

Number 4, September 2003

## A Rapid Assessment of Youth Friendly Reproductive Health Services

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### Summary

*Young people face greater reproductive health (RH) risks than adults, yet they are less willing and able to access RH services. Lack of awareness, inadequate information, and significant barriers posed by the current state of most RH services are perceived as unwelcoming to young clients. Given that the consequences of poor reproductive health in adolescence, such as those stemming from a too-early pregnancy or acquiring a STI or HIV, have serious implications for the future as well as the present, clinical programs need to find practical ways to assess their current operations and take steps to ensure that they are “youth friendly.”*

*The “Clinic Assessment of Youth Friendly Services: A Tool for Rapid Assessment and Improving Reproductive Health for Youth” was developed to facilitate the rapid assessment of youth friendly characteristics, providing the basis for developing and implementing a comprehensive action plan. Among the key issues assessed are provider attitudes, privacy and confidentiality, access to service, supportive policies and administrative procedures. The Tool is implemented through a variety of methods (including provider and client interviews, observation, and review of clinic statistics and policies) and can be used to establish a baseline, prepare a plan for training and service quality improvement, and measure changes in youth-friendliness by conducting periodic reassessments. It also allows for management and staff to become more involved in program operations and provides a means to get input from adolescent clients.*

*Experiences with the Tool in the four African Youth Alliance (AYA)<sup>1</sup> countries (Botswana, Ghana, Tanzania and Uganda) have shown that numerous service elements require upgrading, if the clinics are to successfully attract and serve young clients. The conducting of these baseline assessments has also resulted in important lessons learned that can be applied to future assessments, all with a primary objective of providing youth with better, more sensitive and relevant RH care.*

### I. The Importance of Youth Friendly Services

Although practices differ by region and culture, young people<sup>2</sup> throughout the world are changing their attitudes and behaviors regarding sexual activity. Typically, there is more pre-marital sexual behavior and a delay in the age of marriage, creating a longer period of likely unsanctioned sexual

<sup>1</sup> The African Youth Alliance is funded by Bill and Melinda Gates Foundation and is implemented by three partners: Pathfinder International, PATH, and UNFPA. The project's goal is to improve adolescent sexual and reproductive health by reducing the incidence of STIs/HIV, unwanted pregnancy, and unsafe abortion among young people aged 10-24. The project has five main components: policy and advocacy, behavior change communication, youth friendly services, livelihood skills development, and institutional capacity building.

<sup>2</sup> Young people and youth usually refer to those between the ages of 10 and 24, with adolescents comprising the 10 to 19 age group and young adults the 20 to 24 range. “Youth,” “young people” and “adolescents” will be used interchangeably in this document.

activity and pregnancy. These trends are bound to continue, as the influences fostering such behaviors are also growing: access to media and new ideas, urbanization, breakdown of traditional communication channels through which adults passed on information and guidance to young people, increased education for women, and opportunities for young men and women to interact socially and vocationally.

Despite the differences, **young people continue to face greater reproductive health risks** than adults. Some key examples include the following:

- Young people take higher risks in general, including unprotected sex.
- Young women are less able to resist sexual pressure and coercion.
- Young people in disadvantaged circumstances are vulnerable to sexual exploitation for favors and financial support.
- Young women are disproportionately represented among abortion-seekers, many of whom endure unsafe, clandestine procedures.
- Young women, for biological and cultural reasons, are more susceptible to HIV.

