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LE FONDS FRANÇAIS MUSKOKA
Réduire la mortalité maternelle, néonatale et infantile

Adolescent and Youth Sexual and Reproductive Health and Rights Services

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

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Acronyms

AGUIPSSU	Association Guinéenne de Promotion de la Santé Scolaire et Universitaire [Guinean Association for the Promotion of School and University Health]
AA-HA!	Accelerated Action for the Health of Adolescents
AGBEF	Association Guinéenne pour le Bien-être Familial [Guinean Association for Family Welfare]
AIDS	acquired immune deficiency syndrome
AYSRHR	adolescent and youth sexual and reproductive health and rights
CESSPHAM	Cercle Scientifique Stomatologie-Pharmacie-Médecine [Scientific Association of Stomatology–Pharmacy–Medicine]
CHW	community health worker
CSE	comprehensive sexuality education
CSO	civil society organization
FFM	Fonds Français Muskoka [French Muskoka Fund]
GBV	gender-based violence
HIV	human immunodeficiency virus
HPV	human papillomavirus
ICT	information and communication technology
ICPD	International Conference on Population and Development
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
MAJ	Mouvement d'Action des Jeunes (peer educators associated with IPPF affiliates)
MEN	Ministère de l'Éducation Nationale [Ministry of Education – Senegal]
MSI	Marie Stopes International
NGO	non-governmental organization
PARC	Projet d'Appui au Renouveau des Curricula [Curricula Review Project – Senegal]
RMNCAH	reproductive, maternal, neonatal, child and adolescent health
SBCC	social and behaviour change communication
SDP	service delivery point
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
TFP	technical and financial partner
UNDAF	United Nations Development Assistance Framework
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

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We hereby acknowledge the continuing efforts of Governments, Regional Institutions, Donors, Youth and Civil Society Organizations in supporting, implementing and expanding programmes for the sexual and reproductive health and rights of adolescents and youth in West and Central Africa.

Foreword

The population in West and Central Africa is predominantly young, with 65% under the age of 24 and 32% in the 10-24 age group. This adolescent and youth population encounters daily countless challenges in accessing their primary needs. Needs that can no longer be ignored, as the situation is becoming increasingly concerning.

The population, health and social data underscore the urgency of providing young people, quality sexual and reproductive health and rights services to empower them in order to avoid early and unwanted pregnancies, prevent HIV or address gender-based violence (GBV).

Today in the region, more than one out of ten girls aged 15-19 are already mothers, setting the region's adolescent pregnancy rate at the highest level in the world: more than twice the global average. The highest percentage of unmet need for family planning among married and unmarried women aged 15-24 is also found in the region. Added to this are the high number of early marriages, the low level of girls' education, difficult access to sexual and reproductive health and rights services, gender violence and inequality, etc.

Adolescent and youth sexual and reproductive health and rights are, more than anywhere else, a societal and public health priority in the region. We must address the needs of young people if we are to take full advantage of the demographic dividend, strengthen the resilience and transformation of the continent and achieve the Sustainable Development Goals by 2030 and "the Africa we want" by 2063, following the African Union's roadmap for capturing the Demographic Dividend.

This regional report entitled "**Adolescent and Youth Sexual and Reproductive Health and Rights Services - Key elements for implementation and scaling up in West and Central Africa**" is complementary to the previous regional report on Comprehensive Sexuality Education (CSE) and documents, through concrete examples from four West African countries (Benin, Côte d'Ivoire, Senegal and Togo), highlighting promising practices, lessons learnt, and proposing key recommendations to be shared with all countries in the region.

The French Muskoka Fund is part of this dynamic and enables UNFPA to strengthen technical and financial support for the sexual and reproductive health and rights of adolescents and youth in eight countries in the region. Among the key interventions unanimously recognized as effective are CSE and access to quality adolescents and youth sexual and reproductive health and rights services.

Through this report, the UNFPA Regional Office for West and Central Africa reiterates its full support to governments and other partners for the development and scaling up of adolescents and youth programmes in all countries within the region.

Together, let's make a world where every pregnancy is wanted, every birth is safe, and the potential of every young person is fulfilled.

Mabingue Ngom
Regional Director of
UNFPA for the region
West and Central Africa

Executive Summary

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International research on adolescent and youth sexual and reproductive health and rights (AYSRHR) services has demonstrated what is effective (comprehensive sexuality education (CSE) and AYSRHR friendly services) and should be scaled up, and what is not (youth centres, peer education and one-off public meetings). **Nevertheless, some interventions considered less effective continue to be implemented** and receive financing**. Proven interventions tend not to be scaled up** (for example, CSE and integrated services) often due to the high costs and the time required for scale up. A lack of prioritization and resources also affects the scale-up of effective interventions, as well as the quality of their implementation in the long term.

At the global level, several partners are working to share and disseminate the evidence base on adolescent and youth health, for example, through the

UNFPA will support countries, based on needs and resources, to:

- analyse key technical considerations
- develop a national scaling up plan for AYSRHR services
- mobilize human and financial resources

Accelerated Action for the Health of Adolescents (AA-HA) guidelines.[1] What is now needed is to improve planning and implementation at the national level. The United Nations Population Fund (UNFPA) is well placed to support countries in their analysis of the situation, identifying priorities and developing costed action plans based on proven interventions. Three key areas – technical considerations, creating demand and an enabling environment – need to be addressed to facilitate the provision and scale-up of AYSRHR services.

Technical considerations

Although the countries in the review have policies, strategies and plans that cover adolescents and youth, none have a costed implementation plan for scaling up AYSRHR services that details the necessary actions and the timeline and order in which actions need to be implemented. Countries tend to implement interventions from their strategies based on the financial resources at their disposal. As most of this funding comes from technical and financial partners (TFPs), it is dependent on their interests and geographic priorities, which affects the country's ability to implement a comprehensive response in the short, medium and long term.

The development of an implementation and scale-up plan requires decisions on, for example, the type and mix of service delivery points (SDPs) to be prioritized; the minimum package of services for each type of SDP; the selection of providers for specific services, how they will be held accountable and how they will be trained; and when and how to start, among others. The plan should include at a minimum the recommended methodology and strategies (including for monitoring and evaluation); an analysis of the processes required for progressive implementation; objectives; roles and responsibilities of all stakeholders and the most appropriate coordination and collaboration mechanisms; a description of the actions required at the national, provincial/district and operational levels; an estimate of costs and current available funding; and possible resource mobilization strategies.

All four countries reviewed provide services through a combination of different SDP models and all advocate for the integration of AYSRHR services into public health structures. Currently, the capacity of health facilities to provide quality AYSRHR services is low in all countries reviewed. The package of services differs depending on the SDP model and its level within the health sector (primary health care, district hospital, etc.). Each country will therefore need to develop a minimum package of activities to be implemented at each level and for each SDP model. Given that needs change and a single model is not effective, the package of services must be adapted based on age and sex, among others, which is not always the case.

The package of services, implementation requirements and the combination of SDP models to be prioritized will have an

impact on the scale-up. The integration of AYSRHR services into existing facilities may require health facilities to reorganize, as it will impact the workload of providers. This in turn could impact wait times and the quality of services if staffing levels are not adapted to the need. The identification of providers (midwife, nurse, community health workers (CHWs)) and the services for which they are responsible (all services, provision of contraceptives/family planning only, ante- and postnatal care, gender-based violence (GBV)) is necessary, as this clarification makes it possible to identify human resource needs and to know which staff to train, how to deliver training and for which services.

Norms and standards should be developed or revised by type of SDP to ensure quality services and enable monitoring and evaluation. This should include standards for infrastructure, transport, equipment and technology, medicines and commodities (including contraceptives), as well as human resource requirements, among others. Standards should also define the skills and attitudes required by providers. In addition, decision-making support tools for providers on AYSRHR should be reviewed or developed and disseminated. Three of the four countries in the review and most countries in the region have developed standards for AYSRHR or health services adapted to adolescents and youth. However, implementation is often piecemeal or incomplete, often reduced to dissemination or with very little training and support for providers. In addition, some standards were developed several years ago and may no longer be aligned to the most recent World Health Organization (WHO) guidelines.

All staff in contact with adolescents and youth should be trained, although the content of the training will depend on their roles and responsibilities. Since the number of people to be trained depends on the combination and number of SDPs as well as the package of services and its integration, training could be a factor that influences strategic decisions on scaling up. Training should not only develop skills, knowledge and abilities, but also include values clarification as a methodology to change negative attitudes. Pre- and in-service training is necessary to reach all providers. Although integrating AYSRHR into pre-service training will take longer to implement, it is more cost-effective in the medium and long term. None of the countries in the review have integrated AYSRHR into their pre-service training programmes; all rely on in-service training. Supervision and support to providers, although demonstrated as essential, have been identified as a weakness in many countries.

Improving access to and use of AYSRHR services depends not only on improving service delivery, but also on the context in which adolescents and youth live and interact. It is therefore essential to also create demand, provide adolescents and youth with information and knowledge, and change attitudes and behaviours (for example, on gender inequalities, sociocultural barriers, of parents so that they recognize the merits of children accessing services, and to reduce preconceptions about contraceptives and their side effects).

