



Canada 

# ADOLESCENT FRIENDLY MNCH/SRH SERVICE DELIVERY

Guide for Health Facility Staff



**Please Note:** This guide was developed by Plan International Canada’s gender equality and health teams to assist health facility staff in their provision of gender-responsive MN(C)H/SRH services, primarily for use by Plan International Country Offices implementing MNCH/SRH projects. The information and guidance included in this document however, can be applied to any number of projects or organization working on improved sexual, reproductive, maternal, newborn, and child health services.

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# OBJECTIVES OF THIS GUIDE

This Guide<sup>1</sup> is meant to supplement the capacity building package for all levels of facility based health workers as well as health planners/decision-makers, managers/supervisors for:

- 1) building their understanding of the critical importance of making health services, including MN(C)H/SRH services, friendly for/responsive to<sup>2</sup> the needs of adolescent girls and boys so that they are able to access and utilize these services for the protection of their health and well-being;
- 2) supporting them in taking up contextually relevant measures for making their MN(C)H/SRH specifically and broader health delivery systems adolescent-responsive/friendly in countries working to improve adolescent sexual and reproductive health, including maternal, newborn and child health.

The content of this Guide may prove to be useful for any organization or project addressing adolescent MN(C)H/SRH service delivery and issues, particularly as it concerns:

- Advocacy meetings with national/sub-national ministries of Health and Women's Affairs to draft presentations and/or handouts
- Health service provider training material development and review relating to adolescent sexual and reproductive health (ASRH).
- Training of trainers for health service providers (government, private or CSO)
- Training of health supervisors and managers
- Orientation/training of community health committees
- Orientation/training of project partners implementing activities related to adolescent MN(C)H/SRH
- Orientation of project stakeholders and decision makers
- For any project stakeholders to consult during implementation of project service delivery activities and use as resource material for training their staff

This is a multi-purpose guide for interventions at the service delivery level and is thereby requiring adaptation suited to: 1) the country context particularly with national/sub-national policy directives and guides on Adolescent Sexual and Reproductive health (ASRH); 2) the purpose for which it will be used. **This guide can be used for advocacy efforts with health planners, decision-makers and managers as well as ministries of women's affairs and health. Basically it is designed for the training of health providers, managers, supervisors, planners/decision-makers that is inherent in interventions addressing the delivery of adolescent MN(C)H/SRH services.** While content would need to be contextualized, these are minimal core standards established by WHO. The full content should be delivered in the trainings. For advocacy meetings, it is possible to present the content of the guide without the exercises. However, the adolescent friendly services checklist provided at Annex 2, should be shared with stakeholders in advocacy initiatives also.

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<sup>1</sup> This Guide primarily draws on *Making health services adolescent friendly: developing national quality standards for adolescent friendly health services*. World Health Organization 2012.

<sup>2</sup> The terms "adolescent responsive" or "adolescent-friendly" have been used interchangeably and may be applied as appropriate to country contexts. Although they differ in connotation: "responsive" implies a more active approach that responds appropriately to the needs of adolescent girls and boys; while "friendly" implies a relatively passive approach but geared to being suitable for adolescent girls and boys.

# 1. THE CASE FOR ADOLESCENT-FRIENDLY MN(C)H/SRH SERVICE PROVISION

## 1.1 UNDERSTANDING “ADOLESCENCE”

Adolescence, described as “the second decade of life”, (10-19 years), is a period in which an individual undergoes major physical and psychological changes.<sup>3</sup> Coupled with the physical and psychological, this is a stage in life when there are massive changes in social interactions and relationships. It is a phase in an individual’s life rather than a fixed time period; a phase in which an individual is no longer a child but is not yet an adult.<sup>4</sup> The adolescence period between 10 and 19 years of age- is understood in different ways in different cultural contexts. Almost universally, however, it is seen as a time of transition between childhood and adulthood, a period of physical and psychological changes associated with puberty, and of preparation for the roles, privileges and responsibilities of adulthood.

Adolescents are a diverse group. There is diversity in physical level of growth and development (e.g. between a boy of 12 and 15 and between a boy and a girl of the same age); There is diversity in psychological and social development due to several factors including the area where they live (rural-urban), socioeconomic family status and gender. For example a girl of 13 years of age who is contributing to her family income through work (such as domestic paid work) is likely to be developing very differently from a girl of 13 who is growing up in a protective, caring and financially secure family. Gender norms and practices play a decisive role also in shaping the development of adolescent girls and boys through culturally prescribed behaviours, roles and opportunities provided to them often manifesting in differences in the agency of boys and girls.

Furthermore, adolescence is one of the most rapid phases of human development. The characteristics of both the individual and the environment influence the changes taking place during adolescence. The changes in adolescence have health consequence not only in adolescence but also over the life-course. This is a time of opportunity, but also risk at the same time. Opportunity; as good health practices can be inculcated with long-term effects reducing the likelihood of problems at the later stage of adulthood. Risk; as this is the period when individuals (both boys and girls) are generally experimenting including sexuality with limited access to accurate information, or do not have control over their bodies to negotiate effectively (especially in sexual relationships) and can and do result in long-term health problems for both boys and girls. However, the risks faced in this stage of life are clearly gendered also: for example, the gender socialization of boys to be aggressive or assertive, could lead to health risks related to rash or violent behaviours or substance consumption; and the gender socialization of girls to be non-assertive or submissive could lead to health risks relating to sexually transmitted infections and unwanted pregnancies resulting from unprotected sexual activity.

