tool; OW = outreach worker tool; CM = community member tool; A in C = adolescent-in-community tool; OG = observation guide.

Note:
Although these various tools appear to cover the spectrum of the kinds of services, which according to the WHO (2004) ought to be made available to young people – such as abortion services (N.B. the guide explicitly mentions 'where legal' when referring to pregnancy termination), care during childbirth and contraception – the guide does not appear to engage with the issue of 'diversity', i.e. providing tools to assess to whom precisely a facility caters (and who is excluded). A lot of attention is paid to issues of confidentiality and treatment by health care providers, triangulated in the data collection tools with different types of respondents.

**7.	UNFPA and Save the Children USA (2009). Adolescent Sexual and Reproductive Health in humanitarian settings, A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings**

Background
ASRH Toolkit has been designed to help programme managers to ensure that the sexual and reproductive health needs of adolescents (10-19) are addressed during all emergency situations. Although the ASRH requirements in humanitarian settings do not differ very much from those in more stable settings, they may be overlooked in the emergency context. The tools are, however, also applicable to non emergency settings.

Description
As human rights violations are more common in emergency settings, the manual is firmly rooted in sexual and reproductive rights of adolescents in relation to human rights.
The toolkit is divided in MISP (minimum initial service package) for ASRH and includes components on family planning, gender based violence, maternal and newborn care, STIs including HIV prevention and treatment and mental health and psychosocial support. Each of the MISP components is described in more

detail in the MISP matrix and the Fact Sheets that provide examples of how to identify and address adolescent SRH needs in the community. The MISP is a guideline for priority RH interventions in emergencies and does not specifically describe how to make services adolescent-inclusive, but it summons users to ensure that the SRH needs of adolescents are addressed during implementation of the MISP.

It advises to use standardized RH protocols for quality service provision and to adapt, if needed, to meet specific needs of adolescents. Such protocols could include (1) adolescent- friendly clinical services, (2) clinical management of survivors of sexual violence, (3) treatment and referral of clients with obstetric emergencies, (4) standard precautions, and (5) condom distribution.

Furthermore, the toolkit presents tools for adolescent and community and parental participation in the services making use of several existing models for adolescent participation that have been used in development contexts. It also discusses entry points for ASRH in existing adolescent programmes such as schools, adolescent centres, sports, drama clubs; vocational and skills training programs, media and communications.

Methodology
Assessment tools (mostly in the form of questionnaires) are presented for initial rapid assessment, situation analysis with questions for adolescents, parents, community leaders and health workers. This is followed by questionnaire for adolescents on knowledge, attitudes and utilization of services and sexual behaviour.
Facility based tools make use of the HEADSSS assessment (**H**ome & relationships, **E**ducation & Employment, **A**ctivities & hobbies, **D**rugs, alcohol & tobacco, **S**ex & relationships, **S**elf harm, depression and self image, **S**afety & abuse) that contains questions for adolescents. In addition there is an ASRH health service checklist which is based on the Pathfinder (2003) checklist mentioned under 5.1.

Finally, there is a reference to peer education tools of the Youth peer education network, coordinated by UNFPA. and a section on Community Based Distribution which basically deals with provision of condoms and information by youth peers in the community; a supervision tool for supervisors and a client referral form. It gives attention to the need to ensure the involvement of youth, but also includes tips on how to involve other stakeholders (especially dealing with policy, parents, community leaders).

Note:
The fact that this manual is designed for use in humanitarian setting makes a somewhat different from other tools in that it deals more explicitly with human and child rights, gender based violence, and mental health and psychosocial support that all are extremely important in these settings. It also explicitly addresses the legal setting of YFHS in emergency settings, alerting service providers to the fact that national laws with regard to adolescents' rights may clash with international law. The manual recommends that at all times providers are able to resolve issues in the best interest of the child or adolescent.

8. RutgersWPF and StopAIDSNow (2009). Evidence and rights based planning and support tool for SRHR/HIV Prevention Interventions for Young People

(http://www.rutgerswpf.org/article/planning-and-support-tool)

Background

The planning and support tool focuses on rights based SRHR education and HIV prevention interventions for young people. It is meant for organisations that are either already involved in ASRH and want to analyse their programme or for those who want to start an intervention. It makes use of the Intervention Mapping Model, consisting of 6 steps that are interlinked. The aim of the tool is to encourage people who develop SRHR education to reflect on why certain decisions in programme development and implementations were made/ about the reasons why their programme and its implementation are the way they are.

