Adolescent and Youth Sexual and Reproductive Health and Rights Services

Key elements for implementation and scaling up services in West and Central Africa

Why are adolescent and youth services needed?

In West and Central Africa, 64 per cent of the population is below the age of 24 years.[1] **If this population were educated, healthy and employed, the region could benefit from the demographic dividend**. However, one of the major obstacles to capturing the demographic dividend is the sexual and reproductive health and rights (SRHR) of adolescents and youth[2] in the region, which is characterized by high rates of adolescent pregnancies and a high proportion of unmet family planning needs.

Young people often do not know where and how to access services. In most countries there are very few service delivery points (SDPs) that offer adolescent and youth sexual and reproductive health and rights (AYSRHR) services. Even when these services are accessible, their quality is not certain. In some contexts, national laws and policies impede the provision and use of AYSRHR services. In addition, sociocultural norms such as the pressure to have children, gender inequalities and stigmatization by health-care providers are all obstacles to the use of AYSRHR services.

The low levels of SRHR knowledge among adolescents and youth, along with the limited access to and usage of SRHR services and contraceptive methods, make it essential to provide comprehensive sexuality education (CSE) and ensure access to quality AYSRHR services.

This brochure sets out what is required to provide and scale up AYSRHR services. It documents evidence, promising practices and essential components through a literature review and concrete examples from four West and Central African countries: Chad, Guinea, Senegal and Togo.

What are adolescent and youth sexual and reproductive health and rights (AYSRHR) services?

AYSRHR services are those that respond to the needs of young people. When tailored and quality services are provided, their usage by the target population will increase.

The World Health Organization (WHO) has developed criteria and identified standards to be implemented in all health care settings that host young people. Most importantly, AYSRHR services should be: accessible, acceptable, equitable, appropriate and effective.

Requirements for the provision of effective services

Effective AYSRHR interventions

AYSRHR is a relatively well-studied field with a growing body of evidence that clearly demonstrates what does and does not work:[3]

↪ training of AYSRHR service providers without providing **on-the-job support and supervision** will not increase the uptake of services. Additional measures targeting health human resources (HHR) are therefore required (for example, in- and pre-service training, formative supervision, support to providers, precise job descriptions with responsibilities and reference tools)

↪ **awareness-raising alone** among young people will not increase service utilization; this should be accompanied by initiatives to improve access to and the quality of services

↪ young people are not a heterogeneous group – **needs differ and services should be adapted to circumstances**, such as age, sex, marital/relationship status, etc. (for example, the needs of a 15 to 19 old single adolescent girl are very different to those of a married adolescent girl)

↪ **young people's needs change**, rendering a single model ineffective

↪ **AYSRHR services must be linked to quality CSE**

↪ **integrating** HIV, SRHR and the provision of contraceptive and family planning services can increase effectiveness

↪ **awareness, approval and support** for AYSRHR services need to be strengthened among young people, providers, parents, guardians and religious and community leaders

↪ young people's health is affected by social determinants at every level (personal, family, community and national), with structural factors such as poverty, access to education and gender inequalities, as well as factors such as interfamily relationships and violence negatively affecting their health[4]

↪ **young people's participation in the development, implementation, evaluation and advocacy** of AYSRHR interventions improves their effectiveness

↪ **coordinated and complementary** approaches and strategies are needed.

Global research shows that **youth centres, peer education and one-off public meetings have generally been ineffective** in facilitating access to AYSRHR services, changing young people's behaviour or influencing social norms regarding young people's SRHR.[5]

However, **some interventions considered less effective continue to be implemented** and allocated resources, **while those that have proved effective tend not to be scaled up** (for example, CSE and integrated services), often due to the high costs and time required for scale up.[6] A lack of prioritization and insufficient financial resources have affected the quality and scale up of effective interventions.

Interventions that have proved to be ineffective should be abandoned and proven approaches should be implemented and scaled up with adequate fidelity to ensure their effectiveness. New approaches need to be identified and greater attention paid to prevention, private sector engagement and better access to a wider range of contraceptive methods.[7]

Interventions	Positive impact on the use of AYSRHR services and/or behaviour change	Ineffective
Services adapted to young people's needs	✕	
CSE	✕	
In- and pre-service training on AYSRHR combined with in-service formative supervision and support to providers	✕	
Integration of HIV, SRHR and contraceptive and family planning services	✕	
Awareness and support for AYSRHR services and CSE among young people, their parents/guardians, the community and religious and community leaders	✕	
Youth centres		✕
Peer education		✕
One-off public awareness meetings		✕
Coordinated and complementary approaches/strategies	✕	
Effective interventions implemented and scaled up with fidelity	✕	

As research has identified ineffective strategies, a discussion is now needed in each country to decide on the future of these strategies. Some, such as one-off public meetings, could simply be abandoned, though others, such as youth centres, have received significant human and financial investments and may have been scaled up. Rather than abandoning such strategies, a discussion on how to adapt them for alternative purposes should be initiated.

