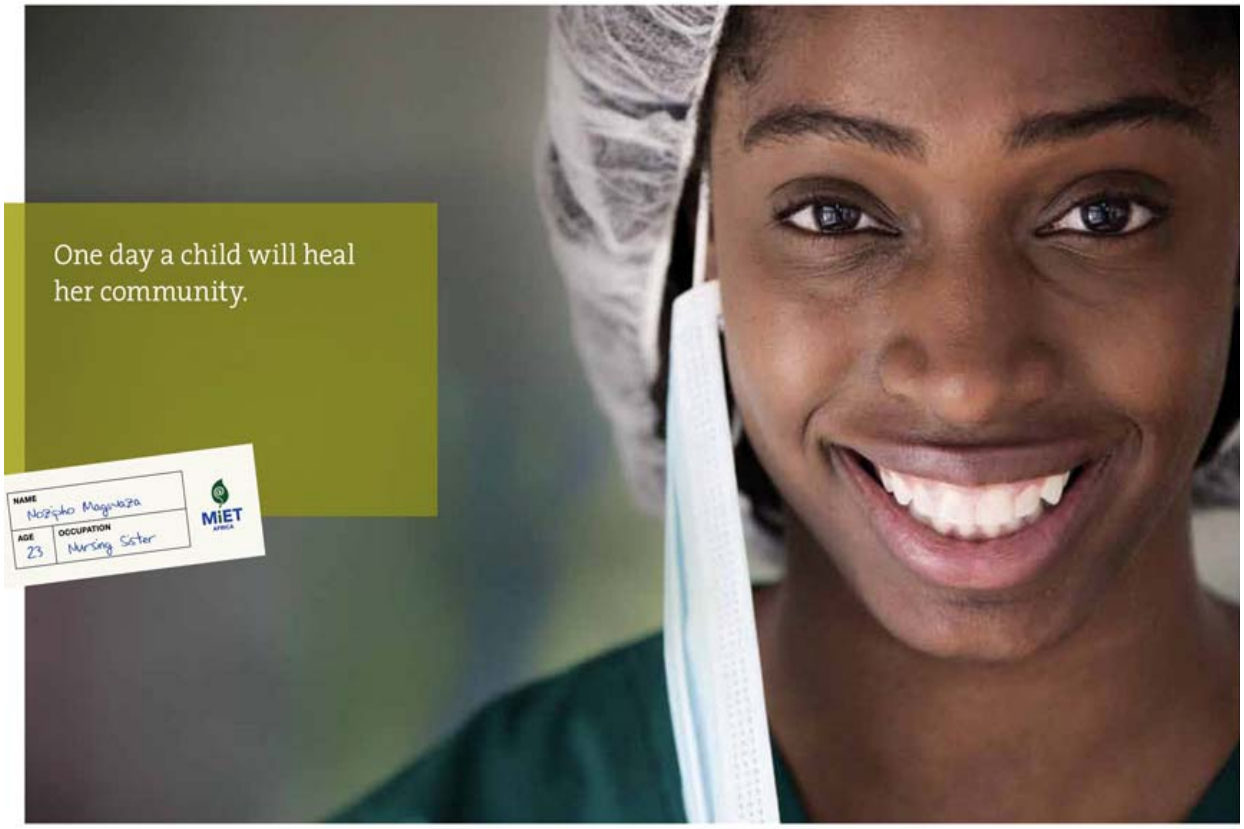


Literature Review:

Youth-friendly Health Services

September 2011

MiET AFRICA

Contents

Acronyms

ESHA	Estonian Sexual Health Association
ICPD-POA	International Conference on Population and Development- Programme of Action
IPPF	International Planned Parenthood Federation
NAFCI	National Adolescent Friendly Clinic Initiative
RFSU	Riksförbundet för Sexuell Upplysning
RHRU	Reproductive Health Research Unit
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UNGASS	UN General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YFHS	Youth-friendly Health Services

1. Introduction

Poor access to quality health care is one of the greatest barriers to the realization of education rights in South Africa. Poor health quality impacts negatively on educational access, retention and achievement of young people in the country. Of particular concern is the access of adolescents to appropriate sexual and reproductive health (SRH) services. This report looks at how health services can be made more adolescent-friendly and considers models that may be successful in the South African context. In particular, the report considers how these services may be linked to schools and communities.

For the purposes of this report, the International Planned Parenthood Federation (IPPF) definition of youth-friendly health services will be used, which is "those that attract young people, respond to their needs and retain young clients for continuing care" (IPPF 2007). Youth-Friendly Health Services (YFHS) that are offered should be based on an understanding of what young people in a given community want and need, and must have respect for the realities of young people's diverse backgrounds (IPPF 2008). "Young people" refers to anyone between the ages of 10 and 24 years of age and "adolescents" refers to people between the ages of 10 and 19 years of age (Bearinger et al 2007)

Although YFHS consider all aspects of the health and well-being of young people, of particular concern is SRH, which includes sexual development, reproductive health, interpersonal relationships, intimacy, body image and gender roles (Baloyi 2006).

This report will first establish the foundation of why YFHS are important, based on international legislation, the South African context and the existing barriers that adolescents experience when accessing health services. The report goes on to explore various models and guidelines for providing YFHS, resulting in a clearly defined essential package of guidelines for the South African context. The report then highlights case study examples of models for YFHS in South Africa and internationally. It then concludes with recommendations for MIET Africa in taking this model forward and incorporating it into existing programmes and education services.