Given adolescents are at the beginning of their sexual and reproductive lives and they are also the next generation of parents. How they undergo preparation for this journey has tremendous implications for their own lives as well as for national reproductive health outcomes, including fertility, safe motherhood and sexually transmitted infections (STIs), particularly HIV/AIDS. As a group, adolescents are generally recognized to have sexual and reproductive health needs that differ from those of adults, and which are still poorly understood in much of the world. Adolescents are particularly vulnerable to reproductive and sexual health needs and are at heightened risk for unsafe sexual and reproductive behaviours. Findings indicate that complications linked to pregnancy and child birth are the second cause of death for 15-19

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<sup>3</sup> *The health of young people: A challenge and a promise.* Geneva, World Health Organization, 1993.

<sup>4</sup> *Ibid.*



year-old girls globally. The poor health outcomes among adolescents is a consequence of a combination of little or no access to quality sexual and reproductive health information and services which are adapted and organized to respond to their needs, in other terms, health services which are adolescent-friendly. Adolescent friendly health services represent an approach which brings together the qualities that young people demand, with the high standards that have to be achieved in the best public services<sup>5</sup>.

Therefore given the above, it is critical that adolescents are not viewed as an undifferentiated monolithic group but their diversity including ethnic, social, disability etc. and the gender-related differences in boys and girls are considered in health service delivery as well.

## 1.2 COMMON ADOLESCENT HEALTH PROBLEMS

Many adolescents make the transition to adulthood in good health, while many others do not and may face some of the health problems such as:

- Sexual and reproductive health problems (e.g. too-early or unintended pregnancy, mortality and morbidity during pregnancy and child birth including due to unsafe abortion, sexually transmitted infections including HIV, harmful traditional practices such as female genital mutilation/cutting (FGM/C), and sexual coercion);
- Problems resulting from malnutrition
- Injuries resulting from violence or accidents;
- Problems resulting from substance use
- Mental health problems;
- Endemic diseases (e.g. tuberculosis and malaria).

As noted earlier, each of these health issues have gender dimensions and some are specific to girls such as pregnancy and child-birth related issues and those linked to harmful traditional practices. Mal or under nutrition affects more girls relative to boys given gender norms pertaining to son preference and traditional practices of serving men and boys food before women and girls. Injuries boys face relate more often to rash behaviours such as accidents and substance abuse tends to be more prevalent in boys. Endemic diseases may be linked to the gender division of labour between boys and girls, for example exposure to dangerous waste during cleaning and sanitation activities, or pollutants related to poor stoves, or exposure to stagnant water during water sourcing or washing activities for girls compared to boys.

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<sup>5</sup> WHO. 2012. Adolescent friendly health services. An agenda for change consulted at [http://apps.who.int/iris/bitstream/10665/67923/1/WHO\\_FCH\\_CAH\\_02.14.pdf](http://apps.who.int/iris/bitstream/10665/67923/1/WHO_FCH_CAH_02.14.pdf)

## 1.3 BARRIERS ADOLESCENT GIRLS AND BOYS FACE IN ACCESSING MN(C)H/SRH SERVICES

In addition to the several socio-economic, structural and gender-related barriers that adult men and particularly women, may face in accessing and utilizing health and particularly MN(C)H/SRH services; adolescent boys and girls (regardless of their marital/union status), face a unique set of barriers that is linked to all the social determinants of health compounded by their age. These barriers and challenges related to availability, accessibility, acceptability and equity of health services are clustered under three headings as follows:

### 1) Individual barriers:

- Lack of knowledge and awareness of boys and particularly girls about the MN(C)H/SRH services available at the health facilities near them. A clear gender dimension to this is, if SRH education is part of secondary school education, for example, and a lower proportion of girls compared to boys are in secondary school, it follows then, that fewer girls will have access to that knowledge. Or if SRH education is carried out for “adolescents” in localities such as in youth clubs or near central market places, and girls are typically less autonomously mobile compared to boys, their access to that information will be lower.
- Taboos and myths dissuading girls and boys from seeking counsel and poor health or advice-seeking behavior. For example, myths about preventing pregnancy by using herbal wreaths tied around their stomach [note: please add relevant local myths and taboos], a result of inaccurate information on SRH.
- Typically low financial capability of boys and girls particularly to cover costs related to accessing health services (such as transportation and/or fees). Adolescent girls’ financial dependency on partners (if in union or married) and family members is a major barrier for autonomous decision-making to access MN(C)H/SRH services. Women by and large, but particularly adolescent girls have little to no financial decision-making capacity in their homes for any matter let alone for their health.
- Low mobility of girls particularly to access services independently. A clear gender dimension relating to mobility is relatively stricter norms surrounding the independent mobility of girls due to gender norms compared to their male peers. Often girls require permission from family members/partners to visit health facilities and in many settings need to be accompanied/chaperoned by male family members.
- Perception of lack of confidentiality on the part of health care providers for SRH services offered and ensuing loss of respect and dignity/or fear of social reprisal because SRH being a sensitive matter for discussion.

### 2) Socio-cultural barriers:

- Negative perceptions of adults with respect to the knowledge, capacities and behaviours of adolescent girls and boys associated with their sexuality, resulting in adults providing limited opportunities to children and adolescents, especially girls to participate in decision-making about their sexuality and health.
- Attitudes of parents or their unwillingness to be involved in discussions and activities related to ASRHR because of their lack of information, education, skills and preparation to provide education and guidance to their sons and daughters around sexuality and reproduction.
- Social norms which dictate the behaviour and sexuality of adolescent and girls particularly and boys.
- Stigma and shame surrounding sexually active adolescents, particularly girls, limit the ability of adolescent girls from accessing MN(C)H/SRH services.



### 3) Structural and institutional barriers:

- Fees for services.
- Lack of gender responsive and adolescent friendly service provision-including issues of privacy, confidentiality and health care provider training capacity etc.
- Judgmental attitudes of health care providers towards adolescents (particularly girls) or their unwillingness to allow the adolescents to attend to their SRH needs.
- Restrictive laws and policies may prevent some health services from being provided to some groups of adolescents (e.g. the provision of contraceptives to unmarried adolescents).
- Restrictive laws and policies related to age of consent and partner/husband's consent related to accessing services (e.g., contraception for unmarried adolescents)
- Lack of or low representation of adolescent boys and girls in community health governance.