Key elements of the provision and scale up of AYSRHR services

An effective response to young people's needs relies on **simultaneous and synergistic actions** to improve the quality of and access to services through training and supervision, a regular supply and effective management of sexual and reproductive health commodities, medicine, and equipment (technical considerations), and the establishment of an enabling environment and demand creation.

The provision and scaling up of AYSRHR services requires the development of an AYSRHR strategy and a **costed national implementation plan** that defines the key elements of the process. This plan can be stand-alone or part of a national SRHR plan, a national adolescent health and well-being plan, or as is becoming increasingly common, a reproductive, maternal, neonatal, child and adolescent health (RMNCAH) plan.

Situation analysis: defining health priorities for young people

1. Needs assessment	2. Landscape analysis	3. Setting priorities
To identify which conditions, health risks and social determinants have the greatest impact on adolescent health and development, both among adolescents in general and among those most vulnerable.	Of existing adolescent health programmes, policies, legislation, capacity and resources within the country, as well as a review of current global and local guidance on evidence-based interventions.	Considering the urgency, frequency, scale and consequences of particular burdens, the existence of effective, appropriate and acceptable interventions to reduce them, the needs of vulnerable adolescents, and the availability of resources and capacity to implement or expand priority interventions equitably.

WHO, Global Accelerated Action for the Health of Adolescents (AA-HA!).
Guidance to support country implementation (Geneva, WHO, 2017).

The first step in developing an implementation plan is to assess needs, analyse the situation and set priorities. Once priorities have been established, decisions will need to be made on different **technical aspects** (such as what combination of SDPs to use and the package of services to be provided) and on how to **create demand** and an **enabling environment**.

The implementation plan should at a minimum include a situation analysis and identified priorities and objectives; the recommended methodology and/or strategies to be used, including for monitoring and evaluation (see technical considerations below); an analysis of the process required for scaling up, including a timeline; the roles and responsibilities of all stakeholders as well as coordination and collaboration mechanisms; the actions required at the national, provincial/district and operational levels; and an estimate of costs, currently available funding and strategies for resource mobilization. National funding is essential for long-term sustainability.

In 2014, Togo developed its *Reproductive Health Services Framework for Adolescents and Youth in School, University and Out-of-School Settings*, which outlines the activities and services to be provided in school infirmaries (in addition to the treatment and management of common diseases and minor injuries and traumas). These include prevention and management of pregnancy; prevention, screening and treatment of STIs, HIV and AIDS; condoms and other forms of contraception; information and counselling on puberty, infertility, gender-based violence (GBV), harmful substances, accidents, child marriage, etc.; and vaccination against human papillomavirus, among others.

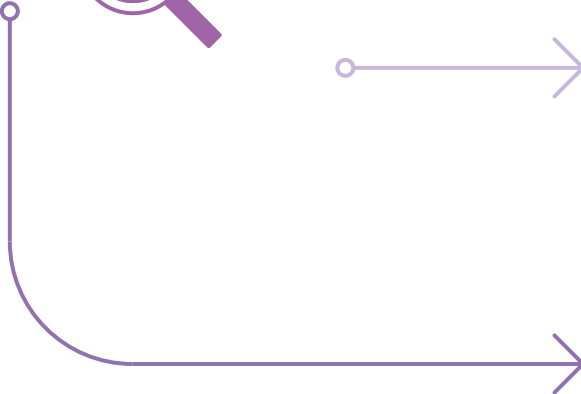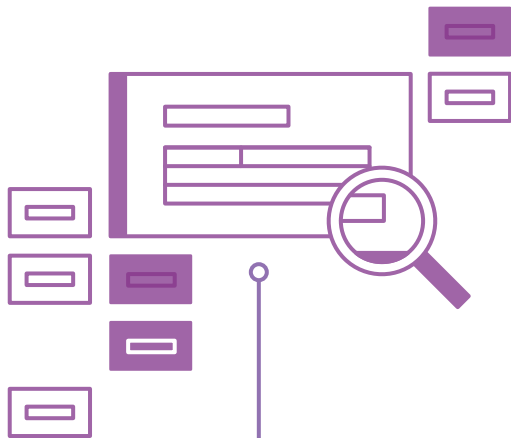**Technical considerations for the provision
and scale up of AYSRHR services**