2. Why the need for Youth-friendly Health Services

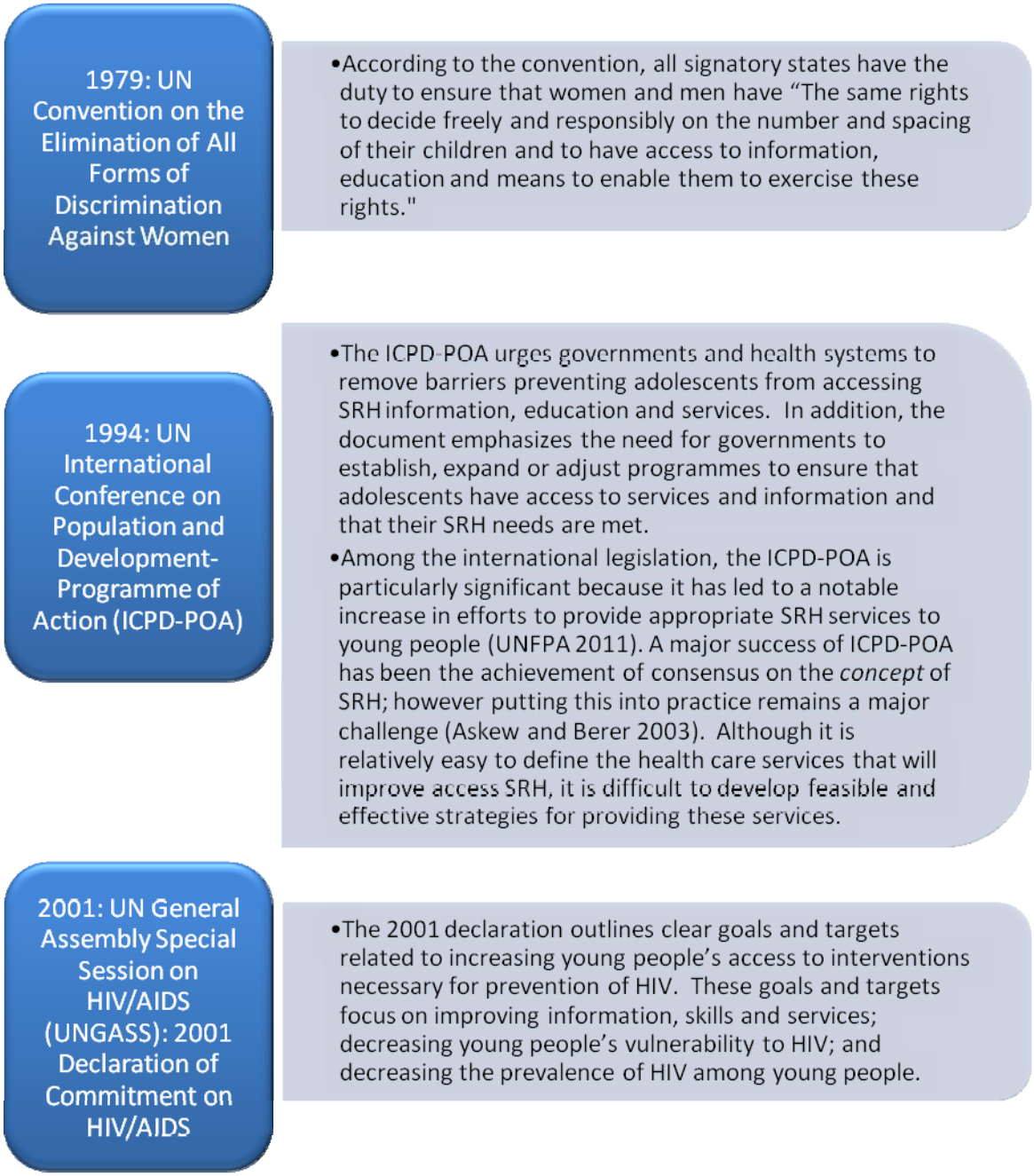
Reproductive health programmes targeted at youth in sub-Saharan Africa were first developed in the late 1970s in response to a growing recognition that young people were poorly informed on SRH. Initial programmes focused mainly on providing information to young people and improving the capacity of parents and teachers to convey such information (Erulkar et al 2005). Unfortunately, to date, programmes that improve young people's actual *access* to SRH services is less developed in the region. This is mostly because of political sensitivity and socio-cultural biases (Erulkar et al 2005).

This section outlines the legislative and contextual background that exists in South Africa and internationally. While the context reveals the need for YFHS, the legislation provides the ethical and legal requirement for providing such services to young people.

2.1 LEGISLATION ON YFHS

Before considering specific international and South African legislation related to YFHS, the issue must first be considered from a human rights perspective. All people, regardless of race, gender, sexual orientation, marital status, age, religious or political beliefs, ethnicity, or disability, have the right to information and access to health services (IPPF 2007). According to IPPF, it is unethical to give information and education on SRH without providing access to appropriate services, including contraceptives and counselling (IPPF 2008).

It is based upon this human rights perspective that several significant international agreements have been passed. These include:



In addition to the international guidelines and agreements listed above, the South African government also provided the following aims of sexuality education for adolescents in 1999:

- Make young people like and respect themselves, and enhance their self-esteem and self-awareness.
- Help adolescents to see sexuality as a natural and positive part of life.
- Teach the skills needed for informed and responsible decisions, including decisions regarding sexual relationships.
- Explore different values and attitudes to enable each adolescent to develop his/her own moral framework.
- Teach adolescents how to protect themselves from exploitation and how not to exploit others.

- Teach adolescents how to communicate and express their needs and feelings.
- Teach adolescents how to use health services and find the information they need.