Social and behavioural change communication (SBCC) activities are implemented in all the countries reviewed. The *C'est la Vie!* [That's Life!] project, which is active at the regional level and in some countries, contributes to SBCC campaigns. However, none of the countries in the review are currently implementing a national SBCC campaign.

The provision and scale-up of AYSRHR services will result in an increased demand not only for equipment and technology, but also for condoms, other contraceptives and medicines. All the countries in the review and several in the region report weaknesses in the functionality of their supply chain, resulting in disruptions.

Monitoring and evaluation is an important component to support the provision and scale-up of AYSRHR services, as it enables interventions to be adapted and improved according to the findings. Depending on the country, some data are collected at different levels, though these data are often not transferred to the national level or analysed. All the countries in the review and many in the region report weaknesses in their monitoring and evaluation systems and a lack of data disaggregated by age, sex, marital status and other indicators. This lack of data is particularly marked for adolescents aged 10–14 years and unmarried adolescents.

Demand creation

Meaningful 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 the countries in the review have youth organizations that are active in AYSRHR whether through peer educators or advocacy groups. Nevertheless, this sector is more developed in some countries, such as Senegal, than in others.

All countries in the review are implementing adolescent and youth empowerment projects. These projects are often coupled with AYSRHR awareness activities. Youth centres are present in all countries reviewed, with most training peer educators and implementing and different types of activities. However, global experience shows that "youth centres, peer education and one-off public meetings have generally been ineffective in facilitating young people's access to AYSRHR services".[2] The allocation of funds for youth centres to improve the use of AYSRHR services should therefore be discontinued. However, in countries that have received significant human and financial investments, these centres could be repurposed. Lessons learned from providing AYSRHR services in youth centres should be identified and shared, and any effective components integrated into AYSRHR service provision. Where youth centres are well established, it is crucial to critically examine the clientele they are serving, discuss a plan for phasing-out the youth centre and ensure that services are available in another accessible SDP.

Research has demonstrated that awareness alone of AYSRHR is insufficient and that quality CSE is needed. No country reviewed has a nationally scaled-up CSE programme in- and out-of-school. Of the four countries, Senegal is the most advanced. Currently, most Governments in the region have neither the human nor the financial resources to scale up CSE nationally.

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Governments and non-governmental organizations (NGOs) are increasingly using information and communication technologies (ICTs) to reach young people not only 'physically' but also through a 'language' that they understand and with which they can identify. Many countries in the region have free telephone hotlines on AYSRHR, for at-risk children or those experiencing GBV. Other ICTs, such as those that are web-based or use social networks, are successfully used in several countries by youth organizations and NGOs (very few government projects use social networks).

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. All countries in the review have initiated activities with religious and community leaders. Other strategies such as community mobilization, parent-child communication programmes, as well as training of influential community members in advocacy and communication on AYSRHR are needed and are being implemented in the region.

Information on the package of services offered and where to access it is essential to increase service utilization. Information can be disseminated through national information education and communication/social behaviour change communication (IEC/SBCC) campaigns, integration into in- and out-of-school CSE (for example, information on SDPs and a referral system to services) and other activities. School clubs, present in the four countries reviewed, are often used to convey information and organize awareness-raising events, sometimes with the support of local health providers. Peer educators often

work in the community, youth centres and schools. ICTs are also used to disseminate information and are an effective and inexpensive mechanism. Different countries in the region are experimenting with activities to strengthen links between the different sectors (such as education and health) in order to increase demand.

Creating an enabling environment

Government ownership and leadership are essential for the provision and scale-up of AYSRHR services. Depending on the country context, this may require changes in policy, laws and budgets that are impossible without high-level leadership. Leadership and ownership are also needed at the provincial/district and operational levels. Although the political will is present in all countries reviewed, it has not always translated into concrete actions.

All countries in the review have either a division, unit or section on adolescent health or a unit more specifically focused on AYSRHR. Most of these units are placed under the aegis of a Directorate of Reproductive Health, Maternal and Child Health or Family Planning. 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 for the integration of AYSRHR services into public health structures.

An enabling legal and policy environment is crucial for the provision and scale-up of AYSRHR services. Some laws may hinder or support the provision 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 or policy establishes the rights of adolescents and youth to AYSRHR services.

Most of the countries in the review have a legal framework that is conducive to scaling up AYSRHR services. However, in all countries there is a lack of harmonization between legislation and policy, a lack of implementing decrees and insufficient knowledge and enforcement of laws and legal texts, which in turn affects implementation.

AYSRHR requires a multisectoral response. Intra- and intersectoral coordination and collaboration with non-governmental partners (at all levels – national, regional/district and operational) are therefore essential for scale-up. The review noted weaknesses in coordination and collaboration in each country, often due to the complexity and number of stakeholders working on CSE and AYSRHR, and in some cases, the responsible unit's lack of authority, mandate, resources, capacity and/or skills to lead coordination.

Within the United Nations system, several mechanisms exist to improve coordination and collaboration, such as One United Nations and the United Nations Development Assistance Framework (UNDAF). The French Muskoka Fund (Fonds Français Muskoka – FFM), through its inter-agency coordination and collaboration mechanism, offers a concrete example of how to improve planning and implementation and increase synergy. However, the recent increase in attention on adolescents and youth still requires the formalization of a clear division of labour

and increased complementarity of activities to ensure that there are no overlaps and that geographic coverage is equitable. Better coordination and collaboration within the United Nations system, other partners and Government would allow resources to be pooled to support the scale up of effective interventions, rather than the current status quo of piecemeal implementation.

Each country in the review implements interventions to improve access to and use of quality AYSRHR services. However, none of the countries have achieved a national scale-up, with most requiring technical and financial support from TFPs. UNFPA has a long history of working on AYSRHR and continues to strengthen its interventions and support to Governments in this area. UNFPA, in coordination with other United Nations organizations and TFPs in each country, has a major role to play.

UNFPA will support countries through technical assistance and use its close working relationships with different sectors and stakeholders (Government, non-governmental, TFPs) to create multisectoral linkages. The priorities and recommendations identified in this report are too many for UNFPA's resources, especially since it already implements several key interventions that are not mentioned here. Country offices will therefore have to decide on their priorities based on UNFPA's comparative advantage and the priorities of the Government and other TFPs.

Each office should review (if it has not already done so) its AYSRHR activities to ensure that they are aligned to the latest global evidence of what does and does not work in order to improve the sexual and reproductive health of adolescent and youth, while taking into account the mandate and activities of other organizations. This would not require a major evaluation of all projects, but rather a review of activities, objectives of the country's programme and an assessment of whether these activities will achieve the objectives, and if not, which interventions could be more cost-effective. This is particularly important given the current global context where financial resources for AYSRHR and HIV and AIDS are shrinking. Research has shown the importance of faithfully implementing and scaling up proven strategies. Unfortunately, the considerable resources required for implementation means that scale-up of activities is rarely carried out with fidelity. This situation should be taken into account when developing or revising country programmes.

1

Introduction

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Objectives and methodology

At the end of 2017, the United Nations Population Fund (UNFPA) undertook four missions in Chad, Guinea, Senegal and Togo to document the process of providing and scaling up sexual and reproductive health and rights (SRHR) services adapted to the needs of adolescents and youth[3] in West and Central Africa. The objectives of the missions were to record the status of adolescent and youth sexual and reproductive health and rights (AYSRHR) service delivery within the context of the French Muskoka Fund (Fonds Français Muskoka – FFM), as well as the activities carried out by the UNFPA regional office on AYSRHR and comprehensive sexuality education (CSE), reviewing and documenting processes, activities, results achieved and promising practices in terms of advocacy, programme development, institutionalization, implementation and scaling up of services.

Specific objectives included analysing, evaluating and documenting key implementation milestones, results achieved, promising practices and challenges identified and overcome, in order to propose recommendations and share lessons learned with other countries in the region. The missions were conducted in three stages:

1. Literature review – Analysis of information and communication documents developed in the country; analysis of national policies and strategies; documentation of specific projects; review of national and international research; and documentation on scaling up interventions to improve access to and quality of AYSRHR services. This review enabled an analysis of the implementation and scaling-up strategies used, the actions carried out and their results, which in turn facilitated the development of research questions and the identification of priorities for the field visits.

2. Field visit during September, October and November 2017 – Key partners were interviewed individually and in groups to collect qualitative data (see country reports for a full list of individuals interviewed).

3. Analysis of the information collected and development of reports for each country.

This regional report, based on the four countries, develops a regional synthesis, which brings together the main results, promising practices, challenges and key recommendations on the different stages of developing and scaling up AYSRHR services. This documentation will be made available to countries in the region and will serve as a basis for the development of UNFPA technical support. In addition to this report, four country reports have been developed and are available. In 2017, UNFPA undertook a similar exercise on the implementation and scaling up of CSE programmes. These two regional reports are therefore complementary.

This report is divided into several chapters. Chapter 2 discusses the context and summarizes the existing evidence base on AYSRHR services, while chapter 3 analyses the essential elements of implementation and identifies promising practices and recommendations to support scale-up. The report concludes with recommendations for UNFPA on short- and medium-term priorities.

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2

Context

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2.1 The sexual and reproductive health of adolescents and youth in the region

In West and Central Africa, 64 per cent of the population[4] is below the age of 24 years. 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 adolescent and youth SRHR in the region, which is characterized by high rates of adolescent pregnancies and a high proportion of unmet family planning needs.