Priority Setting and Implementation Plan Development
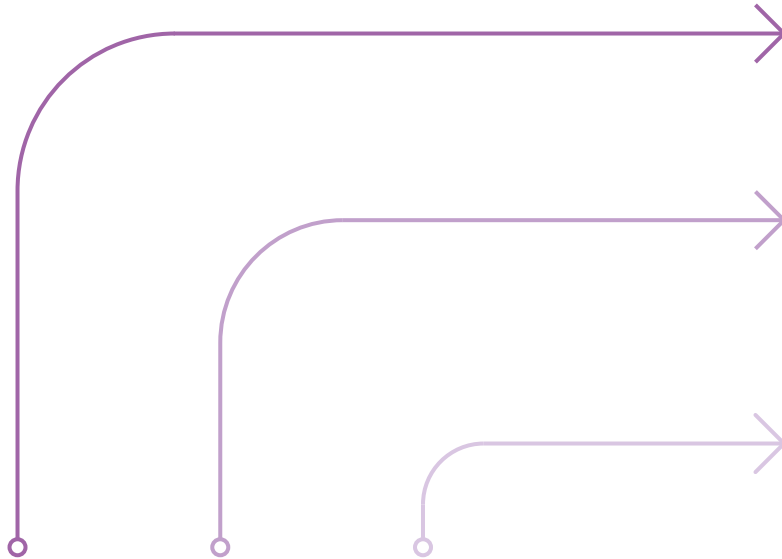
Service delivery points

Package of services and its integration

Monitoring and evaluation

Commodities

Standards and criteria

Provider training, supervision and support

IEC/SBCC

Each country will need to select what combination of service delivery point (SDP) models it will use to provide AYSRHR services, both in the short and long term. This will depend on needs, the feasibility of scaling up the different models and their long-term sustainability.

Each country should ensure that it develops and integrates into its package of essential health services, a minimum package of services for young people (for example, prevention activities, family planning, screening, treatment) to be implemented at each level of the health system and for each type of SDP.

Monitoring and evaluation of inputs, costs, processes, outcomes and impacts help to analyse which strategies are effective in reaching the different subgroups and the most vulnerable. In most countries, data have not been sufficiently disaggregated by age, sex, education level, relationship status, location, wealth quintile, living conditions and other key socioeconomic factors (especially for 10–14-year-olds). This should be addressed by the integration of these disaggregated indicators into existing information systems.

The provision and scale up of AYSRHR services will result in an increased need for medical equipment and supplies, contraceptives and medicines. Depending on the services that will be integrated and the speed of the scale up, it will be necessary to identify essential supplies, the quantities needed and whether existing funds will cover the costs (taking into account the need for items to be free or low cost for young people).

Each country will need to establish or update its standards and criteria for each type of SDP. These should include infrastructure and transport requirements, equipment and technology needs; medicines and commodities (including contraceptives); human resource needs; and the skills and attitudes needed by providers. These documents should be disseminated to all SDPs, a training plan developed and implemented, and a system put in place for support and monitoring and evaluation.

All staff in contact with young people will need to be trained. Training should not only develop skills, knowledge and abilities, but should also include values clarification as a methodology to change negative attitudes towards young people and their SRHR. Formative supervision and continued support to providers are also essential components. Ideally, AYSRHR should be included in the job descriptions of all providers in contact with young people.

Information, education and communication (IEC)/social and behaviour change communication (SBCC). The need to change mentalities is an essential element. This includes, among other things, the need to address gender inequalities, sociocultural barriers, the reasons why young people do not use services and preconceptions about contraceptives and their side effects. Segmentation of the target populations (by age, sex, marital/relationship status, adolescent, youth, parent, religious and community leader, etc.) is essential to develop effective IEC/SBCC interventions, including for the package of services offered and demand creation activities.

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Service delivery points

Possible SDP models are briefly described below, as are some of the aspects to consider when choosing what models to prioritise.[8] Information for this section has been adapted from an Evidence to Action Project and Pathfinder International report.[9]

Integrated/mainstreamed within existing services
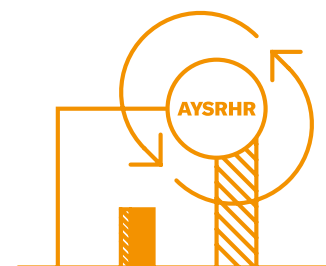
SDP model	In a public or private health facility (but not a separate space). May include information, education and communication (IEC) materials, peer education and activities to promote services. **Highly recommended and a priority to ensure long-term sustainability.**
Advantages	→ **Faster to scale up as the infrastructure is already in place.** → No additional infrastructure costs. → Can be implemented at all levels of the health system.
Disadvantages	→ Less confidentiality. → Requires a reorganization of services within facilities to address increased demand and young people's needs e.g. special opening hours, among others. → Need to **train, supervise and support all staff** of the health facility. → Longer to set up (but has the best potential).
Scale up and sustainability	→ **Good potential for scaling up** as it is institutionalized in the health system and does not require a separate space or a dedicated provider. → **Requires significant initial resources** for the training and support of all providers. **Gradual reduction of costs**. → Costs will decrease over time. → **High probability of sustainability if institutionalized and faithfully implemented.**