South Africa's constitution affirms universal rights to reproductive choice and reproductive health care. Under South African law, anyone 14 years or older has a right to receive contraception (UNFPA 2011).

2.2 ADOLESCENT CONTEXT

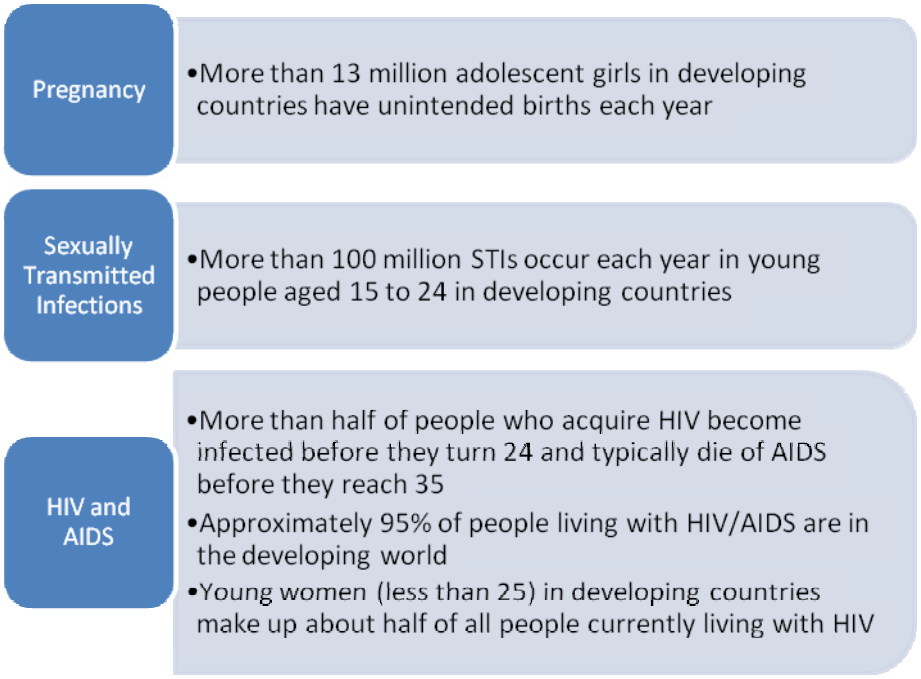
There are several reasons why the SRH of adolescents should receive special attention. To begin with, adolescents experience the following specific vulnerabilities that are unique to their age group: physiological vulnerability; high susceptibility to peer pressure; tendency to engage in risk-taking behaviour; less ability to negotiate safer sex practices; and difficulty accessing reproductive health information and services (Baloyi 2006). With regard to physiological vulnerabilities, adolescent girls have biologically immature reproductive and immune systems, which make them particularly vulnerable to sexually transmitted infections (STIs) (Bearinger et al 2007). In addition, early pregnancy and STIs (including HIV) threaten the health of adolescents more than at any other age group (Bearinger et al 2007).

Adolescent females are further disadvantaged and made vulnerable by the differences in gender norms and pressure to engage in transactional sex for economic reasons. Young girls who are in relationships with significantly older men (intergenerational relationships) are also less likely to have negotiating power in the relationship (Bearinger et al 2007).

A final reason for investing in the SRH of adolescents is that changing the behaviour of young people provides the greatest opportunity for intervening against STIs and AIDS. Research has shown that the few countries that have successfully decreased national HIV prevalence have done so mostly by encouraging safer sexual behaviours in adolescents (Bearinger et al 2007). In addition, investing in the health of adolescents not only improves the health of adolescents today, but also ensures that the next generation of children is healthier. Adolescents with improved SRH knowledge who practise safer behaviours will in turn safeguard the health of their own children in the future (WHO 2002).

2.3 THE HEALTH CONTEXT OF THE DEVELOPING WORLD

Statistics collected by the World Health Organization (WHO) paint a dire picture of the current health status of adolescents in the developing world (WHO 2009):



These statistics further illustrate the sexual and reproductive vulnerability of adolescents, and in particular of young females. Most notably, these statistics have all been collected from developing countries, highlighting the plight of adolescents in the developing context.

2.4 THE SOUTH AFRICAN HEALTH CONTEXT

Although South Africa is considered a middle-income country rather than a developing country, it still experiences many of the same health issues as its neighbours in the developing world. There are high rates of STIs, HIV and pregnancy among adolescents in South Africa (Baloyi 2006). According to WHO, South Africa is currently experiencing a "youth health crisis", partly due to under-nutrition, early child-bearing, high incidence of HIV infection, substance abuse, violence and injuries (WHO 2009). In addition, societal changes caused by modernization and urbanization have led to changes in traditional family structure, leaving many young people unable to rely on parent figures for information and guidance about responsible sexual behaviour (AYA/Pathfinder 2003).

In addressing this health crisis in South Africa, SRH programmes for adolescents can make an important contribution to HIV prevention and treatment. In addition, STI control is important for SRH and HIV/AIDS control (Askew and Berer 2003).

3. Existing barriers to accessing SRH services

This section explores the barriers that currently exist that are preventing adolescents from accessing SRH services.

3.1 STIGMA

A study conducted in Malawi, Ghana, Burkina Faso and Uganda in 2007, found that along with financial cost, social-psychological/stigma issues (e.g. embarrassment or fear) are the most common barriers to adolescents accessing health services (Biddlecom et al 2007). In the study, adolescents reported that it was often the social context surrounding adolescent sexuality that most discouraged them from accessing SRH services (Biddlecom et al 2007). In another study conducted in Burkina Faso, results showed that adults were supportive of young people accessing SRH *information*, but they were less supportive of young people accessing actual services (Ouedraogo et al 2007). This further illustrates the fact that stigma still exists related to young people accessing SRH services. In particular, there is often a negative attitude toward young unmarried women who are sexually active (Erulkar et al 2005).