### EXERCISE #1: EXPLORING BARRIERS TO ADOLESCENT FRIENDLY HEALTH SERVICES

1. Start with group exercise: Unpacking barriers adolescent girls and boys face
2. Form three groups of equal size
3. On flip charts ask each group to discuss and identify barriers adolescent boys and girls can face in their areas in accessing MN(C)H/SRH services as following:

Individual Barriers	
Girls	Boys
Socio-cultural Barriers	
Girls	Boys
Structural/Institutional Barriers	
Girls	Boys

#### Groups report back in plenary:

- Ask other groups to add their inputs
- Ask for key points made by participants in Individual and Sociocultural barriers:
  - Why is it this way?
  - Stress the gender-based differences
- In Structural/Institutional barriers probe :
  - What about the physical infrastructure of facilities?
  - What about attitudes of health workers?
  - What about protocols?

**Top up with the content given above through a PowerPoint presentation.**



## 1.4 COMMITMENTS TO MAKE HEALTH/MN(C)/SRH SERVICES ADOLESCENT FRIENDLY

There is global recognition of the critical importance to overcome the individual, socio-cultural and systemic barriers adolescents face in accessing and utilizing MN(C)H/SRH services to make it easier for adolescents to obtain the health services they need. Many countries, in varying ways articulate a commitment to putting in place adolescent-friendly reproductive health services as articulated **in national (and/or sub-national) policies and/or strategies, regulatory documents** for driving better MN(C)H/SRH outcomes. There is now a need to operationalize this commitment by two complementing efforts:

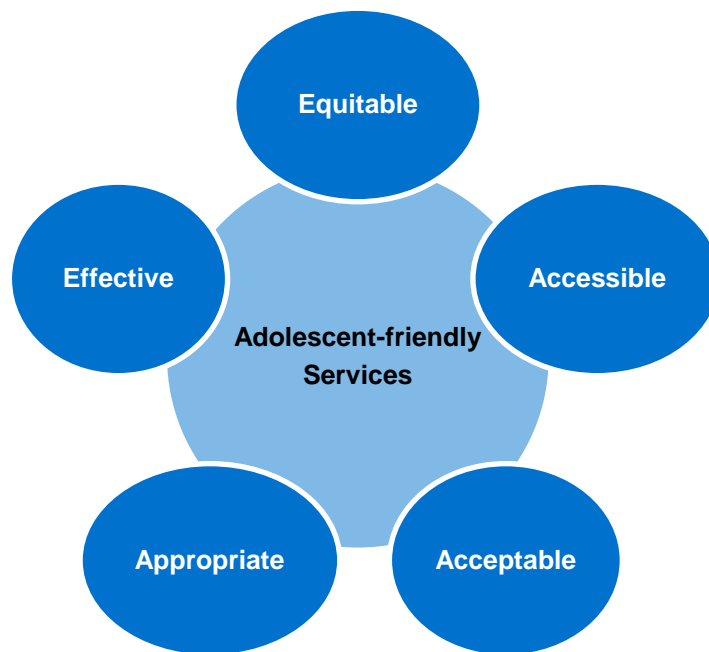
- A. Make health-service provision adolescent friendly, so that adolescent boys and girls are more likely to be able and willing to use these services;
- B. Ensure that the health services required are in fact provided in the right manner.

***In other words, there is a need to increase both adolescent-friendly health service utilization and health service provision.***

***Please Note:*** It is possible to create a section here on respective national (sub-national) ASRH policies/strategies as applicable. Please do highlight the gender responsiveness elements in these documents, where they are integrated. If not, please link to the other national gender equality commitments in health for any countries where interventions are being implemented.

## 2. ADOLESCENT-FRIENDLY MN(C)H/SRH SERVICE PROVISION

The WHO adolescent-friendly quality of care framework provides a generic globally accepted working definition of adolescent-friendly health services. These include dimensions of being **equitable, accessible, acceptable, appropriate and effective**<sup>6</sup>. Key to successful adolescent friendly MN(C)H/SRH service provision, is that it is: a) based on gendered evidence of expressed needs of adolescent girls and boys; and b) girls and boys are empowered participants in setting quality standards and monitoring them.



Salient characteristics of quality adolescent health services dimensions are unpacked below:

<sup>6</sup> *Quality Assessment Guidebook. A guide to assessing health services for adolescent clients.* Geneva, World Health Organization, 2009.

## 2.1 EQUITABLE

All adolescents, that is girls and boys across social strata, urban/rural, regardless of disability, ethnicity, religion etc. not just some groups of adolescents, are **equally able** to obtain the health services that are available.

Characteristics of **equitable** service provision:

### A. Policies and procedures are in place that do not restrict the provision of health/MN(C)H/SRH services.

- There are no laws and policies that restrict the provision of health/MN(C)H/SRH services by age, sex or any other area of difference. For example, declining services to unmarried adolescent girls and boys. OR requiring parental/spousal consent for extending services.
- Procedures are in place to ensure that no factor whether it is based on age, sex, social status, cultural background, ethnic origin, disability or any other reason:
  - hinders the **provision** of health/MN(C)H/SRH services to all or some groups of adolescents;
  - hinders the **ability** of all or some adolescents from obtaining health/MN(C)H/SRH services.

#### Why is this important?

- Restrictive laws/policies are a serious hurdle to public health
- Restrictive laws/policies undermine the fundamental health rights, articulated in national health legislation and policy and rights enshrined in international human rights laws (particularly the UN Convention on the Rights of the Child, art. 24).