Separate adolescent and youth spaces in public or private health facilities

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SDP model	A dedicated provider administers the services. Multiple services may be offered such as contraceptives/family planning, screening for HIV and sexually transmitted infections (STIs), treatment, pregnancy and maternal health. There may be a waiting room with IEC materials and peer education. **Option to expand access, depending on the context.**
Advantages	→ **Less stigmatization, more confidentiality.** → Fewer providers to train, supervise and support. → If services are not free of charge, subsidizing services for young people is an option.
Disadvantages	→ **Need for a separate space/infrastructure.** → **Need for dedicated and trained staff.** → **High turnover of HHR requires constant training of new providers** (if not included in pre-service training). → There is the risk that services will stop being provided when the trained provider leaves or when the project ends.
Scale up and sustainability	**This option is scalable but requires significant resources** (dedicated HHR and space/infrastructure). **Sustainable only if institutionalized in the health system and if there are sufficient HHR.**

Community-based services

SDP model	These services are administered by community health workers (CHWs). **Option to expand access, but the package of services offered will be incomplete.**
Advantages	→ Increases accessibility for a large number of young people. → Condom distribution and counselling/IEC. → Some countries have allowed CHWs to distribute contraceptives. → This option can be complimentary to the integrated or mainstreamed SDP model.
Disadvantages	→ Little privacy or confidentiality. → Services for young people usually restricted to IEC and condom distribution.
Scale up and sustainability	**Scaling up depends on a budget allocation or a donor.** **Sustainability is only possible if the model is institutionalized in the health system** (e.g. the position of CHWs is established and staff are paid by the state).
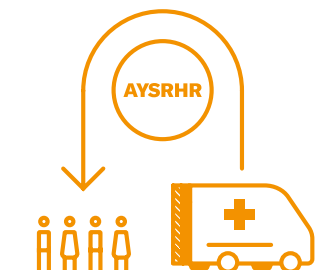
Mobile services

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SDP model	Full range of services offered in a specially equipped van, in a lower level health facility, etc. Services are provided by health professionals. **Option to expand access at least in the short and medium term.**
Advantages	→ **Can reach isolated communities**. → Can have an impact on **contraceptive use and screening**.
Disadvantages	→ **Little privacy.** → Mixes young people and adults. → Mobile clinics are often held during school hours. → **Mobile clinics do not return regularly to the community.** → **More expensive to implement.**
Scale up and sustainability	Can be scaled up **if sufficient resources are allocated and the services offered are part of the existing health system** (or if the private sector scales it up by using cost-recovery mechanisms). **However, the high level of resources required reduces its potential for sustainability.**

School/university infirmaries
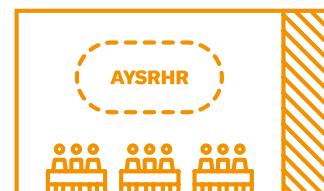
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SDP model	**Health and education services provided within a school or university infirmary.** **Option to expand access only if a school/university infirmary programme is already in place** (may not be cost-effective, if everything needs to be created).
Advantages	→ **Less stigmatization, more confidentiality.** → Services are free of charge. → Easier to connect the CSE to AYSRHR services.
Disadvantages	→ **Few school infirmaries** are operational. → Most school health programmes **are not adequately funded**.
Scale up and sustainability	Scale up depends on the number and quality of the existing infrastructure and staff. This model can be sustainable **if institutionalized in the health and education systems, and if sufficient human and financial resources are allocated.**

Stand-alone clinic
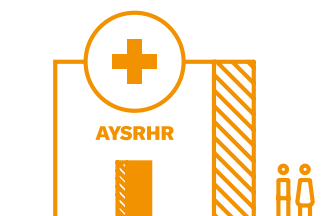
SDP model	Dedicated services for adolescents and youth through the public or private sector. This model is often used by non-governmental organizations (NGOs) and sometimes has peer educators or counsellors on site. Promotion of the services on offer can be conducted in the catchment area. **Option to expand access in the short and medium term.**
Advantages	→ **Less stigmatization, more confidentiality.** → Better attitude of providers and quality of services. → Flexible opening hours. → The **services are generally free of charge** for young people.
Disadvantages	→ **Rarely present outside urban areas**, as it requires a high volume of customers to become profitable, leading to unequal access. → **Too expensive to implement nationally.**
Scale up and sustainability	Requires a lot of resources. Once funding is withdrawn, services collapse (these facilities are often funded by donors). **If the facility receives payment for services and is located in an urban areas with high demand, it can be financially self-sufficient.**