Because of this stigma toward adolescent sexuality, adolescents often report that they do not access SRH services due to fear of being chastised, stigmatised or punished for sexual involvement (Bearinger et al 2007, WHO 2009). This is especially the case for adolescent females (IPPF 2008), who often have a fear of being recognized in the waiting room by adults from their community (WHO 2009, UNFPA 2011).

3.2 NEGATIVE ATTITUDE OF HEALTH-CARE WORKERS

Another significant barrier to adolescents accessing sexual and reproductive health services is the negative attitudes of providers (Biddlecom et al 2007, Erulkar et al 2005). Service providers are often judgemental toward sexually active adolescents and have negative attitudes toward them (AYA/Pathfinder 2003, Oxfam 2007, WHO 2009). Adolescents report that service providers in normal clinics treat them rudely or deny them services (WHO 2009, UNFPA 2011). This reveals that staff may not have the counselling skills and training necessary for dealing with young people (Oxfam 2007). Often clinics are designed for adult clients, and service providers are not trained in adolescent sexuality and youth-friendly SRH concepts (AYA/Pathfinder 2003). As a result, young people are neither well-received nor comfortable in mainstream family planning clinics (Erulkar et al 2005).

3.3 LACK OF KNOWLEDGE

Another barrier preventing adolescents from accessing SRH services is lack of knowledge about *where* to access these services and lack of knowledge about *what* services are available (Biddlecom et al 2007). Many adolescents do not have adequate information on SRH, especially with regards to contraceptives and STIs. For example, a significant proportion of sexually active adolescents do not know where or how to obtain contraceptives or get STI treatment (Biddlecom et al 2007). Unfortunately, many adolescents get information on SRH from each other, and this information is often incorrect (Baloyi 2006). According to Oxfam (2007), poor knowledge and lack of awareness are the main underlying factors for adolescents not using SRH services.

3.4 ADDITIONAL BARRIERS

There are several other important barriers that prevent learners from accessing SRH services. These include:

- Cost (Erulkar et al 2005, UNFPA 2011, Biddlecom et al 2007)
- Inconvenient hours and location (UNFPA 2011)
- Lack of privacy and confidentiality (Oxfam 2007, WHO 2009, Biddlecom et al 2007, Erulkar et al 2005)
- Legal and policy constraints related to age and marital status (UNFPA 2011). Providers may impose age restrictions on family planning methods even when these are not medically justifiable or officially sanctioned (Erulkar et al 2005).

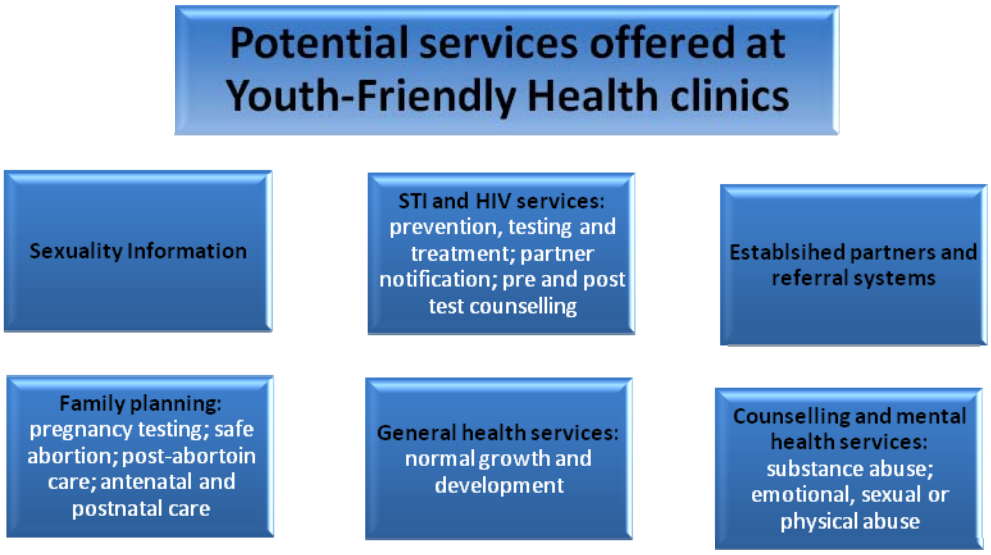
4. Guidelines for Youth-friendly Health Services

Young people's preferences vary widely and are often contradictory (Erulkar et al 2005), especially across varying socio-economic and cultural backgrounds. Thus, the essential package of what is offered at YFHS cannot be fixed, but each community must develop its own package based on economic, epidemiological, and social and cultural constraints (WHO 2002). Despite the need for flexibility of the essential package offered, YFHS must be available, accessible, acceptable and appropriate for adolescents (Bearinger et al 2007). Regardless of the context in which they live, adolescents need:

- a safe and supportive environment that offers protection and opportunities for development
- information and skills to understand and interact with the world
- health services and counselling—to address their health problems and deal with personal difficulties (WHO 2002).

4.1 ESSENTIAL PACKAGE OF HEALTH SERVICES

Several different organizations have developed lists of services which should be provided at YFHS; however this list will vary according to the needs of the community and the context in which they live. The diagram below provides a list of possible services that could be offered at YFHS, based on input from several organizations and researchers.