### B. Health care providers treat all adolescent clients (girls and boys) with equal care and respect, regardless of status (social, physical or civil).

- Health care providers administer the same level of care and consideration to all adolescents regardless of age, sex, social status, cultural background, ethnic origin, disability or any other reason.

### C. Support staff treat all adolescent clients (girls and boys) with equal care and respect, regardless of status (social, physical or civil).

#### Why is this important?

- Being treated disrespectfully is a strong disincentive for adolescents to seek help.
- Being treated equally will have a positive effect on adolescents, encouraging them to attend further appointments and recommend the service to their peers.

## EXERCISE #2: EQUITY IN QUALITY OF ADOLESCENT HEALTH CARE SERVICES

1. Divide participants in 3-4 groups of 6-8 (depending on number of participants). Request each group to discuss the adolescent-friendly quality dimension, identify gaps and what they can do at their level to make their facility adolescent-friendly.
2. Groups report back in plenary, other groups provide input. At the end of this session, health providers/supervisors should have an action plan based on the steps that can be taken locally to ensure equity in providing adolescent friendly health services.

### **Gap between desired quality and actual quality: equity**

**All adolescent girls and boys across social strata, urban/rural, regardless of disability, ethnicity, religion etc., are equally able to obtain the health services that are available**

Desired quality	Actual quality (including gender-related gaps)	What I/we can do/needs to change
<p><b>Policy and procedures</b> are in place and known by all health staff that:-</p> <ul style="list-style-type: none"> <li>• take into account the special needs of different sectors of the population, including vulnerable and under-served groups,</li> <li>• do not restrict the provision of health services on grounds of gender, disability, ethnic origin, religion or (unless strictly appropriate) age,</li> <li>• pay special attention to gender-related factors,</li> <li>• guarantee privacy and confidentiality and promote autonomy so that adolescents can consent to their own treatment and care,</li> <li>• ensure that services are either free or affordable by adolescents.</li> </ul>		
<p><b>Points of health service</b> or health-related commodity delivery:</p> <ul style="list-style-type: none"> <li>• provide the health services and the health-related commodities that adolescents need (either-on the-spot or through referral linkages) without exception</li> <li>• enable adolescents to obtain the health services they need are appealing to adolescents</li> </ul>		
<p><b>Health workers:</b></p> <ul style="list-style-type: none"> <li>• are non-judgmental and considerate in their dealings</li> <li>• with both adolescent girls and boys deliver the services in a friendly and accessible way</li> </ul>		
<p><b>Support staff</b></p> <ul style="list-style-type: none"> <li>• are non-judgmental and considerate in their dealings with adolescent girls and boys</li> </ul>		

## 2.2 ACCESSIBLE

Adolescent boys and girls are **able** to obtain the health services that are available.

Characteristics of **accessible** service provision:

**A. Policies and procedures are in place that ensure that health services are either free or affordable to adolescent girls and boys.**

- All adolescents are able to receive health services free of charge or are able to afford any charges that might be in place.

**Why is this important?**

- Adolescents are generally likely to have limited financial means of their own. Given gender norms, adolescent girls are highly likely to be financially dependent on either partners or families.
- Adolescents who are dependent on their families may not want to 'add to the burden' by asking for money to pay for services and/or for transportation to the health facility.
- They may also be reluctant to disclose why they need to obtain health services. Given socio-cultural stigma and fears of reprisal, this is especially relevant for adolescent girls.

**B. Point of service delivery has convenient working hours for both girls and boys, given the gender division of roles and responsibilities between them.**

- Health/MN(C)H/SRH services are available to all adolescents during times of the day that are convenient to them.
- Health/MN(C)H/SRH services are located at points that are closest to communities (distances are minimized).
- Health/MN(C)H/SRH services are under one window operations minimizing frequent trips to facilities to obtain services.

**Why is this important?**

- Adolescents may find it difficult to obtain health services if the working hours coincide with times when they are busy with study, work or other activities. Given gender roles and the double burden of work (household and productive or study), this is especially important for girls.
- Adolescents may not be able to access services if they are located too far from their communities. Given relative restricted mobility of girls, this is particularly important.
- Adolescents may be dissuaded from utilizing services if they are required to make frequent trips to facilities for obtaining services. This is especially salient for girls, given their greater financial, mobility and autonomy constraints, relative to boys.

**C. Adolescent girls and boys are well informed about the range of reproductive health services available and how to obtain them.**

- Adolescent girls and boys are aware of what health services are being provided, where they are provided, and how to obtain them.
- Information is provided in spaces where adolescent girls and boys gather (schools, youth clubs, market etc.).
- Information is provided to them using all communication channels used by them (IT, electronic media etc. as relevant keeping gender-based differences in mind)
- Information is provided in easy "adolescent friendly" language using illustrations etc. given lower literacy/education levels of girls compared to boys.

### **Why is this important?**

- Informing adolescent girls and boys through appropriate channels about the range of health services available to them can help to encourage usage of services and thereby improve their health outcomes.

### **D. Community members understand the gendered health/(MN(C)H/SRH risks adolescent boys and particularly girls face; and benefits that adolescent girls and boys will gain by obtaining the health services they need and support their provision.**

- Community members (including parents) are well informed in gender-sensitive ways, about the gendered health/MN(C)H/SRH risks adolescent boys and particularly girls face (including those related to harmful traditional practices such as female genital mutilation and cutting (FGM/C) and early marriage); and how the provision of health/MN(C)H/SRH services could help their adolescent girls and boys.
  - Through health outreach workers (community health workers)
  - Community health committees
  - Community traditional and religious leaders
- They equally support the provision of these services as well as their use by adolescent girls and boys.