**Young people are also still less willing and able to seek RH services**, for the following reasons:

- National laws and policies restricting access to care based on age and/or marital status
- Inconvenient hours of operation
- Lack of convenient transportation
- High cost of services
- Poor understanding of their changing bodies and needs
- Insufficient awareness of the risks associated with early pregnancy and STIs/HIV
- Little knowledge of the available services
- Lack of awareness regarding the location of RH services
- Belief that the services are not intended for them
- Concern that the staff will be hostile or judgmental
- Concern over lack of privacy and confidentiality
- Fear of medical procedures and contraceptive methods, including side effects
- Embarrassment at needing or wanting RH services
- Fear that their parents might learn of their visit
- Shame, especially if the visit follows sexual coercion or abuse

Considering that adolescents are reluctant to seek RH services as they are currently provided, it is important to find ways to offer care in a manner that they perceive as more welcoming, comfortable, and responsive. In addition, helping young people to develop good health habits and seek regular care at an early age lays the foundation for ensuring the future of their reproductive health.

In brief, **youth need specialized RH services** because of:

- Specific biological and psychological needs of adolescence
- High risk of STIs, HIV, and pregnancy
- Disproportionately high risk of sexual abuse
- Importance of behavior-related risks that are responsive to education and counseling
- Opportune age/stage to learn good health practices
- Severity of consequences from lack of RH care during adolescence.



## II. Addressing Adolescent Issues

In the scheme of modern existence, the concept of “adolescence” is relatively new. Throughout much of human history, childhood led almost directly to adulthood, with puberty as the defining period of transition. Adolescence is now increasingly seen as an important time for preparing to enter adult life, and social investments in education, vocational training and health are increasingly valued. This period of maturation has lengthened and gained recognition as a critical time for human development.

Having survived the vulnerability of infancy and early childhood, adolescents between the ages of 10 to 14 tend to be generally healthy. However, a different pattern of health concerns emerges during the teenage years, stemming primarily from new forms of behavior. This behavior relates to newly acquired skills, risk-taking, experimentation and a move toward independence. Although adolescent behavior is often viewed as negative or dysfunctional, many of these new expressions, in fact, result from a need to develop the interests, skills, and maturity of their

imminent adulthood. A major challenge for adults and professionals is to assist young people in making the transition to adulthood in a productive and healthy manner.

Because sexual maturation is the major physiological development of adolescence, attention must be given by health professional to its expression and consequences. Health care policymakers and planners are increasingly giving attention to this “new” life phase, recognizing its special needs and responding with various adaptations and efforts to deliver youth friendly services (YFS).

There are many variations of this approach, but simply stated, services are youth friendly if they have policies and attributes that attract youth to the facility or program, provide a comfortable and appropriate setting for serving youth, meet the needs of young people, and are able to retain their

### Characteristics of Youth Friendly Services

#### Provider Characteristics

- Specially trained staff
- Respect for young people
- Privacy and confidentiality honored
- Adequate time for client and provider interaction
- Peer counselors available

#### Health Facility Characteristics

- Separate space and special times set aside
- Convenient hours
- Convenient location
- Adequate space and sufficient privacy
- Comfortable surroundings

#### Program Design Characteristics

- Youth involvement in design and continuing feedback
- Drop-in clients welcomed and/or appointments arranged rapidly
- No overcrowding and short waiting times
- Affordable fees
- Publicity and recruitment that inform and reassure youth
- Boys and young men welcomed and served
- Wide range of services available
- Necessary referrals available

#### Other Possible Characteristics

- Educational materials available
- Group discussions available
- Delay of pelvic examination and blood tests possible
- Alternative ways to access information, counseling, and services



youth clientele for follow-up and repeat visits.

Based on research and assessments, a set of characteristics associated with youth friendly services was identified<sup>3</sup> (see “Characteristics of Youth Friendly Services”). These elements differ in importance to effective service delivery and vary according to region, culture, and various characteristics of the primary target audience (age, sex, sexual experience, and school status). For example, a separate space and special hours appear to be important to young adolescents and those using a clinic before sexual experience, while not nearly so important to older and more sexually experienced teens. Some characteristics, however, appear to be universally critical to young clients; such as the availability of providers who are specially trained, respectful, concerned about privacy and confidentiality, and facilities that offer convenient hours and affordable fees.