Social franchising
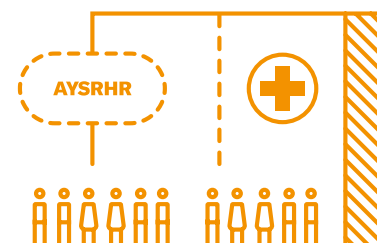
| SDP model	A social franchise can be a stand-alone facility, a separate space or integrated into existing services.
	Option to expand access in the short and medium term.
	May be a long-term option if financially sustainable.
Advantages	→ **Less stigmatization, more confidentiality.** → Flexible opening hours. → Can be linked to social marketing products such as condoms and demand creation to strengthen effectiveness.
Disadvantages	→ **Requires a leader** (often an NGO) for, among other things, training, support and supervision. → Requires a common brand and a centralized marketing strategy. → Requires a quality assurance system. → Requires a clear tariff structure.
Scale up and sustainability	This model can be complementary as it often uses existing infrastructure and HHR. However, these SDPs are **rarely in rural or sparsely populated areas and are therefore difficult to scale up nationally.** **If the facility receives payment for services and is located in an urban areas with high demand, it can be financially self-sufficient.**

Pharmacies

SDP model	Staff provide counselling and basic sexual and reproductive health commodities or services (e.g. condoms, other contraceptives, emergency contraception and treatment for STIs).

Option to expand access in the short and medium term.

Advantages	→ **Fast and relatively anonymous services.** → Easily accessible (except in rural areas).
Disadvantages	→ **Limited package of services offered.** → The **quality varies greatly**, limiting effectiveness and resulting in inadequate services being offered.
Scale up and sustainability	Scalability depends on the **coverage and strength of the existing network** of pharmacies and requires ongoing support to the network. High turnover and high mobility/informality in the pharmaceutical sector would make this option **difficult to sustain**.

Youth centres
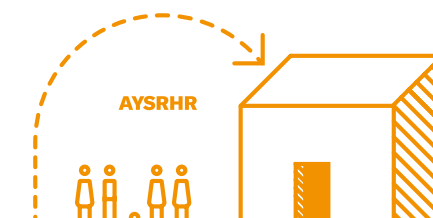
SDP model	Youth centres are recreational and/or vocational training facilities, which may have a space where SRHR services are offered. This can include clinical services, counselling or referral to other services.
	Avoid.
Advantages	→ **Can contribute to the empowerment of young people.**
Disadvantages	→ **Not very effective** in increasing the use of SRHR services. → **Low utilization of services by key target** populations such as adolescents and especially adolescent girls. → **Not cost-effective, with a high cost per service provided.**
Scale up and sustainability	**Very difficult to implement on a national scale.** **Ineffective and expensive.** If already in place, a discussion on how to adapt the space for alternative purposes should be initiated.

Scaling up services and ensuring equal access will only be possible through a **combination of models chosen depending on the context**. Given that some models take time to put in place and that health facilities in many countries have limited capacity to provide quality AYSRHR services, implementation plans must plan for the short, medium and long term.

Scaling up integrated AYSRHR services – the Ethiopian experience

Ethiopia, with the support of technical and financial partners, has initiated the scale up of integrated AYSRHR services at existing service delivery points (SDPs). The process used covers both vertical (institutionalization) and horizontal (geographical expansion) scale up. To ensure an effective scale up, the partners strengthened technical and management capacities of local, regional and central authorities. It should also be noted that the process was funded by donors, which enabled the initial expansion and the institutionalization.

There were three main phases to the scaling up of AYSRHR services:
1. Learning exchange visit to Mozambique; consensus-building; development of a national AYSRHR strategy; selection of 20 pilot sites; and training and implementation.
2. Documentation of experiences at pilot sites; development of a national training programme; learning exchanges with pilot sites; testing of new components for the package of services; and capacity-building of Government and other stakeholders.
3. Development of a new national strategy on the health of adolescents and youth and Regional Health Offices becoming responsible for AYSRHR services.

Results

↪ The number of SDPs providing services that are responsive to young people's needs increased from 14 (in 2006) to 248 in health facilities and on 13 university campuses.
↪ 3,334 providers trained on AYSRHR.
↪ 5 million young people accessed AYSRHR services.
↪ 22,994 peer educators trained.
↪ 14,963,476 young people with access to information on SRHR.

The country plans to expand AYSRHR services to all health facilities. Some regions such as Oromia have already begun to institutionalize AYSRHR in all health facilities.

Sources: Gwyn Hainsworth and others, "Scale-up of Adolescent Contraceptive Services: Lessons From a 5-country Comparative Analysis", *JAIDS: Journal of Acquired Immune Deficiency Syndromes*, vol. 66, Supplement 2 (2014), pp. S200–S208; USAID, Pathfinder International and John Snow, Inc. (JSI), Youth-friendly Services, Piloting to Scaling-up in Ethiopia (December 2016); USAID, Pathfinder International, JSI, Bridging Youth-friendly Services to Scale in Ethiopia (April 2012).