- Among adolescents, 9 in 10 births are the result of child marriage.[5]

- West and Central Africa has the largest percentage (28 per cent) of women aged 20–24 years who reported a birth before 18 years of age.[6]
- The region accounts for the largest percentage (6 per cent) of reported births before 15 years of age.[7]
- Compared with other age groups, adolescents have the lowest contraceptive prevalence rate (21 per cent for the 15–19 age group against 64 per cent for the 35–39 age group) and the highest rate in unmet family planning needs (25 per cent for the 15–19 age group against 14 per cent for the 35–39 age group).[8]

In this context, AYSRHR remains a societal and public health priority more than anywhere else, with a focus on ensuring that young people develop their full potential and that the demographic dividend is captured. The impact of these statistics is reflected in the education sector, through absenteeism, drop-outs, as well as a decline in the quality of education for young people. This in turn impacts the world of work, reducing opportunities and options for young people.

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 CSE and ensure access to quality AYSRHR services.

2.2 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. More specific to the region, the Evidence to Action Project (E2A) is currently conducting a study, in collaboration with the Government, on the provision of AYSRHR services in Senegal. International research highlights, among other things, that:[9]

- training of AYSRHR service providers without proving 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, among others (for example, the needs of a 15–19-year-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 needs to be strengthened among young people, providers, parents, guardians and religious and community leaders
- the early adolescent age group (10–14 years) is very difficult to reach and requires targeting (this is also the age group that has the least reliable data, particularly with regards to SRHR)
- ideally, AYSRHR requires non-judgmental, friendly, welcoming and attractive health facilities, but this is not always the case.

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.[10] Gender inequalities affect young people's ability to make and maintain healthy decisions (for example, it is particularly difficult for young adolescent girls to access and use SRHR services and to demand respect for their rights). To improve access to and use of AYSRHR services, gender inequalities must therefore be addressed, taking into account beliefs, attitudes and norms.

Young people's participation in the development, implementation, evaluation and advocacy of AYSRHR interventions improves their effectiveness, as different approaches are needed to meet the needs of all adolescents and young people. The needs of a 14-year-old girl are very different to those of a 25-year-old woman, and adolescents often have less access to health services that are provided for the general population.

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	×	

A review of the evidence highlights 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.[11]

The authors of the review note that approaches that have proven effective, such as CSE and services adapted to young people's needs, tend not to be scaled up because of the considerable implementation requirements that are rarely met (such as human and financial resources). They conclude that for AYSRHR programmes to be effective, a major effort is required to implement coordinated and complementary interventions and strategies, abandon proven ineffective approaches and implement and scale up successful approaches 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.[12]

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. Others, such as youth centres, have received significant human and financial investments in some countries

and may have been scaled up. Rather than abandoning these, a discussion on how to adapt them for alternative purposes should be initiated. Lessons learned from providing AYSRHR services in youth centres should be identified and shared, with any effective components integrated into AYSRHR service provision. Where youth centres are well established, it is crucial to critically examine the clientele they are serving, discuss a plan for phasing-out the youth centre and ensure that services are available in another accessible service delivery point (SDP).

2.3 Scaling up

Many pilot and small-scale programmes in different countries have proven that improving access to and the quality of AYSRHR services will have a positive impact on young people's SRHR. It is now time to ensure that all adolescents and youth benefit from such services. The question is therefore how can quality AYSRHR services be provided to all adolescents and youth in a country? The answer to this question lies in scaling up.

The World Health Organization (WHO) and ExpandNet define scaling up as "deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and programme development on a lasting basis".[13]

According to ExpandNet, 'deliberate efforts' mark scaling up as a guided process (in contrast to the spontaneous diffusion of innovations), while 'policy and programme development on a lasting basis' stresses the importance of institutional capacity-building and sustainability.

ExpandNet identifies two key types of scaling up:

- vertical, which institutionalizes the process through policy, political, legal, budgetary or other health systems change
- horizontal, which scales up through expansion or replication.

Both types of scaling up are necessary to integrate interventions within the systems of relevant ministries and non-governmental providers, thus ensuring the sustainability of AYSRHR services, as well as their provision throughout the country and for all target populations.

ExpandNet identifies four guiding principles for the scaling-up process:

- systems thinking
- a focus on sustainability
- enhancing scalability
- respect for human rights, equity and gender perspectives.

Chapter 3 identifies the key elements for implementing and scaling up the provision of AYSRHR services in a country. It also identifies the specific characteristics of the region, along with some promising practices and lessons learned before building on country experiences to put forward recommendations for countries attempting to scale up AYSRHR services.

3

Key Elements for the Provision and Scale-Up of AYSRHR Services

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The documentation process in the four countries (Chad, Guinea, Senegal and Togo), as well as a review of the global evidence base, has uncovered a number of key elements for effective implementation and scale-up of AYSRHR services. To date, none of countries reviewed have scaled up AYSRHR services at the national level and all are at different stages of the process. Nevertheless, some promising practices, challenges and recommendations can be drawn from their experiences. The synthesis identified several key elements, some of which can be grouped under technical considerations, while others address the need for demand creation and enabling environments. Other aspects such as financing a scale-up are not addressed in the context of this report but are nevertheless important. The key elements are analysed in this chapter.

3.1 Technical considerations

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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3.1.1 Defining priorities and developing a costed implementation plan

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 a stand-alone or part of a national SRHR plan, an adolescent health and well-being plan, or as is becoming increasingly common, a reproductive, maternal, neonatal, child and adolescent health (RMNCAH) plan.

The first step is a situation analysis of the state of adolescent health, existing services and their usage. This analysis will influence policy and programmatic priorities and should include, among other things, a review of the national and international literature and evidence base; a mapping of existing stakeholders, services and SDPs; the burden of disease; the number of people to be reached and their geographical location; an analysis of barriers; and the development of indicators (such as desired health outcomes). Ideally, the data in the analysis are disaggregated by sex, age, education level, marital or relationship status, place of residence, wealth quintile, living conditions and other key socioeconomic factors. This would allow needs to be identified according to geographical context and/or for target groups, thus enabling priority setting. This disaggregation is rarely available but should not act as an obstacle to the development of an implementation plan. The analysis will also need to include an assessment of pre- and in-service training needs, a review of all existing AYSRHR standards and guidelines and an analysis of the acceptability of AYSRHR services to parents, communities and religious and community leaders.

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).

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The development of an implementation and scale-up plan requires decisions on, for example, type and mix of SDPs to be used; a minimum package of services for each type of SDP; the selection of providers for specific services, how they will be held accountable and how they will be trained; and when and how to start, among others. The plan should include at a minimum the recommended methodology and strategies (including for monitoring and evaluation); an analysis of the processes required for progressive implementation; objectives; roles and responsibilities of all stakeholders and the most appropriate coordination and collaboration mechanisms; a description of the actions required at the national, provincial/district and operational levels; an estimate of costs and current available funding; and possible resource mobilization strategies.

None of the countries visited have a detailed and costed implementation plan for scaling up AYSRHR services. Nevertheless, various plans, strategies and policies exist, which form the basis for implementing interventions in the countries. AYSRHR does not necessarily require its own action plan, but at a minimum must be integrated into another plan, such as an RMNCAH plan, and costed. In Guinea, several documents exist that cover young people, including the Adolescent and Youth Strategic Health and Development Plan for 2015–2019, the National Repositioning Family Planning Action Plan for 2014–2018 and the National RMNCAH Strategic Plan for 2016–2020. The costing of the RMNCAH plan is under way. Senegal developed a National Strategic Plan for AYSRHR (2014–2018) and a Reproductive Health Action Plan for 2012–2015 (Plan

d'action national de Planification Familiale 2012–2015). In Togo, there is a Strategic Plan for Adolescent and Youth Health (2008–2012), though no action plan was developed. A costing exercise was planned for 2017 but has been put on hold as the country has decided to integrate young people's health into the RMNCAH plan, which is currently being developed. Chad does not have a plan or strategy specifically targeting AYSRHR. Family planning policies and standards (2014) and a road map on maternal and child health (which expired in 2016 and has not yet been revised) partially cover young people.

3.1.2 Service delivery points

The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.[14]

Standard 5 WHO/UNAIDS – Facility characteristics

Different models for the delivery of AYSRHR services exist and are being implemented in the region, including those for health, school and community settings. Each model has its advantages and disadvantages. **The combination of SDPs to be used will vary depending on the district, needs, existing facilities and available human and financial resources**. It is likely that any scaling up will require progressive implementation, and the models to be used will depend on needs, the feasibility of scaling up the different SDP models and their long-term sustainability.

The following pages describe the different types of SDP that can be used to provide AYSRHR services and highlights some considerations that can affect which ones to select. The description of the models, i.e. their advantages and disadvantages, the feasibility of scaling up and sustainability, is taken and adapted from a document developed by E2A,[15] *Thinking outside the separate space: A Decision-Making Tool for Designing Youth-Friendly Services*.[16]

The E2A Project initiated a study in collaboration with the Ministry of Health on AYSRHR services in Senegal. The study uses quantitative and qualitative methods to:

1. Examine the characteristics that influence a scale-up of existing adolescent and youth-friendly SDP models.

2. Identify factors that promote or hinder the quality of these services, including the extent to which national standards are applied.