### *How are Service Programs for Adolescents Different from those for Older Clients?*

Unlike reproductive health programs that cater to adults who are often married and have children, adolescent programs are usually pioneering efforts that are more culturally and politically sensitive, due to the fact that most societies frown on teenage sex. Therefore, to be effective, adolescent programs require special adjustments, such as increased privacy and confidentiality, using neutral language (e.g. “youth friendly services”) to reduce stigma, and employing specially trained providers who are comfortable communicating on sensitive topics. Although these challenges require additional planning and expenditures, such programs are often cost-effective in the long run because of the increased pay-off in good adolescent and long-term health. Planning and assessment should be responsive to identified needs and approached systematically.

### **III. Advantages of Using the Clinic Assessment of Youth Friendly Services Tool**

The Clinic Assessment of Youth Friendly Services Tool was developed for AYA to provide a practical mechanism for determining the extent to which existing services are youth friendly and for identifying potential improvements. The Tool was based on findings reported in the monograph *Making Reproductive Health Services Youth Friendly*, published under the Focus for Young Adults Project.<sup>4</sup> Given AYA’s mandate to scale up YFS in Botswana, Ghana, Tanzania, and Uganda, a standardized and easily implemented method for assessing significant numbers of facilities was needed. Because providing RH services to young people is a new activity for most program managers, they need to know how they can adapt their current services, or initiate new services, according to the needs and preferences of their intended clientele. This tool can help program managers and staff members assess their current situation and figure out how to effectively adapt policies, programs, and services so that they will be more youth friendly.

The tool can be used to:

- Assess the current state of youth-friendliness, in order to develop an action plan for making services more attractive and responsive to youth.
- Create an appropriate and practical training plan for upgrading staff skills and competencies with respect to providing YFS.
- Establish a baseline of youth-friendliness with which to compare future quality improvements.

<sup>3</sup> Senderowitz, J. 1999. *Making reproductive health services youth friendly*. Washington, DC: Focus on Young Adults. Pathfinder International.

<sup>4</sup> Ibid.



- Determine the extent to which a facility has improved its youth-friendliness, through periodic reassessments.

There are a number of other advantages and benefits to using this tool, since it provides:

- A hands-on means to get program management and staff involved in understanding their operations and agreeing on a plan to improve their services.
- A means to get input from adolescent clients, thereby increasing the efficacy of their future services.
- An orderly process to look at diverse aspects of clinic operations from several perspectives (client, provider, manager, supervisor).
- A logical process to develop action plans, stemming directly from the assessment, to upgrade youth-friendliness.
- A practical means to create a report on current status (and/or change in status) for funders, policy-makers, and others.
- A way to compare assessment results with others using this standardized tool.

Overall, this tool offers a user-friendly approach to assessing the quality of reproductive health services offered to youth. It has been field-tested and revised, so that it can be applied in a minimum amount of time to gather the most practical information. (See next section for how to conduct an assessment.) The characteristics of youth-friendliness are clearly defined, so that the new user understands the relative importance and purpose of each item. All of the identified items were derived from practical research and evaluation findings on adolescent use of reproductive health services, as summarized in Senderowitz, *Making Reproductive Health Services Youth Friendly*.

#### IV. How to Conduct an Assessment Using the Tool

Although the Tool can be used by an individual program manager or clinician to determine the extent to which services are youth friendly, a team approach has shown to be more beneficial as it allows for different stakeholders to be involved, thereby increasing the participatory nature and ownership of the assessment process. It is best to limit the size of the team to four people or fewer since larger teams can become unwieldy and disrupt the flow of services. Possible team members can include: program managers, supervisors, trainers, Ministry of Health (MOH) or Non-governmental Organization (NGO) staff, clinicians, and youth.