Sources: IPPF 2007, Baloyi 2006, Bearinger et al 2007,Oxfam 2007, Rogstad et al 2002, WHO 2002

4.2 ADOLESCENT PREFERENCES

Several studies have been conducted to determine adolescent preference with regard to YFHS. Although these findings are helpful in gaining an understanding of adolescent preference, they may be context-specific and additional research needs to be done in each community.

According to research conducted in Kenya and Zimbabwe, the following characteristics are the most important to adolescents: confidentiality, a short waiting time, low cost, and friendly staff (Erulkar et al 2005). The least important characteristics are: youth-only services, youth involvement, and young staff. Therefore, according to this specific study, youth do not prioritise stand-alone youth services (Erulkar et al 2005).

An IPPF study conducted in Ghana and Kenya found that the ideal YFHS must have the following services: telephone hotlines, youth-friendly staff, central location that is easy and affordable to reach, services that are subsidized or free, separate room for counselling, and disability-friendly infrastructure (IPPF 2008).

A study conducted in Burkina Faso, Uganda, Malawi and Ghana found that adolescents prefer public clinics, with strong emphasis placed on confidentiality, accessibility and cost (Biddlecom et al 2007).

Therefore, according to these three large-scale studies conducted in Africa, the most important qualities of YFHS for adolescents are: confidentiality/privacy, cost, and youth-friendly staff.

4.3 GUIDELINES

The following table provides general guidelines for several characteristics related to health-care services. These guidelines are meant to inform not only ways of improving health services, but more specifically, ways of making health-care services more youth-friendly.

Health-care Component	Youth-friendly guidelines
Staff	Youth-friendly staff was recognized by Oxfam as the single most important condition for establishing youth-friendly health services (2007). For young people contemplating or engaged in sexual activity, health-care workers play a vital role in the provision of contraceptives and counselling, and have a significant impact on sexual decision-making and behaviour (Bearinger et al 2007). The service providers and non-medical staff at the clinic or health-care centre must be specially trained to meet the needs of young people (WHO 1999, IPPF 2007, Baloyi 2006, IPPF 2008, Oxfam 2007). The required skills include: • familiarity with adolescent physiology and development • familiarity with appropriate medical options according to age and maturity • interpersonal skills to put young people at ease so they can communicate their needs and concerns (Oxfam 2007). Most importantly, the staff should demonstrate respect and concern for young people (Oxfam 2007). In addition, the YFHS should have both male and female staff available (IPPF 2008, Rogstad et al 2002); should have peer educators available (WHO 1999, Oxfam 2007); and should have consistency of staff so that adolescents can see the same counsellor every time they visit the clinic (IPPF 2008). It is important that staff receive ongoing guidance, support and encouragement to reinforce their commitment and competence (IPPF 2007).
Confidentiality and privacy	Confidentiality and privacy are essential in all health-care settings, but especially for adolescents because of the stigma and related social context (WHO 1999, IPPF 2008, Oxfam 2007, Rogstad et al 2002). Privacy refers to both auditory and visual privacy, and thus a curtain or blanket separating a space may not be sufficient (Oxfam 2007). Changes that may be required to ensure confidentiality and privacy include the following: • partitioning of rooms or adding doors • changes in practice of providers • minimizing interruptions during clinic visits (AYA/Pathfinder 2003).
Space	YFHS can be offered in health centres, in the community, through outreach services or at school (WHO 2002). School are particularly important because they serve as an entry point to bringing health services to young people. As shown by the adolescent preferences, it is essential that the location of the services is convenient (WHO 1999, IPPF 2007, Oxfam 2007, Rogstad et al 2002). Although some studies have shown that young people prefer to travel outside of their community to avoid being seen, most cannot afford to travel long distances (Oxfam 2007). It may be beneficial to offer a separate space and times for young people to receive health services (WHO 1999, Oxfam 2007). However, evaluations have shown that this on its own does not bring about increased utilisation by young people because of social/stigma-related barriers which are unrelated to clinic setting (Biddlecom et al 2007).

Time	Health services should be offered at a time that is convenient for young people, such as late afternoons, evenings and weekends (WHO 1999, Oxfam 2007, IPPF 2008). Special opening hours could also be offered to adolescents, separate from the normal opening hours of the clinic (IPPF 2007, Oxfam 2007). Also, with regard to time, it is essential that there are short waiting times and that adequate time is spent on client and provider interactions (Oxfam 2007, WHO 1999), but these are ideal conditions for any health-care environment and not just for adolescents.
Youth involvement	Young people should be involved in the design, implementation and evaluation of health services (IPPF 2008, AYA/Pathfinder 2003, Oxfam 2007, WHO 1999). As part of designing and implementing YFHS in a community, broad-based consultation should be conducted with youth of both genders from different backgrounds (Rogstad et al 2002). In addition, an initial needs assessment should be conducted to determine the specific needs of the intended youth clients (Oxfam 2007). Youth can also become involved with YFHS by working as peer educators (UNFPA 2011).
Cost	YFHS should be either affordable or free (WHO 1999, Oxfam 2007) because the cost of services was seen as one of the most significant barriers preventing young people from accessing health services. However, Oxfam recommends that adolescents should be required to pay something so that they value the service that is provided (2007).
Policies and processes	All of the policies and procedures at the clinic should support the rights of adolescents (Baloyi 2006). Recommended policies include: • drop-in clients are welcome and appointments arranged quickly (Oxfam 2007) • a written policy on management of adolescents under 16 who are sexually active, based on their care needs and their right to confidentiality (Rogstad et al 2002) • a written policy informing consent to and refusal of treatment, based on national legislation (Rogstad et al 2002)
Resources	YFHS should have a wide range of services and contraceptive methods available. In addition, educational materials, condoms and STI drugs should be available on-site (Oxfam 2007, AYA/Pathfinder 2003). The SRH materials should include accurate and complete information about body functions, sex, reproduction and sexual negotiation and refusal skills (Bearinger et al 2007). It is essential that information provided informs learners of their choices and rights (IPPF 2008). Ideally, YFHS should provide “one-stop shopping” to avoid sending adolescents elsewhere for care because they may not follow through with the referral (Oxfam 2007). However, where necessary, partnerships should be formed for providing referrals.
Community	Community support is critical for the successful use of clinics, and as such advocacy and efforts to involve communities are essential (UNFPA 2011). In order to reduce stigma and encourage adolescents to seek health services, it is necessary to gain the support of those important in the lives of young people, including partners, parents and school communities (IPPF 2008). These key stakeholders should be made aware of the health service needs of adolescents, and should be encouraged to support their provision (WHO 2009). An Intervention in Zambia found that positive changes in social and community-level factors played a vital role in improving adolescents’ use of reproductive information and services