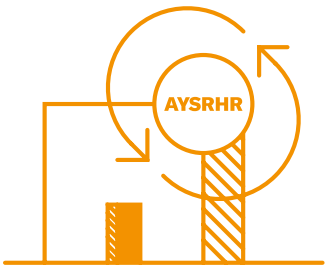
3. Assess the factors that influence the use of services by adolescents and youth, including accessibility, acceptability and ensuring equity of services.

4. Develop recommendations and practical advice for the implementation of the service delivery elements of the National Strategic Plan for AYSRHR (2014–2018).

Although the study focuses on Senegal, the lessons learned could be applied to other countries.

Scaling up AYSRHR services requires the use of a combination of SDP models.

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.
Advantages	→ **Faster to scale up as the infrastructure is already in place.** → Improves access equality. → No additional infrastructure costs. → Can be implemented at all levels of the health system.
Disadvantages	→ Mixes young people and adults, which can act as a barrier. Less confidentiality. → Already overstretched human and financial resources can lead to poor service provision. → Requires a reorganization of services within facilities and changes to facilities' management (e.g. increased demand and services will impact on wait times), as well as changes to opening schedules to ensure better use by young people. → Need to **train, supervise and support all** health facility **staff**. → Success depends on an effective system for provider supervision and support.
Scale up	→ **High potential** (but yet to be demonstrated). → **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. (Potential for economies of scale to occur.)
Sustainability	→ **High potential** (but yet to be demonstrated). → **High probability of sustainability if institutionalized and faithfully implemented.** → Costs will decrease over time.
Recommendations	HIGHLY RECOMMENDED AND A PRIORITY TO ENSURE LONG-TERM SUSTAINABILITY → This model is one of the longest to implement but has great potential. → Planning is necessary in the short, medium and long term. Other SDP models will need to be used in the short and medium term pending the scale-up of this model.

Separate adolescent and youth spaces in public or private health facilities

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.

Advantages

→ **Less stigmatization.**
→ **More confidentiality.**
→ Fewer providers to train, supervise and support.
→ Opening hours can be adapted to young people's needs.
→ Can be implemented at all levels of the health system.
→ 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

→ **This option is scalable but requires significant resources** (dedicated HHR and space/infrastructure).

Sustainability

Sustainable only if institutionalized in the health system and if there are sufficient HHR.

The dependence on available space and dedicated providers means that services may cease when trained providers leave or the project ends.

Recommendations

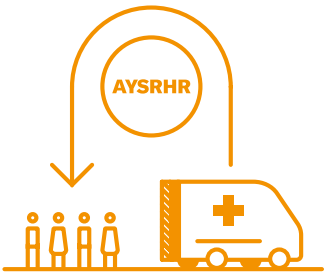
OPTION TO EXPAND ACCESS, DEPENDING ON THE CONTEXT

(If space is available or can be easily integrated into new facilities, HHR and demand permitting, etc.).

Community-based services

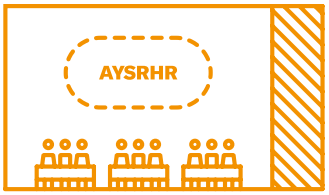
SDP model	These services are administered by community health workers (CHWs).
Advantages	→ Increases accessibility for a large number of young people. → Condom distribution and counselling/IEC. → Distribution of contraceptives (in some countries only for prescription refills, in others CHWs may offer contraceptive methods such as the pill). → This option can be complimentary to the integrated or mainstreamed SDP model.
Disadvantages	→ Little privacy or confidentiality. → Fear of the negative attitude of providers who are often members of the community. → Services for young people usually restricted to IEC and condom distribution. → Strong demand from other clients is likely to affect the quality of services provided to young people. → Recurrent supply chain problems.
Scale up	**Scale-up depends on a budget allocation or a donor.** Implementation difficulties such as the high turnover of CHWs limit the possibility of a scale-up.
Sustainability	**Sustainability is only possible if the model is institutionalized in the health system** (e.g. the position of CHW is established and staff are paid by the State).
Recommendations	OPTION TO EXPAND ACCESS, BUT THE PACKAGE OF SERVICES OFFERED WILL BE INCOMPLETE

Mobile services



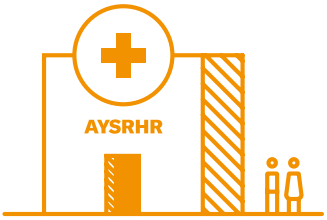
SDP model	Full range of services offered in a specially equipped van; satellite centres (full range of services offered in a tent); services offered by a mobile team of health workers in a lower level health facility, such as a clinic, which usually does not offer these services; and other community outreach events (vaccination days, maternal and child health days). Services are provided by health professionals.
Advantages	→ Can reach isolated communities. → Accessible to a large number of young people (if during a period when they are in the community – after school, holidays, etc.) → Can have an impact on contraceptive use and screening.
Disadvantages	→ **Little privacy.** → Mixes young people and adults, which can act as a barrier. → Need to train, supervise and support all staff. → Strong demand from other clients is likely to affect the quality of services provided to young people. → Mobile clinics are often held during school hours. → **Mobile clinics do not return regularly to the community.** → Requires promotional activities to improve use. → Depending on the country context, there may be fewer services available than a static SDP. → **More expensive to implement.**
Scale up	→ 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 through cost-recovery mechanisms).
Sustainability	→ **The need for significant resources reduces the potential for sustainability** (in a context of limited resources).
Recommendations	OPTION TO EXPAND ACCESS AT LEAST IN THE SHORT AND MEDIUM TERM

School/university infirmaries



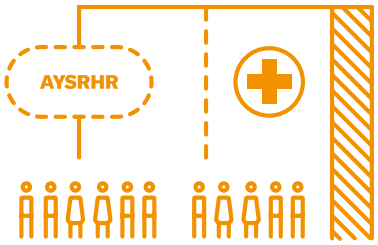
SDP model	Health and education services provided within a school or university infirmary.
Advantages	→ **Less stigmatization.** → **More confidentiality.** → Provider attitudes and the quality of services offered may be better. → Opening hours can be adapted to young people's needs. → Services are free of charge. → Can increase contraceptive use. → Easier to connect CSE to AYSRHR services.
Disadvantages	→ Low numbers of school infirmaries in most countries in the region make a national scale-up difficult. → Most school health programmes are not adequately funded. → School infirmaries **are often not fully functional.** → Requires dedicated and trained staff. → The services offered may depend on the decisions of the Ministry of Education.
Scale up	→ **Scale-up depends on the number and quality of the existing infrastructure and staff.**
Sustainability	→ This model can be sustainable **if institutionalized in the health and education systems, and if sufficient human and financial resources are allocated.**
Recommendations	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). It should be noted that school health programmes have great potential to increase access and usage of AYSRHR services even in the absence of a school infirmary (e.g. through CSE and referrals to AYSRHR services).

Stand-alone clinic



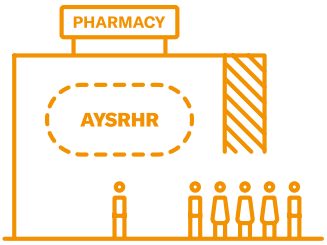
SDP model	Dedicated services for young people. This model is often used by the private sector, including NGOs or other private providers, although in some countries it has been implemented by the public sector. This model sometimes has peer educators or counsellors on site, and promotion of the services on offer can be conducted in the catchment area.
Advantages	→ **Less stigmatization.** → **More confidentiality.** → Better attitude of providers and quality of services. → Flexible opening hours. → To improve utilization, **services are generally free of charge** for young people or at minimal cost.
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	Requires a lot of resources and is usually **successful only in urban areas with a high demographic density.**
Sustainability	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 area with high demand, it can be financially self-sufficient.**
Recommendations	OPTION TO EXPAND ACCESS IN THE SHORT AND MEDIUM TERM Can be a long-term option if financially sustainable, but this is unlikely outside of high-density urban areas.

Social franchising



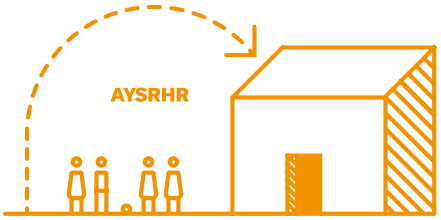
SDP model	Social franchising is a network of providers/health facilities bound by a contractual agreement to provide services under a common brand/name with certain quality standards maintained. Support can come from the private sector, the public sector or a combination of both. A social franchise can be a stand-alone facility, a separate space or integrated into existing services.
Advantages	→ **Less stigmatization**. → **More confidentiality.** → Fewer providers to train, supervise and support. → Opening hours can be adapted to young people's needs. → Can be linked to social marketing products such as condoms and demand creation, which can be mutually reinforcing.
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	This model can be complementary as it often uses existing infrastructure and HHR. But these SDPs are **rarely in rural or sparsely populated areas and are therefore difficult to scale up nationally.**
Sustainability	**If the facility receives payment for services and is located in an urban area with high demand, it can be financially self-sufficient.**
Recommendations	OPTION TO EXPAND ACCESS IN THE SHORT AND MEDIUM TERM → Can be a long-term option if financially sustainable, but this is likely to be limited to urban areas with a high demographic density.