The team should begin by familiarizing themselves with the assessment tool and discussing their objectives in conducting a YFS assessment. The Tool is organized according to the following sections:

- General background information
- Client volume and range of services
- Personnel and supervision
- Assessment of youth-friendliness

Each section begins with a description of the information being collected and instructions for collecting data. The section on youth-friendliness is broken into twelve subsections based on the characteristics of a youth friendly program. The subsections are:





- Location
- Facility hours
- Facility environment
- Staff preparedness
- Services provided
- Peer education/counseling
- Educational activities
- Youth involvement
- Youth supportive policies
- Administrative procedures
- Publicity/recruitment
- Fees

Determining the degree of youth-friendliness can be subjective and difficult to quantify; therefore, the ideal characteristics are described at the end of the Tool as a reference for the user. This description can be used as a benchmark, so that the user has some comparison for making a judgment on different aspects of youth friendly services. The team should review the description and agree beforehand on the definitions and standards related to each characteristic before beginning the assessment.

Several methods are used to collect data. These include:

- A review of clinic records (usually of most recent data)
- Interviews with clinic managers and staff
- An examination of the clinic layout and environment
- Interviews with clients
- An observation of client-provider interaction
- A review of clinic policies and procedures

Often a combination of these methods is needed to answer a specific question. To help the user, a notation of the suggested method to collect data is provided beside each question in the tool.

### ***Assessment Process***

The assessment should be scheduled ahead of time with the clinic manager. The assessment process should begin by introducing the team to the clinic manager and other staff as appropriate. The team should briefly discuss the objectives of the assessment and the process for carrying it out. It is important that the clinic staff understand that the assessment tool is designed to identify both areas where services are already youth friendly and those that need improvement. It is not designed to simply find fault.

The team should then begin completing their assigned sections, being careful not to disrupt client flow. The Tool has a place to record answers, comments, and recommendations. The recommendations will be used subsequently to develop an action plan for improving services. By talking with the staff at the facility, especially the clinic manager, it will be possible to assess willingness to introduce or strengthen youth friendly services. The head of the clinic should be involved as much as possible, since s/he will be key in changing staff attitudes and practices. Before interviewing adolescent clients or observing procedures, obtain informed consent. All clients have

the right to refuse being interviewed or observed, without having their appointment cancelled or rescheduled.

After the assessment has been completed, the team should debrief with the facility manager and key staff members to share findings, analyze the results, and solicit suggestions for improvement. Debriefing also allows the staff to clarify and add information that may have been overlooked by the assessment team. It is imperative that the team conveys the assessment results in a constructive and diplomatic way so that clinic staff feels included and not alienated. The discussion should begin with areas that show the greatest strengths.

The team should also arrange to work with facility staff on developing an action plan to address any gaps or weakness found during the assessment. An action plan template is included at the end of the Tool. The action plans identify a range of quality improvements from those that the clinic staff can easily do themselves (e.g., minimize interruptions during client visits by moving supplies that are often needed out of a consultation room) to those that require technical assistance (e.g., examining and changing commodity supply logistics to reduce stockouts). Supervisors should periodically review these action plans to monitor progress toward achieving youth-friendliness. Based on the need to certify clinics once they have become youth friendly, a certification tool that can be used in conjunction with the assessment tool is currently being pre-tested.

## V. Summary of Findings (4 countries)

The assessment process described above was a key component of Pathfinder's strategy to expand youth friendly services in the four AYA countries. Teams of three or four people, comprised of MOH/NGO personnel, youth, and AYA staff, conducted one-day facility assessments of public-sector and NGO clinics to determine the current state of youth-friendliness. In order to implement youth friendly services in all the districts selected under the AYA project, facility assessments were conducted in phases. Under Phase I, assessments were conducted in 10 facilities in Botswana, 14 in Ghana, 13 in Tanzania, and 23 in Uganda. In Botswana, eight of the ten clinics assessed were government facilities and two were Botswana Family Welfare Association (BOFWA) clinics. In Ghana, only NGO facilities were assessed, of which four were operated by the Planned Parenthood of Ghana (PPAG) and ten by the Christian Health Association of Ghana (CHAG). In Uganda, almost