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Create demand

Participation, awareness-raising and empowerment of adolescents and youth

The participation and involvement of adolescents and youth in AYSRHR is essential. Global experience shows that AYSRHR interventions are more effective when adolescents and youth participate in their development, implementation, evaluation and advocacy. **All four countries in the review have youth organizations active in AYSRHR, including in advocacy**. However, these young people (very few are adolescents) are often from urban areas and are well educated, meaning they may not necessarily represent adolescents and youth from poorer rural areas with different needs. A **diversity** of age, sex, context (urban and rural), educational level and socioeconomic level is necessary to ensure that all young people are represented.

Comprehensive sexuality education

CSE is a "curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives."[10] Quality CSE enables young people to acquire skills such as assertiveness, communication, negotiation and refusal, and allows them to understand gender-related social norms, which will help tackle GBV.

Research shows that awareness of SRHR is insufficient. Achieving significant impact will only be possible through the provision of quality CSE that is linked to AYSRHR services. It is therefore essential to develop and implement quality CSE in and out of schools, and to integrate a referral system to AYSRHR services either during CSE classes and activities or by planning joint activities between the health and education sectors. For more details on establishing and scaling up CSE, please refer to the brochure and report developed by the United Nations Population Fund West and Central Africa Regional Office (UNFPA WCARO).[11]

Information and communication technology

Information and communication technologies (ICTs) are becoming increasingly important in the lives of young people. Whether in urban or non-urban areas, most young people have access to social networks (via mobile phones) and media (television, radio, etc.). These sources of information and communication are often the only easily accessible sources, but they do not always convey accurate or correct information. The web can be both positive and negative (for example, harm, harassment), though too often, young people cannot differentiate.

Governments and non-governmental organizations (NGOs) are increasingly using ICTs to reach young people not only 'physically' but also through a 'language' that they understand and with which they can identify. In addition, many countries in the region have free telephone hotlines, either on AYSRHR or for at-risk children or those experiencing GBV. The hotlines are manned or automated.

C'est la Vie! – a regional level programme

The *C'est la Vie!* [That's Life!] programme, a social and behaviour change communication (SBCC) initiative focusing on maternal and child health, reproductive health, quality of care and GBV, was launched in 44 countries in sub-Saharan Africa. The initiative uses educational entertainment and consists of a television series and a cross-media campaign on radio, social media, the Internet and through community communication activities. Guidebooks, one per episode, cover specific themes and are developed to enable a facilitator to lead debates following the screening of an episode. Screenings and debates take place in schools and health facilities and debates can also be aired on the radio.

Positive results include:
- 135 hours of airtime on pan-African television
- more than 20 million viewers on TV5 Monde Afrique alone
- more than 200,000 episodes watched on TV5's VOD platform (it is the platform's most watched content)
- *C'est la Vie!* broadcast on national public and private television channels in 30 countries
- a pilot campaign via digital media (one month) resulted in 1,900 pages/day visited and 250,000 people reached, of which 40 per cent were 15–25-year-olds
- 100,000 fans on Facebook
- 16,000 subscribers on YouTube and 50,000 views per episode
- one radio series of 31 episodes, each 20 minutes, broadcast in French on RFI Afrique (4–5 million listeners per episode).

For further information, see: http://www.ongraes.org/nos-programmes/sante-sexuelle-et-reproductive/cest-la-vie/ *(in French).*

Awareness-raising among and mobilization of parents, communities and community and religious leaders

Sociocultural barriers and the fact that sexuality is considered a taboo subject make it difficult to discuss and can create barriers to the access and use of AYSRHR services. As a result, the information provided by schools, parents, friends and religious leaders about sexuality is often contradictory. Global experience shows that the participation of tutors, parents, communities and community and religious leaders in the development and implementation of CSE programmes and AYSRHR services contributes significantly to overcoming barriers and increasing impact.

Overcoming sociocultural barriers requires a successful SBCC campaign that addresses negative societal norms and attitudes and raises the awareness of parents and communities on AYSRHR. Campaigns can include the use of the media as well as more personal interventions such as activities in schools with parents, activities to improve parent/child communication and training of influential community members in advocacy and communication on AYSRHR.

In Guinea, in an effort to counter negative provider attitudes and identify the beliefs and prejudices that affect their provision of services to young people, the Ministry of Health has implemented **joint training sessions for providers and young people**. Although this programme has not yet been evaluated, the role-playing exercises and conversations allowed participants to observe and begin to understand each other's difficulties and concerns. Role-playing allowed providers to train with young people who could provide them with feedback on their performance.