Pharmacies



SDP model	Staff provide counselling and basic sexual and reproductive health commodities or services (e.g. condoms, other contraceptives, emergency contraception, treatment for STIs).
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. → The provision of services is limited by the time available (if there are many clients, the provider is unlikely to take the time to explain in detail).
Scale up	→ **Scalability depends on the coverage and strength of the existing network of pharmacies and resources to ensure quality and ongoing support to the network.**
Sustainability	→ High turnover and high mobility/informality in the pharmaceutical sector would make this option difficult to sustain.
Recommendations	OPTION TO EXPAND ACCESS IN THE SHORT AND MEDIUM TERM (BUT DIFFICULT TO IMPLEMENT).

Youth centres



SDP model	Youth centres are recreational and/or vocational training facilities. They may have a room or space where health workers provide clinical services (preventive or basic), advice, counselling or referrals to other services. Sometimes, these can be a centre (play area, computer room) located within the confines of a health facility.
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. Often used by youth (most often male), who could access services through a different SDP. → **Not cost-effective, with a high cost per service provided.** → **Difficult to scale up nationally.**
Scale up	**Very difficult to implement on a national scale.**
Sustainability	**Ineffective and expensive.**
Recommendations	**AVOID** IF ALREADY IN PLACE, A DISCUSSION ON HOW TO ADAPT THE SPACE FOR ALTERNATIVE PURPOSES SHOULD BE INITIATED.

Note: Adapted from 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/Pathfinder International, 2015).

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Scaling up services while guaranteeing a certain equality of access will only be possible through a combination of models adapted to the local context. Since the speed at which different models become fully operational differs, action plans must plan for the short, medium and long term.

Very few countries in Africa have managed to scale up AYSRHR services at the national level, while ensuring they are aligned to the WHO global standards.[17] Ethiopia (see box) is an example of a country that has had some success with support from different stakeholders. The country has integrated AYSRHR services, rapidly increasing the number of SDPs offering such services, and has initiated a national scale-up. All four countries reviewed are using a combination of SDP models and advocate the integration of AYSRHR services into public health structures.

Currently, the capacity of health facilities to provide quality AYSRHR services is low in the four countries reviewed, and in some countries, NGOs run a large proportion of the facilities offering a comprehensive package of AYSRHR services. This could have an impact on the long-term sustainability of programmes if state ownership does not occur and if the cost of maintaining these facilities is not integrated into the State's budgetary allocation.

Scaling up integrated AYSRHR services – the Ethiopian experience

Ethiopia, with the technical and financial support of Pathfinder, John Snow, Inc. (JSI), the United States Agency for International Development (USAID) and the Korean International Cooperation Agency (KOICA), 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 be noted that the process was funded by donors, which enabled the initial expansion and the institutionalization.

To support stakeholder implementation and coordination, the programme established Regional AYSRHR Officer positions in four regions. These positions enabled, among other things, the strengthening of local stakeholders' capacities; learning exchanges between the different sites; the integration of AYSRHR into a formative supervision system (to improve the quality of the services offered); and facilitated the institutionalization of AYSRHR into regional workplans and budgets, thus ensuring long-term sustainability. To improve coordination and collaboration, quarterly meetings were held for district and regional health authorities, health facility staff and peer educators.

There were three main phases to the scaling up of AYSRHR services:

Initial phase (2006–2008)

- Learning exchange visit to Mozambique (to visit the Geração Biz [busy generation] programme, also run by Pathfinder).
- Consensus-building among key stakeholders on the process and key strategies for scaling up.
- Development of criteria for the selection of SDPs to provide AYSRHR services and the selection of 20 pilot sites.
- Development of a national AYSRHR strategy and standards and procedures for the implementation of AYSRHR services.
- Training of providers and peer educators.
- Implementation in 20 pilot sites.

Scaling up (2008–2014)

- Documentation and dissemination of lessons learned from implementation in the pilot SDPs.
- Development of a national provider training programme on AYSRHR and the establishment of a regional networks of trainers.

- Learning exchanges with pilot sites.
- Testing/piloting of new components to improve the AYSRHR package of services.
- Capacity-building of Government and other stakeholders to improve and intensify AYSRHR activities.
- Horizontal scale-up, with AYSRHR services provided in 248 SDPs.

Transition phase (2015–2016)

- Regional Health Offices use existing SDPs as models.
- Regional Health Offices organize training courses on AYSRHR.
- Development of a new national strategy on adolescent and youth health.
- The Regional Health Offices take on responsibility for the provision of AYSRHR services and the management of peer educators.

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 had 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.

Married adolescents and youth also benefit from a national programme, through which community health workers (CHWs) (35,000 in the country) distribute contraceptives. The existence of policies that support adolescents' access to contraceptives regardless of their marital status, the decentralization of implementation to the regions (planning and budgeting) and health information systems that collect and report relevant data are identified as key factors in the success of the family planning programme.

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).

Promising practice from the region:

In response to weaknesses in public services and in order to improve the quality of and access to AYSRHR services, several countries are developing partnerships between the public sector, the private sector, NGOs and TFPs. In Guinea, the Bleu Écoute centre (see box) combines the four sectors. In Senegal, the Division for School Health of the Ministry of Education has been piloting a partnership with Marie Stopes International (MSI) (an NGO) since the beginning of the 2017 school year to provide AYSRHR services in certain school infirmaries.

Bleu Écoute – a promising multisector partnership

Bleu Écoute is an independent centre dedicated to providing clinical and advisory services to young people. The centre is a partnership between:

- the Association Guinéenne pour le Bien-être Familial [Guinean Association for Family Welfare] (AGBEF), an NGO affiliated to International Planned Parenthood Federation (IPPF), which manages the centre
- the Bolloré Group, a private company that provides the premises (infrastructure) and covers maintenance and the salary of the centre's manager
- the Ministry of Health, which provides the staff (a doctor and a nurse), and
- UNFPA, which provides financing for commodities and equipment, and supports activities organized by the centre.

The centre offers a comprehensive package of services that includes counselling, testing, treatment, condoms and other contraceptive products. Services are offered at a minimal cost, which allows for some cost recovery (for example, the Jadelle implant is offered at GNF 10,000, the official price, while in hospitals the price can rise to GNF 150,000). In addition to the professional staff, the centre has a group of peer educators – the Mouvement d'Action des Jeunes (MAJ), which is present in most AGBEF structures – who carry out many activities to increase demand for services.

MAJ youth members lead discussions with young people, implement topic-specific awareness campaigns, advocate in the community, raise young people's awareness and refer young people to the centre for service delivery.

MAJ facilitators go door-to-door in the centre's catchment area to reach out-of-school young people. To implement campaigns, the centre works closely with the neighbourhood leaders. These Chiefs identify young people to support and facilitate the campaign. MAJ facilitators are also on duty at the centre where they use games and other activities to discuss AYSRHR with young people who come to use the services.

The centre and MAJ are very active on social networks. Several WhatsApp groups have been created, such as the one on responsible sexuality and rights. Ten young people manage the WhatsApp groups, and the Facebook page under the name *The Generation that Dares* is managed by the Bloggers Association of Guinea (ABLOGUI). Social networks are used to initiate discussions on different themes. On average, 20–30 participants are active during the debates. At the end of discussions, one of the centre's managers summarizes and highlights important messages.

The centre is located in the Blue Zone, a private campus/space for youth, whose membership is open to all at minimal cost. The Blue Zone is a project of the Bolloré Group, an international company specializing in transport and logistics, communication and electricity storage solutions. The Blue Zone was conceived as a space for the development of economic, cultural and sporting activities. It is powered by photovoltaic panels that ensure spaces are lit, supplied with drinking water and connected to the Internet. The campus includes sports facilities, a cinema, a meeting place and a theatre. MAJ youth and professionals from Bleu Écoute also implement awareness activities in the Blue Zone. In addition to access through the Blue Zone, a direct street entrance to Bleu Écoute allows non-members of the Blue Zone to use the clinic's services.

Although cost recovery is not sufficient to cover all the centre's costs, the partnership shares costs, which allows for some sustainability. Not only are the costs lower for each organization, but their contributions are in line with their mandates (UNFPA provides contraceptive products and the Ministry provides medical staff). However, as an independent centre, this model cannot be scaled up as it requires a high population density and private sector support.

The centre opened in early 2017 and has not yet been evaluated. Nevertheless, the centre notes that usage is increasing and that more girls than boys use the centre for contraceptives/family planning and STI diagnoses and treatment.

3.1.3 The package of services and its integration

The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.[18]

Standard 3 WHO/UNAIDS – Appropriate package of services

The package of services adapted to young people's needs will differ depending on the SDP model and the level at which it is offered. The package will be more comprehensive in a district/national hospital than at the community level and will depend on the infrastructure and staff in place. Each country should ensure that it defines and integrates into its defined minimum activity package the minimum package of services for young people that should be implemented at each level of the health system and for each SDP model. The AYSRHR service package will have to take into account the fact that adolescents and youth are not homogeneous, and neither are their needs. The package of AYSRHR services offered in health facilities and at higher levels should cover at a minimum education, prevention and counselling activities (such as CSE or STI/HIV, pregnancy, GBV, puberty, family planning); distribution of condoms and provision of contraceptive products; testing and treatment (for STIs and HIV, for example); and vaccinations, including the human papillomavirus (HPV) vaccination.