### Helpful Tips

- When preparing to conduct an assessment, inform the clinic manager or supervisor that that team will need to review three months of service statistics, so that these can be ready in advance.
- Assign different sections of the tool to different team members. Where possible, it is good to have more than one team member conduct interviews or observations to counteract personal bias and to make the assessment more objective.
- Carefully review the reference section in the back of the tool on characteristics of youth friendly programs before beginning.
- Ask the clinic manager about the routine of the service providers and schedule data collection accordingly. For instance, if a section requires observation or interviews with clients, schedule this during busier periods and leave other activities such as the review of policies for times that are less busy.
- Whenever possible, obtain your information by direct observation.
- Be flexible—it may not be possible to complete the whole tool at one time. The team may have to wait to observe some procedures at another time.
- Use your judgment and ask other pertinent questions that may not be on the tool.



all the facilities were government facilities with a few NGO clinics. In Tanzania, five clinics were private-sector facilities and the rest were public-sector facilities. Based on the findings, action plans are being developed and technical assistance is being provided to improve the quality of youth friendly services. A summary of the key findings from the four countries follows below.

***NGO clinics were better poised to meet the needs of young clients.***

Quality improvements are needed in most of the clinics throughout the four AYA countries, though NGO clinics show a significantly higher degree of youth-friendliness compared to those run by the government. NGO clinics were usually less crowded and cleaner than government facilities, which accommodate larger numbers of clients due to the fact that services are free or highly subsidized, often resulting in long waiting times and limited provider-client interaction. NGO providers usually served young people more expeditiously and were able to spend more time with their adolescent clients. In addition, most government facilities were not attractive to young people, due to poor maintenance, limited seating in the waiting areas, and overall cleanliness. In addition, provider burnout at government facilities often resulted in low motivation to serve adolescent clients.

***While geographic location was not a barrier to access, hours of operation and fees for services did hinder young people's ability to access RH services in two of the countries.***

Most facilities were well located and within easy reach. However, the majority of clinics were not open during convenient times for youth, such as weekends or evenings. Although some of the facilities offered emergency or curative services 24 hours a day, RH services were offered only during regular business hours on weekdays. The one exception was at public sector facilities in Uganda, where services were usually available in the late afternoon and weekends.

Most young people in Botswana and Uganda reported that fees for service were affordable, whereas they posed a barrier to care for many Ghanaian youth. This difference between the countries can be explained by the fact that in Ghana, the team primarily assessed NGO clinics. This finding highlights one of the challenges faced when implementing youth friendly services. On one hand, NGO clinics usually deliver a higher quality of service making them more attractive to youth; however, NGO clinics usually charge higher fees in order to recover costs since they do not usually receive government subsidies. Public sector facilities, on the other hand, may be affordable to youth, but are often crowded with long lines and overburdened staff. In Tanzania, fees were also identified as a barrier to attracting youth to NGO clinics, but even some of the public-sector facilities were not affordable for youth in the community.

***No separate space or times for serving young people.***

Most facilities did not set aside special examination or waiting space or clinic hours to serve young people, despite a few exceptions. Only two NGO clinics, PPAG in Ghana and BOFWA in Botswana, actually offer adolescent-only clinics, rather than separate space or hours dedicated to adolescents within general services. However, most young people reported they would like their own space or clinic hours, so that they do not have to "mix" with the adult clients, since one of the biggest barriers was fear of being seen by adults from their community. Many young people expressed a preference for separate waiting space, more than a need for separate examination rooms. By offering special hours, a clinic can utilize existing space and ensure privacy.