	(Mmari and Magnani 2003).
Advocacy	Advocacy should be conducted to inform youth about the services that are available, and the location and opening hours of services, and to reassure them of the quality and confidentiality of services (Oxfam 2007). As already mentioned, advocacy should also be aimed at other key stakeholders in the community to inform them of the health needs and rights of adolescents.

5. South African case studies

There are several case studies of South African initiatives which have resulted in successful implementation of YFHS. One effectively implemented programme is highlighted here to serve as an example for further implementation and upgrading.

5.1 THE NATIONAL ADOLESCENT FRIENDLY CLINIC INITIATIVE (NAFCI)

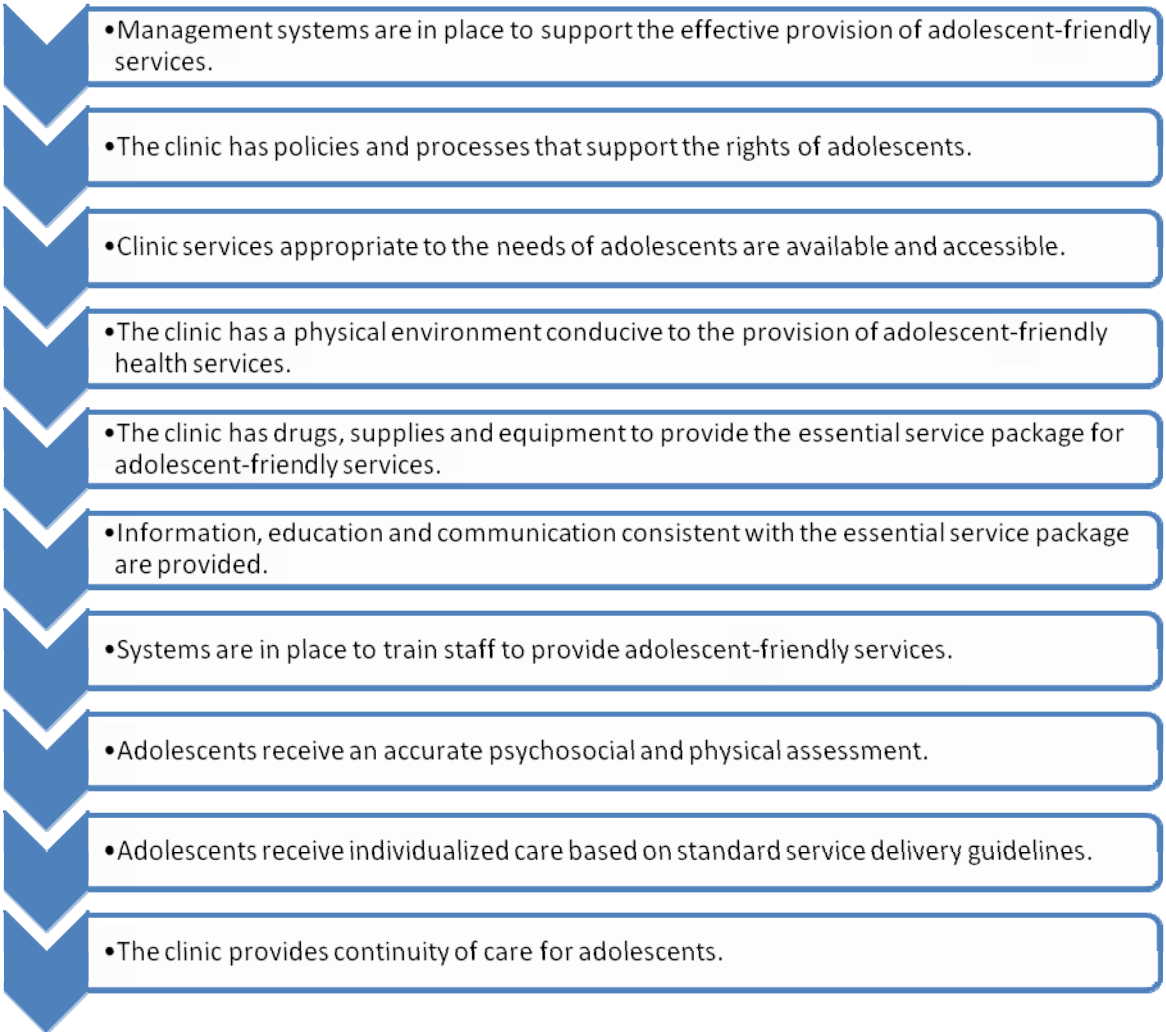
The National Adolescent Friendly Clinic Initiative (NAFCI) was coordinated by the Reproductive Health Research Unit (RHRU), University of Witwatersrand and Chris Hani Baragwaneth Hospital, in partnership with LoveLife. NAFCI was formed based on the recognition that a successful sexual health campaign must be supported by health services that accommodate the needs of young people. In addition, the partners recognized that the public health sector is the most sustainable venue for providing health services that can reach out to many adolescents, thus public health clinics were identified as the vehicle for providing services to deal with the HIV epidemic. The initiative was conceptualized and implemented between 1999 and 2005, reaching all nine provinces by January 2001.