The package of services for young people, the support needed for its implementation, as well as the combination of SDP models recommended, will impact scale-up. Although the integration of AYSRHR services does not necessarily require a new structure or additional providers, good planning is needed. Integration could have some management implications, for example, requiring a reorganization of how a health facility provides services, as the additional services could impact the workload of providers. This in turn could impact client wait times and the quality of services provided if the workforce is not adapted to the need. The identification of providers (for example, midwife, nurse, CHW) and the services for which they are responsible (such as all services, contraceptives/family planning services only, pregnancy, GBV) is necessary, as this clarification makes it possible to identify human resource needs and to know which staff to train, when and on what content.

Other impacts include:

- infrastructure needs (for example, if the model of a separate space is selected, then a private space will need to be identified or built)
- the equipment and technology needed at each level of the health system
- commodities requirements, procurement, supply chain management and inventory management
- transportation needs.

The integration of AYSRHR services into an existing health facility and the services it offers can be achieved through training specifically appointed staff to provide all services for young people or by training all staff in AYSRHR services. The latter would require young people to see several providers as needed (for example, a midwife for pregnancy or a nurse for STI treatment). The option chosen will impact the health facility's management, the training of health personnel and waiting times, among others.

Young people's SRHR needs change, rendering a single model ineffective. The service package must be adapted to the young person's age, sex, marital status and other circumstances. The needs of a 15-19-year-old single adolescent girl differ dramatically from those of a married girl who wants to start a family. Early adolescence (10–14 years) is a poorly served group that requires particular targeting.

3.1.4 Development of standards and procedures for AYSRHR services

WHO and UNAIDS have developed global standards for quality adolescent health services. The purpose of these standards is to help countries implement a normative approach to improve the quality of adolescent and youth health services. These standards can be used as such or revised and adapted to the country context.

WHO/UNAIDS global standards for quality health-care services for adolescents

Standard 1	Adolescents' health literacy	The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Standard 2	Community support	The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.
Standard 3	Appropriate package of services	The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.
Standard 4	Providers' competencies	Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health-care providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.
Standard 5	Facility characteristics	The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
Standard 6	Equity and non-discrimination	The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
Standard 7	Data and quality improvement	The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.
Standard 8	Adolescents' participation	Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

Source: WHO and 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).

Ministries of Health are responsible for the development or updating of norms and standards for each type of SDP, which should include, among other things, infrastructure needs, transport, equipment, medicine and commodities (including contraceptives), as well as human resource needs. The establishment of standards is therefore closely linked to the development of a minimum package of services for young people and can be merged into a single document. The standards should also define the skills and attitudes needed by providers, such as understanding what makes adolescents and youth vulnerable, the services they need and how these services should be provided (for example, confidentially). In addition to operational norms, standards and procedures, decision support tools for providers on AYSRHR should be reviewed or developed. Once finalized, these documents should be disseminated to all SDPs, a training plan developed and implemented, and a system put in place for monitoring and evaluation, supervision and support.

The development of national standards and procedures ensures that all providers, whether public or non-governmental, know what they need to provide and their responsibilities in this regard. In addition, these documents establish criteria that allow for an assessment on the user-friendliness of services offered. Through such an evaluation, persistent gaps and problems can be identified and corrective measures determined. National standards can also be used to accredit (or even franchise) SDPs, which would help reduce barriers as facilities that are recognized as adolescent and youth-friendly will attract more clients.

Three of the four countries in the review and the majority of countries in the region have developed standards for AYSRHR or health services adapted to adolescents and youth. Nevertheless, implementation is often incomplete, in some cases restricted to document dissemination or with very little training or support for providers. In addition, some standards were developed several years ago and may no longer be in line with the most recent WHO guidelines.

Promising practice from the region: 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, as well as the treatment and management of common diseases and minor injuries and traumas. These activities and services include prevention and management of pregnancy; prevention, screening and treatment of STIs, HIV and AIDS; provision of condoms and other forms of contraception; information and counselling on puberty, infertility, GBV, harmful substances, accidents and child marriage; and vaccination against HPV

3.1.5 Provider training, supervision and support

Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health-care providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.[19]
Standard 4 WHO/UNAIDS – Providers' competencies

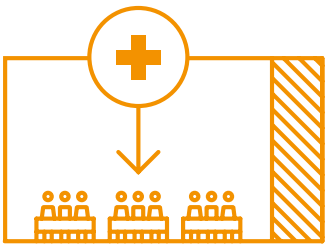
Countries' choices of which strategies to prioritize to provide and scale up AYSRHR services, as well as the package of services for each type of SDP, will affect the number and category of staff (midwife, nurse, CHW, doctor, supervisor, health information system manager, etc.) to be trained and the content of the training. All staff in contact with young people should be trained, although the content of the training depends on their individual role. Since the number of people to be trained is based on the SDP model and the service package and its integration, training could be a factor influencing the decisions on which implementation strategies to prioritize for a scale-up. Integration throughout the public health system would require almost all staff to be trained, which would be more expensive and time-consuming in the short term.

Since one of the greatest barriers to the use of services by young people is the negative attitude of some providers, their training requires not only the development of skills, knowledge and abilities, but should also include values clarification as a methodology to change negative attitudes. Providers must understand, among others, the principles of equity and respect for the rights of young people, including confidentiality. Training must therefore enable providers to identify their attitudes, beliefs, prejudices and negative judgments that could affect their interactions with young people, in order to break down taboos and obstacles to quality delivery.

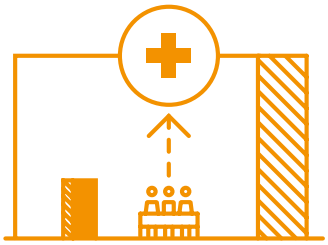
The high staff turnover rate in most countries leads to a constant need for training. To overcome this situation, the integration of adolescent and youth health into pre-service training is essential. Pre- and in-service training is therefore necessary to reach all providers. Each type of training has its advantages and disadvantages (see table below). The integration of adolescent and youth health (which includes SRHR) into pre-service training takes longer to implement but will be more cost-effective in the medium and long term. A large proportion of this content is already included in most basic training, although there is often a gap between national and international standards and curricula. Ideally, the content of pre-service training should be standardized for all training institutions, whether public or private.

In addition to training, providers will need terms of reference that make them specifically responsible for AYSRHR, formative supervision and support, continuous learning, and reference and decision-making

Advantages and disadvantages of different types of training



Type of training	Pre-service training
Advantages	→ More cost-effective. → Allows for more in-depth training. → Allows for long-term sustainability.
Disadvantages	→ Will affect the pre-service training programme curricula and schedules.
Decisions/ implications	Pre-service training may depend on another ministry (or the private sector), which requires coordination between ministries and can complicate or delay implementation. Several decisions will need to be made on the course and its content, such as whether it will be: → optional → a stand-alone course → integrated into other subjects → taught over the duration of the pre-service training programme or over a term, etc. In addition, a decision will be required as to what content will need to be integrated into which training (midwife, doctor, nurse, CHW, etc.).



Type of training	In-service training
Advantages	→ Essential to reach those already in service.
Disadvantages	→ More expensive and difficult to scale up (not sustainable). → Difficult to allocate sufficient time for quality training. → Training is often reduced to technical content, with little time allocated for attitudinal analysis.
Decisions/ implications	Some decisions on methodology will be required, i.e., who will train providers and how will they do so? Experience shows that knowledge of the medical aspect is not the only factor for a successful trainer. Good training skills are essential, and although cascade training is less costly, it is also less effective. **The choice of methodology for in-service training will therefore be dependent on the numbers to be trained and the funding available.**

In the long term, pre-service training is to be prioritized, although in-service training will always be necessary.

The two types of training must be implemented simultaneously. In the short term, in-service training will cover more staff, especially while the pre-service curricula are being revised and rolled out.

tools. Although the evidence base shows that ensuring providers are supervised and supported is essential for the provision of quality services, such supervision and support is weak in many countries. Supervisors often do not observe providers with young people, and as some do not themselves have a good understanding of AYSRHR, they cannot provide effective support and mentoring to providers. Supervision and support require the District Medical Officer, the District Management Team, the SRHR Focal Point and the Chief of the health facility to provide ongoing support. Training for these staff should therefore include a section on supervision and support. In addition, each country will need to identify possible activities through which to support providers. This could include establishing mechanisms within health facilities where providers could discuss the challenges of providing AYSRHR services and attempt to identify solutions. Ideally, to improve the quality of services provided and ensure accountability, AYSRHR should be included in the job descriptions of all providers who come into contact with young people.

In-service training of providers is taking place in all the countries reviewed, although no country was able to pinpoint the numbers trained, as the training is organized by different stakeholders (governmental and non-governmental). In many countries, different TFPs support the training of providers, each focusing on themes that are of particular interest to them. Better coordination would allow standardization, improve the quality of the content, and provide an opportunity for AYSRHR training to be integrated at a lower cost. This would also avoid duplication and ensure better geographical coverage. The four countries reviewed are far from achieving national coverage, and rural and hard-to-reach areas have received less training than their urban counterparts. No country reviewed had integrated AYSRHR into pre-service training programmes.