***Young people were afraid to be stigmatized, if they were seen entering a room that was labeled “family planning” or if others in the community knew the reason they had accessed services.***

Many facilities label their rooms so clients can quickly identify where to go for certain services. However, many young people did not want to be seen entering a room labeled “family planning” or “STI clinic.” Furthermore, RH services are traditionally offered in maternal and child health (MCH) clinics and young men reported that they would rather self-treat a STI than be seen seeking treatment at a MCH clinic. Young people were concerned with privacy and confidentiality. There was a fear that the provider would share their personal business with adult community members. Most facilities that were assessed could make changes to meet their young clientele’s desire for confidentiality and privacy by simply erecting doors to examination rooms (so their interactions cannot be seen or heard), closing existing doors, minimizing interruptions during visits, and ensuring that records are stored in a confidential manner.

***Providers had not received specialized training and often their attitudes deterred young people.***

In all four countries, most providers had not yet been trained nor staff oriented on the special needs of adolescents. Providers reported that they were often uncomfortable addressing the problems of adolescents, because they had not been trained in providing YFS. For the most part, job aids on adolescent reproductive health are nonexistent. In addition, many providers in Tanzania, Uganda, and Botswana were not even adequately trained in basic reproductive health.

Although there are no national policies in the four AYA countries restricting adolescents from receiving services due to their age or marital status, many providers imposed their own personal values and biases, which led to younger and sometimes single adolescents not being served well. Although training may address some of these biases, this finding highlights the need to carefully select service providers for their interest in youth friendly services.

Current supervision of providers was found to be inadequate in all four countries, emphasizing the need for managers to be trained in supervision of youth friendly services. Good supervision and support are needed for the implementation of a new initiative such as youth friendly services, or providers will forget what they learned during training and revert to their old practices and biases.

***For the most part, clinics offered a range of services and commodities.***

Under the AYA program, a minimum package of services was outlined that included:

- Information and counseling on sexuality, safer sex, and reproductive health
- Contraception with an emphasis on dual protection
- STI diagnosis and management
- HIV counseling (and referral for testing and care)
- Pregnancy testing and antenatal and postnatal care
- Counseling on sexual violence and abuse (and referral for needed services)
- Post-abortion counseling and contraception (with referral for management of emergency complications when necessary)

Surprisingly, most clinics in all four countries already offered these services. Overall, the two greatest weaknesses were counseling on sexuality and safer sex, and on sexual violence and abuse. In addition, all of the referral systems needed to be strengthened particularly with regard to tracking and follow-up to ensure that clients had received appropriate care at the referral site. A range of

contraceptive methods was available in both public sector and NGO clinics, although many facilities in Botswana, Tanzania, and Uganda experienced periodic shortages of commodities.

***Condoms were not promoted or widely available.***

Despite the prevalence of HIV, condoms were not widely available in most of the clinics that were assessed. Most facilities required that a young person actually see a provider to receive a condom, or if they dispensed condoms, they did so in a public place such as a table in the middle of the waiting room. A few clinics in Botswana and Tanzania had made attempts to widely distribute condoms and had placed baskets of condoms at the dispensary, in the washrooms, or in private corners. Many providers reported being reluctant to give condoms to younger adolescents even if they knew the person was sexually active, because they were afraid of the community's reaction.

***Youth involvement was virtually non-existent in both NGO and public sector clinics.***

In general, young people were not involved in the design, implementation, or evaluation of RH services. Although most providers and managers reported that they would like to involve young people more in decision-making, most of them did not know how to establish effective mechanisms for feedback. Some facilities did have peer educators although most of these programs were quite weak with little mentoring or supervision. However, it should be noted that PPAG had established a formal network of peer educators and feedback mechanisms, such as client exit interviews, mystery clients<sup>5</sup>, and the inclusion of youth on management committees. By involving youth in various ways, PPAG was able to tailor services so that they were more attractive to youth.

***Promotion of services and publicity on the clinic's location and hours was inadequate.***

Potential young clients must be aware of a clinic's location and the services that it offers. In all four countries, promotion of services needs to be strengthened. Most adolescents reported that they only heard about a clinic and its services by word of mouth. In Tanzania, NGO clinics face an additional challenge in publicizing their youth friendly programs, because of a national law restricting private clinics from advertising their services through mass media. However, even simple measures such as signboards in the community listing the hours and location of the clinic as well as services provided would increase awareness of youth friendly services. Outreach by peer educators or other community health workers has also proven to be an effective means of promoting services.