Chad – Islam as a positive force for family planning

Since 2015, UNFPA has supported the Chadian High Council for Islamic Affairs (Conseil Supérieur des Affaires Islamiques du Tchad) to counter the preconceptions that Islam prohibits family planning. One of the first activities was a study tour by council members to Bangladesh and Indonesia in August 2015. This trip was followed by a workshop held in the Great King Faisal Mosque to exchange experiences on family planning. Imams, preachers and students participated in the workshop. A positive outcome of the workshop was that 450 Muslim leaders recognized the importance of family planning in a country's development and committed to raising awareness among their followers about its benefits. Following the workshop, the Association of Preachers organized an awareness and information session on family planning, which was attended by 650 faithful. In July 2017, a regional symposium (to support the Sahel Women's Empowerment and Demographic Dividend (SWEDD) project) brought together 1,200 religious leaders on the theme Islam, Demographic Dividend and Family Welfare. In addition, UNFPA supported the rehabilitation and expansion of the Great Mosque's health centre, which provides family planning services to the faithful.

The project with the High Council for Islamic Affairs continues to organize symposiums and workshops in regions to raise the awareness of Imams, preachers and other religious and community leaders. The project hopes to be scaled up at the national level. Advocacy towards religious leaders has had additional positive impacts, such as the solemn commitment of 21 communities to abandon female genital mutilation and the promotion of initiation rites without excision.

Referral mechanisms to AYSRHR services

Increasing the uptake of AYSRHR services requires the elimination of sociocultural barriers as well as users knowing what services are on offer, and how and where to access to these services. Activities to strengthen links between the Ministries of Health and Education are therefore essential. Information on the package of services and where to access it can be communicated through different mechanisms, such as extracurricular activities in school clubs or ICTs which are an effective and inexpensive mechanism for transmitting information.

Since the objective is to orient young people towards an SDP that is responsive to their needs, it is of key importance that **all AYSRHR interventions identify and communicate the nearest and most appropriate SDP**. In addition, NGOs and civil society organizations (CSOs) are working to create links and reduce barriers, for example by setting up voucher systems for free access to health services or providing transport to facilitate access to SDPs.

Creating an enabling environment

Leadership and management of the AYSRHR programme

Providing and scaling up AYSRHR services is impossible **without government ownership and leadership**. To be effective, services must be integrated into existing systems and must be part of the core activities of the Ministry of Health. Depending on the country context, this **may require changes in policy, laws and budgets** that are impossible without high-level leadership. The interest in the **demographic dividend** in the region is an opportunity to integrate the AYSRHR into the Government's agenda and budget and to justify the roll out of interventions by the different ministries. Leadership and ownership are also needed at the **provincial/district and SDP levels**.

Many countries have a **division, unit or section on adolescent health**, or a unit more specifically focused on AYSRHR. Although these units exist, they are often **weakened** by limited human and financial resources and a positioning that does not allow them to work easily with other sections of the Ministry, which is essential to ensure the integration of AYSRHR services into public health structures.

Legal and policy environment

An enabling legal and policy environment is essential for the provision and scale up of AYSRHR services. A national law or policy that makes it mandatory for health workers to provide AYSRHR services without restriction provides justification for the provision of these services to parents and guardians, and allocates responsibility for their delivery. In addition, **a law/policy establishes the rights of adolescents and youth to AYSRHR services**. Laws can either hinder or facilitate the provision of AYSRHR services. Such laws include those on the legal age of marriage, age of consent, age and marital status requirements to access to SRHR services and restrictions on the provision of services to young adolescents aged 10 to 14 years.

Although the legal framework is often conducive to scaling up AYSRHR services, in many cases there is a lack of harmonization between legislation and policy, and **insufficient knowledge and enforcement of laws and legal texts**. The situation analysis should therefore include a review of the political and legal environment to identify potential barriers and what corrective measures may be required. In addition, the AYSRHR implementation plan should include the dissemination of amended laws and policies and put in place enforcement mechanisms.

Coordination and collaboration

Coordination and collaboration within and across sectors and with non-governmental partners is needed at all levels: national, regional/district and operational.

↳ Integrating AYSRHR services requires collaboration and coordination within the Ministry of Health.

↳ Facilitating access to and use of AYSRHR services requires a multisector response and therefore needs coordination and collaboration between relevant sectors, such as education, youth, gender, social action and justice, and with various non-governmental stakeholders.

↳ Coordination and collaboration are often the weak link due to the complexity and number of stakeholders working in CSE and AYSRHR. The specific role of each actor must be understood, and each held accountable. This situation may be compounded by a lack of understanding of the role of coordination and a lack of capacity to coordinate. In addition, **the responsible unit within the Ministry of Health often does not have the authority, mandate, resources, capacity or skills to lead the coordination**.