Through one of the components of the Sahel Women's Empowerment and Demographic Dividend (SWEDD) project, UNFPA is supporting the creation of regional centres of excellence for the pre-service training of midwives and the establishment of a midwifery degree. These centres are an opportunity to integrate adolescent and youth health into pre-service training.

Promising practice from the region: 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 implemented joint training sessions for providers and young people. Although this activity was not evaluated, the role-playing exercises and conversations allowed participants to observe and begin to understand each other's perspectives, difficulties and concerns. Role-playing allowed providers to train with young people who could provide them with feedback on their performance.

3.1.6 Social and behaviour change communication

Improving access to and use of AYSRHR services depends not only on the systems in place at the SDP, but also on the context in which adolescents and youth live and interact. Some young people have preconceptions about SRHR and may feel fear, shame or stigmatization. Community disapproval acts as a barrier not only to young people's access, but also to service delivery. Providers are often members of the community in which they work and live, with the societal constraints of that community.

The need to change attitudes is therefore essential. This includes, among others, the need to address gender inequalities, sociocultural barriers, the reasons why young people do not use services, preconceptions about contraceptives and their side effects, the ineffectiveness of focusing on abstinence (as demonstrated by the evidence base), and the need to involve parents in health and sexuality education.

A national information, education and communication (IEC) or social and behavioural change communication (SBCC) campaign can:

- begin to sensitize young people and their gatekeepers about AYSRHR
- contribute to making AYSRHR services acceptable
- begin to address gender inequalities in beliefs, attitudes and norms that have a major impact on SRHR, particularly for girls and women

National and local campaigns can be implemented on topics including: sexual and reproductive rights and existing laws, gender equality, HIV, the importance of providing SRHR services for health, and access to services. The priority topics will depend on the national context and the societal barriers to access and use of AYSRHR services that have been identified. Various media can be used, including radio, television (for example C'est la Vie! – see 3.2.3 for more details), billboards, mobile phones and other mHealth mechanisms, social networks, etc. Given the number of stakeholders that are active in this area (including NGOs and the private sector), coordination and collaboration are particularly important when developing and implementing an IEC/SBCC campaign. They will not only help ensure standardization and the quality of messages, but will also reduce the risk of gaps or duplication, thereby making the national campaign more effective.

In addition to a national campaign for adolescents and youth, their parents, guardians and community and religious leaders (see section 3.2.4 for more details on this target population), educational materials on AYSRHR should be developed for adolescents and youth and made available at the various SDPs and disseminated through awareness-raising activities.

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One size does not fit all – adapting the activities or message to the target population

Segmentation of the target populations using factors such as age, sex, marital status, adolescents, youth, parents, leaders, etc. is essential if effective messages and interventions are to be developed. This segmentation is therefore necessary for IEC/SBCC, demand-creation activities and the package of services.

3.1.7 Commodities and supply chain management

The provision and scale-up of AYSRHR services will result in an increased need for commodities such as technical equipment, contraceptive products including condoms, and medicines. Depending on which services are to be integrated and the speed of the scale-up, it will be necessary to establish a list of essential commodities and the quantities desired, and to determine whether existing funds will cover costs (taking into consideration the need for free or low cost services for young people, as cost is a major barrier to service usage). These additional requirements will need to be integrated into the national procurement plan and supply chain management systems.

All the countries in the review and many countries in the region report weaknesses in the functionality of their procurement, storage and distribution systems, resulting in stock-outs in SDPs. As a key partner for the supply of family planning products, UNFPA is working to reduce bottlenecks and deliver contraceptives at the last mile.

3.1.8 Monitoring and evaluation and data disaggregation

The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.[20]

Standard 7 WHO/UNAIDS – Data and quality improvement

Monitoring and evaluation is an important component of providing and scaling up AYSRHR services, allowing interventions to be adapted based on findings. It is performed at the national, provincial/district and SDP levels. Depending on the country, some data are collected at different levels, but the data are often neither transferred to the national level nor analysed. Monitoring and evaluation of inputs, costs, processes, outcomes and impact can help to analyse which strategies are effective in reaching the different subgroups and the most vulnerable. However, in many countries the lack of human and financial resources at all levels affects monitoring and evaluation.

All the countries in the review and many countries in the region report weaknesses in their monitoring and evaluation systems and a lack of data disaggregated by age, sex, education, marital status, location, wealth quintile, living conditions and other key socioeconomic factors that would allow for a more in-depth analysis of needs by geographical location and target subgroups. Data for some targets such as unmarried adolescents and youth, and especially adolescents aged 10–14 years, are particularly scarce and difficult to collect.

Although disaggregated data on young people and their transfer to the national level would enable better targeting and improve efficiency, it is important not to create a parallel system. Adolescent and youth-specific indicators, their collection and reporting should therefore be integrated into the existing health information system.

The lack of disaggregated data is a major obstacle to the provision of quality health services that respond to the needs of adolescents and youth, but should not be used as an excuse for inaction. Data on young people, even if insufficient, as well as data on the burden of disease in adults can be used to develop interventions. As disaggregated data would also be useful for advocacy towards policymakers, Ministries of Finance and TFPs for a greater allocation of resources, it is recommended that countries that are not already doing so initiate changes to ensure data are disaggregated.

3.2 Demand creation

3.2.1 Participation, awareness-raising and empowerment of adolescents and youth

Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.[21]
Standard 8 WHO/UNAIDS – Adolescents' participation

The participation of young people in all aspects of AYSRHR is essential. Global experience shows that adolescent and youth participation in the development, implementation and evaluation of, and advocacy for, AYSRHR improves the effectiveness of interventions. All the countries in the review have youth organizations that are active on SRHR and its advocacy, however most often they are represented by educated urban youth (with very few young adolescents). This group does not necessarily represent other adolescents and youth (for example, from poor rural areas) whose needs may differ substantially. A range of ages, sexes, contexts (urban and rural), educational levels, and socioeconomic levels, among other factors, is necessary to ensure that all adolescents and youth are represented.

Participation is more developed in some countries than in others. For example, Senegal has a number of organizations active in AYSRHR whose contributions range from running specific campaigns to participating in the development of the CSE programme.

Senegal: a dynamic civil society

Senegal has a number of organizations active in the field of AYSRHR that work independently and collaboratively. An example of effective collaboration was the partnership between Parole aux Jeunes [Young People's Voices], AfriYAN/Girls, Réseau des Jeunes en Population et Développement [Youth Population and Development Network], Mouvement d'Action des Jeunes [Youth Action Movement], Groupe pour l'Etude et l'Enseignement de la Population [Population Study and Teaching Group, GEEP], Sénégalaise Dreams, Réseau des Bloggeurs du Sénégal [Senegal Bloggers' Network], etc. These organizations launched a campaign in 2015 (Youth and Social Networks on Adolescent and Youth Reproductive Health) with the hashtags #FAGARU #JOTNA, meaning 'It's time to protect yourself'. The campaign used these hashtags to promote young people's sexual and reproductive health through articles, photos and videos. In 2015, an evaluation of the campaign showed that it had achieved its objectives: number of tweets, improved dialogue on AYSRHR, etc. The evaluation also noted the need to provide more information on how to access AYSRHR information and services.

Source: Maria Haapasalo. Study on the Social Media Campaign #Fagaru Jotna. Senegalese Youth/Sexual and Reproductive Health/Social Networks (UNFPA Senegal, 2014).

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Adolescent and youth empowerment helps create the skills and attitudes necessary for young people to make informed decisions about relationships, sex, their body, life, family and community. **All countries in the review implement empowerment projects**, whether through ministries (such as Youth, Women, Social Services, etc.) or through NGOs. These projects are often coupled with awareness-raising on SRHR. Youth centres[22] are present in all countries and most of them train peer educators and implement HIV/STI/pregnancy prevention activities, film screenings, talks, theatre, music and awareness-raising activities coupled with testing, entrepreneurship training, etc. However, research has shown that "Youth centers, peer education, and one-off public meetings have generally been ineffective in facilitating young people's access to sexual and reproductive health (SRH) services, changing their behaviors, or influencing social norms around adolescent SRH."[23] As a result, resources allocated to increase the usage of AYSRHR services should no longer be used to fund youth centres. However, in countries that have received significant human and financial investment, the centres could be repurposed.

TECHNIDEV – Empowering young people in Chad

TECHNIDEV uses a comprehensive approach to strive to empower adolescents and ensure their academic success. The entry point of the project is tutoring, into which reproductive health education has been integrated (to reduce the risk of the project being rejected, the organization does not use the term 'sexual'). The project builds on the synergy between education and reproductive health. Education is a protective factor, as a good understanding of reproductive health and the ability to make healthy decisions enable adolescents to protect themselves and reduce the risk of dropping out.

The organization works with secondary schools to create welcoming tutoring centres (within the schools) that are managed and run by a trained and paid facilitator. These multimedia centres are equipped with computers, Internet access, and teaching materials in both paper and digital formats, although the equipment differs depending on the centre/secondary school. The didactic materials cover the school curriculum as well as reproductive health education. In addition, in some centres that do not have permanent facilitators or Internet access, a system has been set up to allow students to contact a teacher directly to request academic support.