### **Why is this important?**

- Communities are likely to oppose the provision of MN(C)H/SRH services to adolescents, especially girls, if they do not understand – or trust – their value.
- Engaging men and women community members in a respectful discussion and
- working to create a shared understanding on this issue will help to ensure that the required health services can be provided, and obtained, without opposition.

### **E. Some SRH health services and health-related commodities are provided to adolescent boys and girls in the community by selected community members, outreach workers and adolescents themselves.**

- Adolescent girls and boys are provided health services in gender-sensitive ways, close to where adolescents are including through:
  - Outreach workers
  - Selected community members trusted by adolescents
  - Adolescent girls and boys themselves (e.g. through existing youth clubs etc.)

### **Why is this important?**

- Adolescents, especially girls, may be reluctant to visit health facilities and other points of delivery.
- Some of them, particularly girls, may be unable to do so.
- Outreach workers, selected community members and adolescent boys and girls themselves can extend the reach of health/MN(C)H/SRH services into the community in locally acceptable and gender-sensitive ways.
- The provision of health/(MN(C)H/SRH information and services by people they can easily relate to and in places they frequent may be welcomed by adolescents.

### EXERCISE #3: EXPLORING ACCESSIBILITY

1. Divide participants into five groups by each characteristic OR depending on number of participants into two groups giving Group 1 A & B and Group 2 C,D,E. Request each group to discuss the adolescent-friendly quality dimension, identify gaps and what they can do at their level to make their facility adolescent-friendly.
2. Groups report back in plenary, other groups provide input. At the end of this session, health providers/supervisors should have an action plan based on the steps that can be taken locally to ensure equity in providing adolescent friendly health services.

#### Gap between desired quality and actual quality: accessibility

#### Adolescent boys and girls are able to obtain the health services that are available.

Desired quality	Actual quality (including gender-related gaps)	What I/we can do/needs to change
A. Policies and procedures are in place that ensure that health services are either free or affordable to adolescent girls and boys. <ul style="list-style-type: none"> <li>• All adolescents are able to receive health services free of charge or are able to afford any charges that might be in place.</li> </ul>		
B. Point of service delivery has convenient working hours for both girls and boys, given the gender division of roles and responsibilities between them. <ul style="list-style-type: none"> <li>• Health/MN(C)H/SRH services are available to all adolescents during times of the day that are convenient to them.</li> <li>• Health/MN(C)H/SRH services are located at points that are closest to communities (distances are minimized).</li> <li>• Health/MN(C)H/SRH services are under one window operations minimizing frequent trips to facilities to obtain services.</li> </ul>		
C. Adolescent girls and boys are well informed about the range of reproductive health services available and how to obtain them. <ul style="list-style-type: none"> <li>• Adolescent girls and boys are aware of what health services are being provided, where they are provided, and how to obtain them.</li> <li>• Information is provided in spaces where adolescent girls and boys gather (schools, youth clubs, market etc.).</li> <li>• Information is provided to them using all communication channels used by them (IT, electronic media etc. as relevant keeping gender-based differences in mind)</li> <li>• Information is provided in easy “adolescent friendly” language using illustrations etc. given lower literacy/education levels of girls compared to boys.</li> </ul>		
D. Community members understand the gendered health/MN(C)H/SRH risks adolescent boys and particularly girls face; and benefits that adolescent girls and boys will gain by obtaining the health services they need and support their provision.		
E. Some SRH health services and health-related commodities are provided to adolescent boys and girls in the community by selected community members, outreach workers and adolescents themselves.		



## 2.3 ACCEPTABLE

Adolescent girls and boys *are willing* to obtain the health services that are available.

Characteristics of **acceptable** service provision:

### A. Policies and procedures are in place that guarantee client confidentiality.

- Policies and procedures are in place that maintain confidentiality of adolescent girls and boys at all times (except where staff are obliged by legal requirements to report incidents such as sexual assaults to relevant authorities). AND assurance of absolute confidentiality are assured to the adolescent girls and boys by staff verbally, stressing except where legal obligation requires disclosure to authorities.
- This means policies and procedures address:
  - Registration – information on the identity of the adolescent girl/boy and the presenting issue are gathered in confidence;
  - Consultation – confidentiality is maintained throughout the visit of the adolescent (i.e. before, during and after a consultation);
  - Record-keeping – case records are kept in a secure place, accessible only to authorized personnel;
  - Disclosure of information – staff do not disclose any information given to or received from an adolescent girl or boy, to a third party (for example, family members, school teachers or employers) without their consent.

#### Why is this important?

- Adolescents generally are very sensitive to privacy and confidentiality. Adolescents from around the world say that concerns about lack of privacy and confidentiality discourage their use of health services.
- This is particularly relevant for adolescent girls (especially if unmarried or not in union) due to the stigma they face or fear of reprisal from their family, school or community. These fears are real and very important to allay. It is generally because of a lack of trust and confidence that drives adolescent girls to seeking counsel or services from untrained service providers such as TBA etc. that can and do have considerable consequences or risks for adolescent girls.

### B. Point of service delivery ensures privacy.

- The point of service delivery is located in a place that ensures the privacy of adolescent users from all other adult clients and between adolescent clients such as secluded “Youth Corners”.
- It has a layout that ensures **both visual and auditory** privacy throughout an adolescent girl’s or boy’s visit.
- This includes the point of entry, the reception area, the waiting area, the examination area and the patient-record storage area.

#### Why is this important?

- WHO data<sup>7</sup> and Plan International’s experience with adolescent programming reveals adolescent boys and girls give high priority to privacy. They are more likely to obtain the health services they need if they are confident that they will not be seen by anyone else, and that the privacy of their records will be maintained.