The aim of NAFCI was to improve the quality of YFHS at the primary care level and to strengthen the public sector's ability to respond appropriately to adolescent health needs. The three key objectives of the initiative were:

- to make health services accessible and acceptable to adolescents
- to establish national standards and criteria for adolescent health care in clinics throughout the country
- to build the capacity of health-care workers to provide high-quality adolescent health services.

NAFCI relied on a participatory approach, using national and international consultation as well as focus groups with adolescents, to design the programme and develop the standards for adolescent-friendly health services. They adopted a quality improvement approach that benefits all clients who use the services, with special attention to the needs of adolescents.

The following standards were designed to determine whether or not a clinic could be defined as adolescent-friendly:



An Essential Service Package, based on primary-level care services that had been defined by the National Department of Health for clinics throughout the country, was developed, which included:

- 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 contraceptive pills, emergency contraception, injectables and condoms
- pregnancy testing and counselling, antenatal and postnatal care
- pre- and post-termination of pregnancy counselling and referral
- STI information, including information on the effective prevention of STIs and HVI, diagnosis and syndromic management of STIs.

By 2005, there were 350 active NAFCI sites in South Africa, 13% of these in KwaZulu-Natal. According to a study conducted by WHO on the initiative (2009), there were several significant lessons learned from implementation. First of all, they found that clinics are able to implement the standards regardless of their size and location. Clinics involved had a cleaner environment than those not involved, and privacy was maintained. They found that in NAFCI clinics, infection prevention measures were carried out more consistently and the

clinic staff had been transformed into a team that takes responsibility for the quality of care. In addition, clinic staff had skills to solve problems and take action and staff attitudes in many of the clinics had changed dramatically towards youth. More young people were using the clinics and outreach activities were being conducted in schools and with other youth organizations (WHO 2009).

In addition, it became clear that partnership at all levels was crucial, but in particular with the Department of Health. Support was required at provincial, district and local levels. Selecting innovative and dedicated clinic managers to facilitate was also essential. It was beneficial to provide technical support to clinics to ensure that all standards were consistently implemented. In order to create staff commitment and buy-in, it was also important to have ongoing capacity building. The involvement of youth and community was seen as being vital to the success of the programme. And finally, it is essential that NAFCI are rooted within the primary health-care system to secure, support and sustain the changes implemented (WHO 2009).

A study conducted on the NAFCI programme in Limpopo found that adolescents made use of NAFCI service, especially services related to contraceptive methods, pregnancy and STIs. However, the numbers of adolescents becoming pregnant and contracting STIs did not decrease in the study sample. There was a feeling that the HIV counselling and testing services were not adequately utilized (Baloyi 2006).

6. International case studies

In addition to the South African example, there are also international examples of successful YFHS implementation. As mentioned earlier, there are huge regional and country-level variations in the patterns and prevalence of adolescents' sexual behaviours and reproductive health outcomes (Bearinger et al 2007). However, these international examples can provide insight into how YFHS interventions can be designed and implemented in the South African context.

6.1 RIKSFÖRBUNDET FÖR SEXUELL UPPLYSNING (RFSU) CLINIC IN SWEDEN

RFSU is part of IPPF's member association in Sweden, and is the largest youth clinic in the country. It provides advice, treatment and services for people with problems related to sexuality, including people with disabilities and victims of sexual violence. The clinic offers designated hours for young people and free services, including:

- contraceptive counselling and STI prevention
- sexual counselling

- psychotherapy.

The staff at the clinic includes a physician, midwives, nurses and psychotherapists (IPPF 2007: 2).

6.2 The Estonian Sexual Health Association (ESHA)

ESHA is also an IPPF member association. In 1991, ESHA opened its first Youth Counselling Centre, which aimed to encourage responsible sexual behaviour by young people under 25, and to minimize the number of unwanted pregnancies and STIs. There are currently 18 ESHA Youth Counselling Centres in Estonia. In 2006, the 18 centres had 27 763 visitors. The services offered at the centre are free and include:

- contraceptive and sexual counselling
- STI/HIV testing
- pre- and post-abortion counselling
- counselling for rape victims
- sexuality education lectures
- free condom distribution.

ESHA provides clinic staff with basic and ongoing training in working with young people, covering issues such as sexuality, sexuality education, STIs, HIV and gynaecological examination. This training focuses on capacitating staff to explore their attitudes and to discuss their experiences of working with young people. This helps to improve service quality (IPPF 2007: 2).

Baseline Study Findings

Statistics collected indicated that children and adolescents made up 40% of the population; early sex initiation was being reported (boys 13 years; girls 15 years); almost 10% of reported AIDS cases were among persons under the age of 19; adolescent girls were three times more likely than boys to become HIV infected; high rates of forced sex (20%), transactional sex (20%) and multiple sex partners (48% men, 16% women) were also being reported; and young girls were having sex with HIV infected older men (50% report sex partner to be 5–10 years older). There were also reports of risky sex practices between young people and transport operators being widespread ("sex on the bus" phenomenon).