Description

The tool concerned with the process of inclusive planning in which young people, (health) facilitators, parents and other adults are involved. It is not focusing on clinical health services, but more on youth SRH development and how this can best be supported. The tool is based on a rights based approach (supporting young people's sexual and reproductive rights) and on the behaviour change approach (focusing on the factors that shape young people's (sexual) behavior, including attitudes, skills and social influence).

Methodology

The tool gives 6 elements of intervention planning: (i)stakeholder involvement; (ii) needs assessment; (iii) objectives; (iv) intervention design; (v) adoption and implementation; (vi) monitoring and evaluation. Each of these elements is subdivided in a number (28) of characteristics and for these indicators are formulated on the activities (what) and on the process (how). These indicators can be seen as questions to be asked. In addition, an in depth description is given for each of the characteristics. The section below gives an overview of characteristics and indicators.

A.   Involvement (step 1)
1. Are the right people in the project team?
2. Are young people involved in intervention planning?
3. Are facilitators involved in intervention planning?
4. Are the relevant decision-makers involved in intervention planning?

B.   Needs assessment/situation analysis (step 2)
5. Is the intervention based on a needs assessment?
6. Is the intervention based on a situation analysis?

C.   Objectives (step 3)
7.   Are the health goals of the intervention clearly outlined?
8.   Are the behavioural messages for young people clear and consistent?
9.   Does the intervention address all relevant and changeable personal determinants of behaviour?
10.   Will enough be done to promote a supportive environment?
11.   Is the intervention based on a holistic approach?

D.   Evidence-based intervention design (step 4)
12.   Is the intervention explicit about sexuality?
13.   Do facilitators create a safe setting for young people to participate?
14.   Does the intervention provide correct and complete information?
15.   Does the intervention address risk perception?

16. Does the intervention help people understand and develop their own attitudes, values and awareness of social influence?
17. Does the intervention include interactive skills training?
18. Do young people have access to individual support?
19. Does the intervention promote communication with parents or other adults?
20. Are the topics in the intervention covered in a logical sequence?
21. Does the intervention appeal to the target group?
22. Has the intervention been tested?

E. Adoption and implementation (step 5)
23. Have you done anything to increase adoption of the intervention?
24. Is the intervention implemented by appropriate facilitators?
25. Do the facilitators get training and support to implement the intervention properly?
26. Is implementation sustainable?

F. Monitoring & evaluation (step 6)
27. Have you evaluated the change in behavioural determinants (outcome evaluation)?
28. Did you monitor the intervention's design and implementation (process evaluation)?

Note:
This tool addresses with determinants of behaviour, consistency in messages and a holistic approach. It furthermore explicitly deals with sexuality, values, interactive skills training and selection and training, supporting and monitoring of facilitators (these may be health workers, but can also be teachers, community leaders or others).

9.   WHO (2011) Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries

The guidelines have been developed through systematic review of the evidence and technical expertise of policy-makers, programme managers and front-line workers from countries around the world, in partnership with many key international organizations working in this field.

The guidelines provide recommendations on action and research for: a) preventing early pregnancy: by preventing marriage before 18 years of age; by increasing knowledge and understanding of the importance of pregnancy prevention; by increasing the use of contraception; and by preventing coerced sex; b) preventing poor reproductive outcomes: by reducing unsafe abortions; and by increasing the use of skilled antenatal, childbirth and postnatal care.

These guidelines are primarily intended for policy-makers, planners and programme managers from governments, nongovernmental organizations and development agencies. They are also likely to be of interest to public health researchers and practitioners, professional associations and civil society organizations.

The publication's two main objectives are to:

(1) identify effective interventions to prevent early pregnancy by influencing factors such as early marriage, coerced sex, unsafe abortion, access to contraceptives and access to maternal health services by adolescents; and
(2) provide an analytical framework for policy-makers and programme managers to use when selecting evidence-based interventions that are most appropriate for the needs of their countries and contexts.
The table below gives an overview on desired outcomes and the recommendations for action to get these outcomes.