<sup>7</sup> *Adolescent-friendly health services: An agenda for change*. Geneva, World Health Organization, 2003. *Global Consultation on adolescent-friendly health services. A consensus statement*. Geneva, World Health Organization, 2002. Dick B, Ferguson J, Chandra-Mouli V, Brabin L et al. A review of the evidence for interventions to increase young people’s use of health services in developing countries in Ross D, Dick B, J Ferguson (Eds.). *Preventing HIV/AIDS in young people: A systematic review of the evidence from developing countries*. Geneva, World Health Organization, 2006.

- This is particularly relevant for adolescent girls seeking services. They are highly unlikely to visit, if they are not sure they may be seen by others, particularly adults from their communities.

**C. Health care providers are non-judgmental, considerate, easy to relate to and know how to communicate with adolescents.**

- It is crucial health care providers do not criticize, scold or judge their adolescent patients (boys and girls equally) even if they do not approve of their words and actions.
- It is critical they are considerate to their patients and reach out to them in a friendly and respectful manner.
- This includes not undermining their existing knowledge about MN(C)H/SRH issues, but building on it with accurate information and counseling.

**Why is this important?**

- Health care providers do not need to abandon their own beliefs and values, but they must ensure that these beliefs and values do not negatively influence the way in which they deal with their adolescent patients. This is particularly important for adolescent girls, who may already be facing greater stigma and judgment from the community in comparison to boys.
- In addition, the ability to respond to adolescent girls and boys with empathy and sensitivity will contribute to the development of good communication and mutual respect.
- Judgmental, inconsiderate and unfriendly behaviour will hinder communication. It is also likely to turn adolescents away, particularly girls.

**D. Point of service delivery ensures consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral.**

- Adolescent boys and girls are able to consult with health care providers at short notice, whether they have a formal appointment or not. This is particularly important for girls, who face several mobility challenges as noted earlier including permission from family members; and time constraints given their gender roles relating to household care work.
- If their medical condition is such that they need to be referred elsewhere, the referral appointment should also take place within a short timeframe.
- For girls, a referral to a higher facility can cause concerns and stress, it is critical health providers:
  - Ask her who could accompany her stressing the importance of her husband's/male partner's or other person freely chosen by her presence.
  - Ensure that all required details of the information and documents that should be sent with the girl are complete and duly sent. This should include: a written record of the clinical findings, any treatment given before referral and specific reasons for making the referral. The referral form should accompany the girl (often carried by her or by the accompanying person) and give a clear designation of which facility the patient is being sent to. A carefully filled referral card can help the girl get timely attention at the receiving facility.
  - The decision to refer might be frightening or distressing for the girl so it is important that health providers have **empathy** and compassion and give the girl relevant information such as:
    - Reasons and importance of the referral, risks associated with not going
    - How to get to the receiving facility – location and transport
    - Who to see and what is likely to happen
    - What arrangements for accompanying partners/family members are in place at the receiving facility and what more is required (reminding them of the necessary birth related items as required)
    - The process of follow-up on their return
  - Health providers can show empathy in understanding the implications of referral for the adolescent girls. The adolescent girl may be:
    - Frightened of the unknown, frightened of becoming more ill or even dying
    - Concerned about meeting the costs of transport, treatment and accommodation (if these are not free)

- Concerned about leaving house or farm or productive work that needs to be done that is part of her responsibilities
- Concerned about other children at home that she may have. In this case and the one regarding housework/work, health providers must stress the importance of the girl's partner/husband/spouse/family members taking care of housework and other children in her absence so she gets the necessary care and not risk her health.
- In all cases reassure the woman and her partner/family using a gentle and polite tone.
- Health providers can contact the referred facility to prewarn them of the girl's arrival, if the communication mechanism is there.

#### **Why is this important?**

- Adolescents are more likely than adults to be deterred by long waiting times or by rigid appointment-making policies.
- Having to wait for an appointment for a long time could lead to a missed appointment or seeking help from other possibly less effective or even harmful service providers offering shorter waiting times. This often has lasting detrimental health consequences for adolescent girls.

#### **E. Point of service delivery has an appealing and clean environment.**

- A point of health service delivery that is welcoming, attractive and clean to adolescent boys and girls. This includes:
  - Physical cleanliness
  - Separate restrooms for boys and girls
  - Separate waiting areas for boys and girls
  - Safe spaces devoid of any potential sexual harassment or abuse, such as well-lit hallways, near water source etc.

#### **Why is this important?**

- Adolescent boys and girls – like adults – may not want to go to a poorly maintained and dirty place. The facilities physical environment being clean and welcoming is critical.
- Separate waiting areas and restrooms for boys and girls contribute to their sense of privacy and safety, which for girls is of especial significance.

#### **F. Point of service delivery provides information and education through a variety of channels.**

- Informational materials that are relevant to the health of adolescent girls and boys are available in different formats (e.g. posters, booklets and leaflets).
- They are gender-sensitive, presented in a familiar language, are easy to understand (such as illustrations) and are eye-catching.

#### **Why is this important?**

- Adolescents who visit the facility may not know what they need to understand about the health problems that could affect them. They may have received incorrect information from their peers or other sources. This is particularly relevant for girls who face great information access relative to boys due to gender related barriers such as mobility constraints.
- They may have questions but may be embarrassed (particularly girls due to cultural censure) to ask their parents, teachers or others.

#### **G. Adolescents are actively involved in designing, assessing and providing health services.**

- All adolescent girls and boys are equitably and systematically given the opportunity to share their experiences in obtaining health services, and to express their needs and preferences (through regular feed-back mechanisms and targeted consultations for example).



- They are involved in certain appropriate aspects of health service provision (see accessibility section above).

**Why is this important?**

- Involving adolescent girls and boys equitable in assessing service provision, and in actually participating in service provision, can help make health services more sensitive and responsive to their needs.
- Service delivery designed and organized without their voices, will likely not meet their needs and in turn will likely not be utilized.