***Most policies were supportive of youth friendly reproductive health services.***

In all four countries, governments have been increasing their attention to adolescent reproductive health. All four countries have written policies that support the delivery of services to youth regardless of marital status or age. The one exception was Zanzibar in Tanzania, where government policies pose restrictions on unmarried adolescents receiving services, and enforce a law that states if an unmarried woman under the age of 18 falls pregnant, the couple can be jailed.

## VI. Lessons Learned

- Team members should be chosen who are interested in youth friendly services and who will be involved in the subsequent technical assistance process or supervision.

<sup>5</sup> The use of mystery clients is a technique where young people affiliated with the assessment team pose as clients needing a particular service, in order to assess the quality of YFS services provided.



The selection of clinics to implement youth friendly services should be done carefully. A strong commitment from management and staff should be an essential criterion for selection.

- Management must be sensitized and committed, before the assessment process begins.
- Clinics should be notified in advance of the assessment dates, the process, and the anticipated role of the management and staff during the assessment.
- The assessment process takes longer than expected. With one day budgeted per clinic, the teams found that extra time was needed for detailed discussion on issues and to reach consensus on findings and recommendations. Without consensus, there is the possibility that some team members will feel alienated and not fully contribute to future technical assistance.
- Additional time also needs to be allocated for writing the assessment reports. The process of report writing allows for the team to analyze findings and develop recommendations for improvements, and increase their ownership of the process. With these concerns in mind, one and a half to two days is a recommended time period for the assessment process.
- Data was often not disaggregated by age groupings in the assessment tool (10-14, 15-19, 20-24); therefore, it was necessary to go through individual service registers in order to obtain the needed information. Assigning two people to work on data may be necessary, so that each person can work on different registers to ensure that all the needed data is collected in one day.
- Although national policies that are supportive of YFS may exist, it should not be assumed that providers or clinic managers are well versed in them. Team members should familiarize themselves beforehand with any policies that impact the provision of RH services to youth.
- Before beginning an assessment, identify individuals who will be able to provide technical assistance and determine what the process for providing it will be, so that if needed, technical assistance for quality improvements can begin shortly after completing the assessments.

## VII. Conclusion

In many developing countries, the population of young people is on the rise, as is the risk of unwanted pregnancy, STIs, and HIV/AIDS. And yet, they have been traditionally underserved when it comes to their sexual and reproductive health needs. As donors and governments begin to focus more attention on increasing the availability of RH services to young people, program managers and clinic staff need guidance on how to adapt current services so they are more youth friendly. A participatory assessment process ensures that clinic staff members are involved throughout the identification of needed quality improvements and the development of implementation plans. The Clinic Assessment of Youth Friendly Services tool and the lessons learned from the AYA experience can be applied to increase the efficiency and effectiveness of assessments carried out in other developing countries.



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Facility Assessment Reports from Uganda, Tanzania, Botswana, and Uganda.

## **ACKNOWLEDGEMENTS**

The following Pathfinder staff or consultants were involved in the assessment process in the four AYA countries (Botswana, Ghana, Tanzania, and Uganda) and it is their findings which contributed to this paper: Nelson Keyonzo, Naomy Achimpota, Andrew Arkutu, Emmanuel Essandoh, Neo Mokgautsi, Sophia Ladha, Joy Mukaire, Lucy Asaba, and Tijuana James-Traore. In addition, the authors would like to thank all the team members from the different implementing partners that participated in these assessments as well as all the facility staff and accommodating clients that made these assessments possible.



These findings would not have been possible without the funding and support of the African Youth Alliance Program, funded by the Bill and Melinda Gates Foundation.