Outcome	Recommendations
Reduce marriage before the age of 18 years	• Encourage political leaders, planners and community leaders to formulate and enforce laws and policies to prohibit marriage of girls before 18 years of age. • Undertake interventions to delay marriage of girls until 18 years of age by influencing family and community norms. These interventions should be undertaken in conjunction with interventions directed at political leaders/planners. • Implement interventions to inform and empower girls, in combination with interventions to influence family and community norms, to delay the age of marriage among girls under 18 years of age. • Increase educational opportunities for girls through formal and non-formal channels, to delay marriage until 18 years of age.
Reduce pregnancy before the age of 20 years	• Advocate for adolescent pregnancy prevention among all stakeholders through interventions such as: information provision, sexuality and health education, life skills building, contraceptive counselling and service provision, and the creation of supportive environments. • Maintain and improve efforts to retain girls in school, both at the primary and secondary levels. • Offer interventions that combine curriculum-based sexuality education with contraceptive promotion to adolescents, in order to reduce pregnancy rates. • Offer and promote postpartum and post-abortion contraception to adolescents through multiple home visits and/or clinic visits to reduce the chances of second pregnancies among adolescents.
Increase use of contraception by adolescents at risk of unintended pregnancy	• Undertake efforts with political leaders and planners to formulate laws and policies to increase adolescent access to contraceptive information and services, including emergency contraceptives. • Undertake interventions to influence community members to support access to contraceptives for adolescents. • Implement interventions to improve health service delivery to adolescents as a means of facilitating their access to and use of contraceptive information and services. • Implement interventions at scale that provide accurate information and education about contraceptives, in particular curriculum-based sexuality education (CBSE), to increase contraceptive use among adolescents. Conditional recommendation:

	• Implement interventions to reduce the financial cost of contraceptives to adolescents.
Reduce coerced sex among adolescents	• Continue efforts with political leaders, planners and the community to formulate laws and policies that punish perpetrators of coerced sex involving adolescent girls, to enforce these laws and policies in a way that empowers victims and their families, and to monitor their enforcement. • Implement interventions to enhance adolescent girls' abilities to resist coerced sex and to obtain support if they experience coerced sex by: building their self-esteem; developing their life skills in areas such as communication and negotiation; and improving their links to social networks and their ability to obtain social support. • The above interventions should be combined with interventions to create supportive social norms that do not condone coerced sex. • Implement interventions to engage men and boys to critically assess gender norms and normative behaviours (e.g. gender transformative approaches) that relate to sexual coercion and violence. Combine these with wider interventions to influence social norms on these issues.
Reduce unsafe abortion among adolescents	• Ensure that laws and policies enable adolescents to obtain safe abortion services. • Enable adolescents to obtain safe abortion services by informing them and other stakeholders about: the dangers of unsafe methods of interrupting a pregnancy; the safe abortion services that are legally available; and where and under what circumstances these services can be obtained legally. • Identify and overcome barriers to the provision of safe abortion services to adolescents. • Ensure access to post-abortion by adolescents care as a life-saving medical intervention, whether or not the abortion or attempted abortion was legal. • Ensure that adolescents who have had abortions can obtain post-abortion contraceptive information and services, whether or not the abortion was legal.
Increase use of skilled antenatal, childbirth and postnatal care among adolescents	• Provide information to all pregnant adolescents and other stakeholders about the importance of utilizing skilled antenatal care. • Provide information to all pregnant adolescents and other stakeholders about the importance of utilizing skilled childbirth care. • Promote birth and emergency preparedness in antenatal care strategies for pregnant adolescents (in household, community and health facility settings). • Expand the availability and access to basic emergency obstetric care (BEmOC) and comprehensive emergency obstetric care (CEmOC) to all populations, including adolescents.

Note:
Although the guidelines are not specifically on youth sexual and reproductive health services, they are included in the tools as the recommendations are all concerned with adolescent youth, what services are needed and how to reach the target group more effectively. As such they strengthen the call for YFH services and in addition give guidelines on laws and policies that are needed to reduce the incidence of early pregnancy and poor reproductive health outcomes. Such policies are also important for YFH services as a whole.