## EXERCISE #4: ACCEPTABILITY EXERCISE

**Given acceptability is one of the most critical of the quality dimensions for adolescent-friendly service delivery, an integrated method of exercise is suggested for training health providers/supervisors:**

1. Before sharing the content above, **do a “Quick pulse check”**, ask participants to share:
  - a. What do they understand by **acceptability** as a quality of care dimension in adolescent-friendly MN(C)H/SRH service provision?
  - b. What would be the key characteristics of acceptable health services for adolescent girls and boys?
  - c. Why is this important?
2. Take notes on a flip chart
3. Tell them we will now see what the quality standards are.
4. Make the presentation for each sub-category from A-G (7 core characteristics)
5. Stop after each characteristic i.e. A,B,C,D,E,F,G:
  - a. Divide them into 3-4 groups depending on number of participants
  - b. Ask them to answer the questions on a flip chart or a pre-pared hand-out as following

What is the desired quality?	What is the actual quality? (what are the gender-related gaps?)	What I/we can do/needs to change?
A. Policies and procedures are in place that guarantee client confidentiality.		
B. Point of service delivery ensures privacy.		
C. Health care providers are non-judgmental, considerate, and easy to relate to.		
D. Point of service delivery ensures consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral.		
E. Point of service delivery has an appealing and clean environment.		
F. Point of service delivery provides information and education through a variety of channels.		
G. Adolescents are actively involved in designing, assessing and providing health services.		

**Note:** You will need to provide a printout of the detailed content for each characteristics as provided above when they are doing group work. They may not recall the standards. It is critical they assess “actual quality” in relation to the desired quality standards.

This session may take the longest and requires adequate time.

At the end of this session participants should have an action plan for acceptability based on the steps that can be taken locally to ensure equity in providing adolescent friendly health services.

## 2.4 APPROPRIATE

The **right** health/ MN(C)H/SRH services (i.e. the ones they need) are provided to adolescent girls and boys.

Characteristics of **appropriate** service provision

- The health needs and problems of all adolescent girls and boys are addressed by the health services provided at the point of health service delivery, or through referral linkages.
- The services provided meet the special needs of marginalized groups (ethnic groups, disabled, hard to reach etc.) of adolescent girls and boys, as well as those of the majority.
- Appropriateness includes:
  - “age appropriateness” i.e. suitable for the age of the adolescent girl/boy
  - “gender appropriateness” i.e. relevant to the specific gender-related needs and interests of boys and girls
  - “context appropriateness” i.e. based on contextual evidence (data and consultation with adolescent boys and girls)
  - level of health facility appropriateness (i.e. which adolescent health package is to be provided at primary, secondary, referral level)
  - In each instance the services should be comprehensive.

**Why is this important?**

- All adolescent girls and boys should be able to obtain the MN(C)H/SRH health services that meet their needs as per their age, their context and in gender-responsive ways. If not, it is likely they will not either utilize them altogether, or may not return.
- These MN(C)H/SRH health services should preferably be available from one point of health service delivery, or from a set of points that are linked together in an accessible manner.

### EXERCISE #5: EXPLORING APPROPRIATENESS

Health providers as such, may not have control/influence/authority over what package of adolescent MN(C)H/SRH services should be set at various levels of facilities.

For this session, after presenting, conduct a discussion with them to reflect on their experiences regarding the appropriateness of the packages they deliver:

- What adolescent health/ MN(C)H/SRH package do you generally deliver based on physical, social and psychological health and development needs? Are MN(C)H/SRH needs and problems of *all adolescent girls and boys* addressed by the health services provided by them? Which needs are not addressed and what can be done to ensure provision?
- Which adolescents (probe by age, sex, vulnerability) tend to seek out services more than others? Why?
- Which adolescents tend not to seek out services (probe by age, sex, vulnerability)? Why?
- What in your opinion would make service delivery more friendly for adolescent boys and girls from an appropriateness quality standard?

## 2.5 EFFECTIVE

The right health services are provided in the **right way**, and make a positive contribution to the health of all adolescent girls and boys.

Characteristics of **effective** service provision:

### A. Health care providers have the required competencies to work with adolescents and to provide them with the required health services.

- Health care providers have the required knowledge and skills to work with adolescents, and to provide them with the required health services.
  - Training on adolescent friendly health service delivery
  - Orientation/training on applicable (national/subnational) ASH policy/strategy/guidelines
- Self, peer and supervisor assessments are carried out in the context of regular supportive supervision.

#### Why is this important?

- Health care providers need to be competent in:
  - working with adolescents in general and understanding the different gender-related barriers and issues faced by girls and boys particularly
  - 'adolescent-specific' differentiated by girls and boys aspects of providing health promotion, preventive, curative and rehabilitative services
  - interpersonal relations and communication
- If any of these core competencies are missing, the acceptability and appropriateness of the service delivery will be negatively affected.

### B. Health care providers use evidenced-based protocols and guidelines to provide health services.

- Health service provision is based on protocols and guidelines that are technically sound and of proven usefulness.
- They are adapted to the requirements of the national/subnational situation and approved by the relevant authorities.
- They are readily available to staff.

#### Why is this important?

- In using such tools, health care providers are assured of the best course of action in responding to their adolescent patients.
- Using these tools fosters consistency in quality of care.

### C. Health care providers are able to dedicate sufficient time to deal effectively with their adolescent clients.

- Health care providers are able to dedicate sufficient time to deal effectively with their adolescent patients.
- There is/are dedicated/trained same sex personnel to see adolescent boys and girls respectively.