6.3 Jamaica: Mobile Reproductive Health and Information Unit—Bashy Bus

The Bashy Bus project, being implemented by the Children First Agency in Jamaica in collaboration with the Ministry of Health and the United Nations Children's Fund (UNICEF), is a mobile reproductive health service for adolescents and youth. Cases of HIV and AIDS were increasing steadily in Jamaica, particularly in areas where there were high rates of internal migration and population movement as a result of urbanisation and tourism. The planning process for the project was informed by a baseline survey assessing youth knowledge, needs and interests. HIV and AIDS is a global concern and in Jamaica the number of cases of AIDS has been steadily increasing.

The Bashy Bus is marketed as a safe space for young people to learn about sex and sexuality in a youth-friendly environment. The services are offered free of charge and encourage young people to make healthy decisions and to change to positive practices and behaviours. Staff on the Bashy Bus include a trained counsellor, lab technicians and trained adolescent peer educators.

Between March 2005 and May 2007, over 20 000 young people between the ages of 10 and 24 benefitted from the Bashy Bus. The project targets adolescents along major transport and high-HIV-prevalence routes.

The objectives of the project include:

- Disseminate HIV/AIDS and adolescent SRH information, counselling and services to over 20 000 young people along major transport routes in rural communities
- Increase the awareness and knowledge of vulnerable adolescents to SRH, abstinence, safe sex, sexuality and HIV/STI prevention in a wholesome environment using a youth-friendly approach
- Provide rapid testing and voluntary counselling and testing services to young people
- Provide skill-building training in the uses of cultural approaches to 40 peer educators to undertake interventions among high-risk adolescents
- Reduce stigma and discrimination against persons living with or affected by HIV and AIDS through advocacy and public education.

Source: Creative Exchange: The network for culture and development (www.creativexchange.org) accessed 22 September 2011

7. Recommendations for MIET Africa

Based on the relevant literature and case studies presented in this report, the following recommendations should be made for MIET Africa related to the implementation of YFHS in schools:

- The most significant barriers experience by adolescents in accessing YFHS were cost, staff that were not youth-friendly, the location of clinics, and lack of privacy and confidentiality. These issues need to be addressed by any YFHS intervention to ensure that adolescents access youth services.
- Interventions which were most successful combined: training of clinic staff, facility-based improvements and community-based activities to inform and mobilize support (World Health Organization 2006). Thus, any intervention implemented by MIET Africa must include these components. Community advocacy and mobilization is of particular importance in getting support for adolescents accessing SRH information and services.
- Studies have found that adolescents are less concerned with youth-only services, youth involvement in services and young staff, and more concerned with confidentiality, short waiting times, low cost and friendly staff (Erulkar et al 2005). Thus, interventions need to focus more on structural changes in health services and less on making services more youth-friendly (i.e. separate facilities).
- In addition to upgrading of existing facilities to meet SRH service preferences of adolescents, it is necessary to improve community support for adolescent SRH, as this is a strong predictor of young people seeking SRH services (Erulkar et al 2005).
- The most successful intervention is a three-pronged approach including:
    - clinical services that assure accessible and high-quality reproductive health care
    - sex education programmes that provide developmentally appropriate, evidence-based curricula
    - youth-development strategies to enhance life skills, connections to supportive adults and educational and economic opportunities (Bearinger et al 2007).

- Schools serve as a key entry point for providing the necessary advocacy and education, and for getting adolescents involved in SRH information and services (WHO 2009).

Based on the above recommendations, MIET Africa should seek to establish a partnership with an existing service provider who is already successfully implementing YFHS in KwaZulu-Natal. Potential partners include:

- Marie Stopes (www.mariestopes.org.za; 0800 11 77 85):

  As a government approved health facility, Marie Stopes clinics aim to prevent unwanted births and to afford women the right to have children by choice and not by chance. The services include safe abortions, sterilisation, counselling, contraceptives, gynaecological check-ups, HIV tests and blood-pressure testing.

- Planned Parenthood Association of South Africa (www.ppasa.org.za; 011 88 01 191):

  Planned Parenthood is a non-governmental organisation providing reproductive health information and services. It is structured as a membership organisation with local member clinics providing appropriate, holistic sexual and reproductive health interventions in local communities.

- LoveLife (www.lovelife.org.za):

  LoveLife is South Africa's largest national HIV prevention initiative for young people and is committed to reducing the prevalence of HIV and AIDS through youth development. See the section on NAFCI for more information on the services provided.

- US Doctors for Africa: Project Mobile Clinic Africa (www.usdrfa.org, 01 818 728 6629):

  The project aims to deploy 200 mobile health clinics and 2000 medical professionals in communities throughout sub-Saharan Africa over the next 10- 15 years. The aim of the project is to deliver basic primary healthcare to millions of people living in rural areas that have little or no access to advanced healthcare.

- Family Health International Mobile Health Clinics (www.fhi.org; 012 423 8600):

  FHI and the Project Support Association of Southern Africa has partnered to launch mobile clinics to provide rural South Africans access to HIV counselling and testing, referrals to treatment and a variety of reproductive health services, including family planning.

The above organisations all provide either clinic-based YFHS or mobile health services, but none of them combine the standards and practices of YFHS with a mobile clinic. Coupled with MIET Africa's interventions and existing partnership with the provincial Department of Education, a partnership with a health service provider could prove very effective in reaching adolescents and in providing a comprehensive service to young people. This would fill a gap in that no other service providers are currently offering mobile health services geared to adolescents and no service providers are currently bringing health services to adolescents in schools. Such an intervention could take a holistic approach by including accessible SRH services, educational programmes in schools and sustainable livelihood youth development strategies.

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