Key elements for the implementation and scale up of AYSRHR services

| Create demand | Technical consideration | Enabling environment |
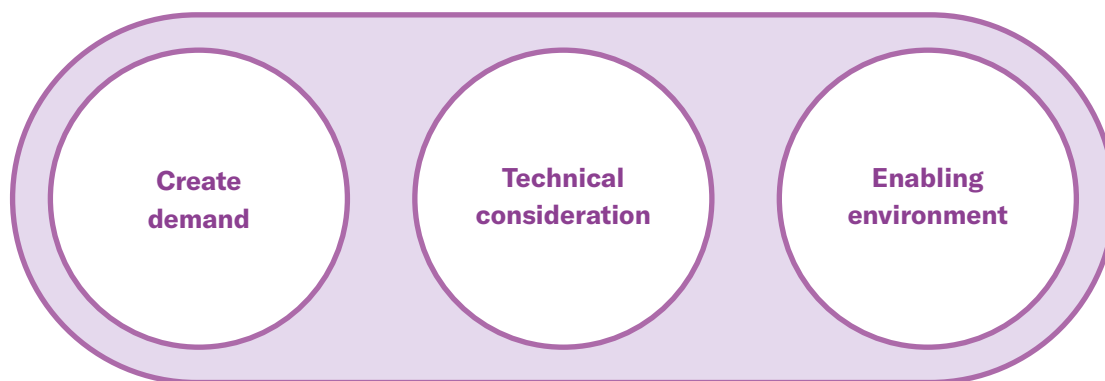
A role for each stakeholder

Scaling up of AYSRHR services is not only the responsibility of ministries and NGOs and the partners that support them. Politicians, religious and community leaders, journalists and other media, individuals, families and communities, and young people themselves also have an important role to play in improving quality and access to services and in creating demand and an enabling environment.

Scaling up quality AYSRHR services is a long-term project that involves institutional changes at all levels as well as societal changes. Any scaling up plan must therefore take into account the short and long- term. The difficulty of implementation and the time required to achieve a national scale up are offset by the positive impact on the health and education of adolescents and youth, and therefore on the development of their country.

Endnotes

1 United Nations Population Fund West and Central Africa Regional Office (UNFPA WCARO). Transforming and Uplifting Lives. One Region One Mission. Annual Report 2015. West and Central Africa Regional Office (2015).

2 The United Nations defines persons aged 10–19 years as adolescents and youth as persons aged 15–24 years. Together, adolescents and youth are referred to as young people, encompassing the ages of 10–24 years.

3 Venkatraman Chandra-Mouli and others, "Twenty Years After International Conference on Population and Development: Where Are We With Adolescent Sexual and Reproductive Health and Rights?", Journal of Adolescent Health, vol. 56, S1eS6 (2015); Venkatraman Chandra-Mouli and others, "What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices", Global Health: Science and Practice, vol. 3, No. 3 (2015), pp. 333–340; World Health Organization (WHO) and Joint United Nations Programme on HIV and AIDS (UNAIDS), Global standards for quality health-care services for adolescents. A guide to implement a standards-driven approach to improve the quality of health-care services for adolescents (Geneva, WHO, 2015).

4 Russell M. Viner and others, "Adolescence and the social determinants of health", The Lancet, vol. 379 (2012), pp. 1641–1652.

5 Venkatraman Chandra-Mouli and others, "Twenty Years After International Conference on Population and Development: Where Are We With Adolescent Sexual and Reproductive Health and Rights?", Journal of Adolescent Health, vol. 56, S1eS6 (2015); Venkatraman Chandra-Mouli and others, "What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices", Global Health: Science and Practice, vol.3, No. 3 (2015), pp. 333–340.

6 Venkatraman Chandra-Mouli and others, "What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices", Global Health: Science and Practice, vol.3, No. 3 (2015), pp. 333–340.

7 Venkatraman Chandra-Mouli and others, "What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices", Global Health: Science and Practice, vol.3, No. 3 (2015), pp. 333–340.

8 Adolescent and Youth Sexual and Reproductive Health and Rights Services. Key elements for implementation and scaling up in West and Central Africa. UNFPA WCARO, 2019.

9 Callie Simon and others, Thinking outside the separate space: A decision-making tool for designing youth-friendly services (Washington, D.C., Evidence to Action Project and Pathfinder International, 2015).

10 For more details on the essential components of CSE, please refer to: United Nations Educational, Scientific and Cultural Organization (UNESCO), International technical guidance on sexuality education. An evidence-informed approach. Revised edition (2018).

11 UNFPA WCARO, Comprehensive Sexuality Education. Evidence and promising practices in West and Central Africa (2019). Brochure and report. https://wcaro.unfpa.org/en/publications/comprehensive-sexuality-educationkey-considerations-implementation-and-scaling-west-and