#### Why is this important?

This is important for two reasons:

- Firstly, adolescents (particularly girls) may find it difficult to communicate, be shy or frightened and may need extra time and encouragement to talk about their real concerns;
- Secondly, because health care providers need adequate time to deal with their patients in an effective and satisfactory manner from the adolescent boys'/girls' perspective.



**D. The point of service delivery has the required equipment, supplies, and basic services necessary to deliver the required health services.**

- Each point of health service delivery has the necessary equipment, supplies (including medicines, IEC materials) and basic services (e.g. water and sanitation) needed to deliver essential health services.
- There are separate waiting areas for adolescent boys and girls and separated from adult clients.
- There are separate toilets for adolescent boys and girls.
- The facility is safe for adolescent girls specifically devoid of any potential sexual harassment/abuse either by health staff or clients.
- The infrastructure and layout is such that ensures visual and auditory privacy (between adolescent boys and girls) and between adolescent and adult clients.

**Why is this important?**

- Without the basic materials, health services cannot be provided effectively. Boys and girls may not return if they find the services unsatisfactory.
- The provision of health services in such a context may even endanger the health and safety of adolescent girls and boys.



## EXERCISE #6: EFFECTIVE HEALTH SERVICES FOR ADOLESCENCE

Note: **Effectiveness** is also one of the most critical of the quality dimensions for adolescent-friendly service delivery. For this session also an integrated method of exercise is suggested for training health providers/supervisors:

1. Before sharing the content above, **do a “Quick pulse check”**, ask participants to share:
  - a. What do they understand by **effectiveness** as a quality of care dimension in adolescent-friendly MN(C)H/SRH service provision?
  - b. What would be the key characteristics of effective health services for adolescent girls and boys?
  - c. Why is this important?
2. Take notes on a flip chart
3. Tell them we will now see what the quality standards are
4. Make the presentation for each sub-category from A-D (4 core characteristics)
5. Stop after each characteristic i.e. A,B,C,D:
  - a. Divide them into 3-4 groups depending on number of participants
  - b. Ask them to answer the questions on a flip chart or a pre-pared hand-out as following

What is the desired quality?	What is the actual quality? (what are the gender-sensitivity gaps?)	What I/we can do/needs to change?
A. Health care providers have the required competencies in adolescentspecific areas to offer health promotion, prevention and treatment based on relevant circumstances.		
B. Health care providers use evidenced-based protocols and guidelines to provide health services.		
C. Health care providers are able to dedicate sufficient time to deal effectively with their adolescent clients		
D. The point of service delivery has the required equipment, supplies, and basic services necessary to deliver the required health services.		

**Note:** You will need to provide a printout of the detailed content for each of the characteristics as provided above when they are doing group work. They may not recall the standards. It is critical they assess “actual quality” in relation to the desired quality standards.

This session may take longer and requires adequate time.

At the end of this session participants should have an action plan for effectiveness based on the steps that can be taken locally to ensure equity in providing adolescent friendly health services.

*At the end of the training for health providers/supervisors/managers, hand out the checklist provided at Annex 1 to each participant and go over it with them collectively by asking them to fill it out after consensus on each point. Discuss the result of the exercise. If there are more NO answers than YES, ask them what can be done by them locally to improve service delivery for adolescent boys and girls?*

# ANNEX 1: ADOLESCENT FRIENDLY SERVICES CHECKLIST

(from African Youth Alliance/Pathfinder International)

<i>Characteristics</i>		<i>Yes</i>	<i>No</i>
<b>Health Facility Characteristics</b>			
1	Is the facility located near a place where adolescent boys and girls congregate? (youth center, school, market, playground)		
2	Is the facility open during hours that are convenient for adolescent boys and girls – (particularly in evenings or at the weekend)?		
3	Are there specific clinic times or spaces set aside for adolescents? Are the spaces separated for boys and girls?		
4	Are there separate and safe toilets for girls and boys?		
5	Are SRH services offered for free, or at rates affordable for adolescents?		
6	Are waiting times short?		
7	Do counseling and treatment rooms/spaces allow for privacy (both visual and auditory)?		
8	Is there a Code of Conduct in place for staff at the health facility?		
9	Is there a transparent, confidential mechanism for adolescents to submit complaints or feedback about SRH services at the facility?		
<b>Provider Characteristics</b>			
1	Have providers been trained to provide gender-sensitive, adolescent-friendly services?		
2	Have all staff been oriented to providing confidential adolescent-friendly services (receptionist, security guards, cleaners, CHWs)?		
3	Do the staff demonstrate respect when interacting with adolescents? (more for supervisor)		
4	Does the provider ensure client's privacy and confidentiality? (more for supervisor)		
5	Does the provider set aside sufficient time for client-provider interaction? (more for supervisor)		

<b>Characteristics</b>		<b>Yes</b>	<b>No</b>
6	Are same sex peer educators or peer counselors available for girls and boys? (to be adapted as per country norms and protocols)		
7	Are health providers assessed using quality standard checklists? (more for supervisor)		
<b>Program Characteristics</b>			
1	Do adolescents (boys and girls) play a role in the operation of the health facility?		
2	Are adolescent girls and boys involved in monitoring the quality of SRH service provision?		
3	Can adolescent girls and boys be seen in the facility without the consent of their parents or spouses?		
4	Is a wide range of SRH services available for adolescent girls and boys (FP, STI treatment and prevention, HIV counseling and testing, ante- and postnatal care, delivery care)?		
5	Are there written guidelines for providing adolescents services?		
6	Are condoms available to both young boys/men and young girls/women?		
7	Are gender-sensitive SRH educational materials, posters or job aids on site, which are designed to reach adolescents?		
8	Are referral mechanisms in place for transportation of adolescent pregnant girls with obstetric emergencies?		
9	Are adolescent-specific indicators monitored on a regular basis? (e.g. number of adolescent clients disaggregated by age and sex)		





# Canada

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