Additional training is offered to students on computer sciences and reproductive health, and student ambassadors are trained to become AYSRHR peer educators. Awareness sessions on topics such as early marriage and family planning are organized for students by their peers, to enable them to access information and request the AYSRHR services they need.

Training on subjects considered 'private' or 'sensitive' is provided by a woman (usually the school nurse) at the all-girls secondary school, where the centre's facilitator is a man. As early marriage is a subject that affects many young girls, this theme is used to address other SRHR issues. The peer educators from the all-girl secondary school have also taken it upon themselves to initiate discussions on early marriage in their own communities.

TECHNIDEV also trains teachers on the seven modules of the reproductive health learning materials. The one-day training teaches them how to integrate the content into their courses and they develop a road map for integrating the materials into their classes.

In the all-girls school, a comprehensive approach is in place and includes the provision of AYSRHR services through the school infirmary. Contraceptive equipment and supplies were provided by UNFPA.

The country's context (a high rate of early pregnancies and early marriages) requires a multi-pronged approach and the use of different entry points. Empowerment and tutoring are entry points that play on the synergies between health – in particular SRHR – and education. This model differs from youth centres in that it is located in secondary schools, thus providing easy access to the target group; it can reach young adolescents; and its primary objective is not to improve the use of SRHR services. TECHNIDEV builds on its objective of empowering youth and improving academic performance to address topics that can affect academic success, such as SRHR.

Sources: TECHNIDEV documents and the 2016 Muskoka Fund Report.

3.2.2 Comprehensive sexuality education

The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.[24]

Standard 1 WHO/UNAIDS – Adolescents' health literacy

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."[25]

Key concepts, topics and learning objectives by age group are developed in the *International Technical Guidance on Sexuality Education (Revised edition).*[26] The guidance identifies eight key concepts:

1. Relationships
2. Values, rights, culture and sexuality
3. Understanding gender
4. Violence and staying safe
5. Skills for health and well-being
6. The human body and development
7. Sexuality and sexual behaviour
8. Sexual and reproductive health

Research has shown that there is insufficient awareness of SRHR. It is only the provision of quality CSE, linked to AYSRHR services, that makes appreciable impact possible. It is therefore essential to develop and implement quality CSE in- and out-of-schools, and to integrate a system for referral to AYSRHR services either during CSE classes and activities or by planning joint activities between the health and education sectors (see 3.2.5 for more details).

The four countries of the review are at different stages of developing and implementing CSE, and **none have a nationally scaled-up in- and out-of-school programme.**[27]

Identification of key themes and curriculum development is only the first step. Other technical considerations such as teacher training, supervision and support, whether CSE should be a stand-alone subject or integrated into existing subjects, as well as other key elements such as advocacy, coordination and collaboration are essential for effective implementation. For more details on establishing and scaling up quality CSE, please refer to the brochure and report developed by UNFPA WCARO.[28]

Development of a school-based CSE programme – Senegal

In Senegal, a coalition of stakeholders has initiated work to develop CSE. A workshop to discuss possible content was held in the presence of several ministries, the United Nations, TFPs and civil society organizations (CSOs). The workshop resulted in the development of a reference document identifying the seven main themes of CSE for the country. A workshop with Ministry of National Education (MEN) experts was held to finalize its contents and ensure their compliance with the MEN guidelines and standards. This process allowed stakeholders to express their opinions, propose components and reach a final consensus.

The country has elected to integrate the seven themes into primary and secondary school curricula during the planned curricula review, which is being undertaken by the Projet d'Appui au Renouveau des Curricula [Curricula Review Project, PARC]. The review has started, but will take several years to develop and complete. Until integration is achieved, existing projects such as the GEEP project in secondary schools will continue to provide sexuality education.

3.2.3 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 have access to media (television, radio, etc.) and the web, including social networks (via mobile phones). These are often the only easily accessible sources of information, but they do not always convey accurate or appropriate information. The web can be both a positive and a negative force (for example cyberbullying and harassment). Too often, young people cannot identify misinformation and do not have the tools to protect themselves from the negative aspects of the web.

Governments and 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. Many countries in the region have free telephone hotlines either on AYSRHR (for at-risk children) or on GBV. These hotlines are either manned or automated, such as the Gindima telephone service in Senegal. Gindima, which means 'enlighten me' in Wolof, was launched on 12 August 2016 to provide young people in the regions and rural areas with access to automated SRHR information. By the end of 2017, more than 200,000 calls had been placed to this hotline, which is accessible in French and Wolof 24 hours a day, seven days a week. Gindima provides information on seven main themes: the menstrual cycle; STIs and HIV and AIDS; anatomy and puberty; contraception; pregnancy; violence, female genital mutilation and abuse; and sexuality.

C'est la Vie! – a regional level programme

ICTs are used by regional programmes and by a number of different NGOs. The *C'est la Vie!* (That's Life!) programme, a social and behaviour change communication 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!* was 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).*

Paroles aux Jeunes [Young People's Voices] – ICTs in action

The organization Paroles aux Jeunes in Senegal uses the various ICTs at its disposal to implement several activities. The organization is running an AYSRHR digital campaign via Facebook, Twitter, blogs and other digital media outlets, with support from rappers and other leading figures in the country. Paroles aux Jeunes also organizes various events and competitions, including the Red Card to Child Marriage campaign conducted in the form of a 'tweet-up' in collaboration with other countries in the region. To tackle misinformation on SRHR online, the organization trains young people on how to use social networks and talk about SRHR. In addition, a Paroles aux Jeunes club has been established in each region with its own Facebook page. These clubs also work with the peer educators of local youth centres.

The organization is popular, with 40,000 young people following it and contributing through social networks. A moderator checks the posted content, however due to the number of platforms in existence, this can be complicated and difficult to do in a timely manner.

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

The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.[29]

Standard 2 WHO/UNAIDS – Community support

Sociocultural barriers and the fact that sexuality continues to be considered a taboo subject make it difficult to discuss sexuality and can create barriers to access and use of AYSRHR services. As a result, the information provided by schools, parents, friends, religious leaders, and so on about sexuality is often contradictory.

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

All countries in the review have initiated activities with religious and community leaders. In Senegal, the Réseau Islam et Population developed arguments that could be used to promote family planning, by identifying the verses of the Qur'an and the hadiths of the prophet that support the use of family planning and sex education, as well as counter arguments for those who oppose family planning and SRHR education. The same work has been initiated with the Chadian Higher Council for Islamic Affairs (see box below).

Chad – Islam as a positive force for family planning

Since 2015, UNFPA has been supporting the Chadian Higher Council for Islamic Affairs (Conseil Supérieur des Affaires Islamiques du Tchad) to counter the preconceptions that Islam prohibits family planning. A study tour by Council members to Indonesia and Bangladesh took place 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 for 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 level symposium (to support the SWEDD project) brought together 1,200 religious leaders around 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 Higher Council for Islamic Affairs continues to organize symposiums/workshops in the regions to sensitize Imams, preachers, and other religious and community leaders. The project hopes to scale up nationally. 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.

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International research 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. To do so will require implementing interventions such as community dialogues and mobilization, parent-child communication programmes, as well as training of influential community members in advocacy and communication on AYSRHR. Existing community bonds, as well as partnerships with the community and local organizations, can be used for this purpose.

3.2.5 Referral to AYSRHR services

Increasing the uptake of AYSRHR services requires the elimination of sociocultural barriers as well as users knowing which services are available, and how and where to access these services. Several countries in the region are experimenting with activities to strengthen linkages between different sectors and create demand for services. Linkages between the Ministries of Health and Education, which are key to AYSRHR, can be created through:

- classroom visits to the local health facility to familiarize students with the facilities and services offered
- CSE classes to refer learners to local SDPs providing AYSRHR services
- activities carried out by health-care providers in schools and
- joint training of health-care providers and teachers from the same locality, and their subsequent development and implementation of a plan for CSE and AYSRHR activities

NGOs and CSOs are also working to create linkages and reduce barriers, for example by setting up voucher systems to access health services free of charge, or by providing transport to SDPs.

Information on the package of services and where to access it can be communicated through different mechanisms. School clubs in the four countries are often used to convey information and organize awareness-raising events, sometimes with the support of health-care providers. Peer educators work in the community, youth centres and schools. In addition, ICTs are an effective and inexpensive mechanism for transmitting information. Since the objective is to orient adolescents and youth towards an SDP that it responsive to their needs, it is crucial that all AYSRHR interventions identify and communicate the nearest and most appropriate SDP.

Gamal Abdel Nasser University Medical Centre in Conakry: a multisectoral collaboration

The Gamal Abdel Nasser University Medical Centre in Conakry is a good example of multisectoral collaboration. Some commodities, equipment and staff are provided by the Ministry of Health, while UNFPA supports the supply of family planning products, and the Ministry of Education is responsible for the structure and its maintenance. The centre offers a comprehensive package of services that includes prevention, screening and treatment, implemented by staff including a doctor, laboratory assistant and nurse.

The centre provides services to:
- university students (12,000)
- teaching researchers and supervisors (703)
- students and learners from local schools and other educational institutions and
- the surrounding communities

Services offered include:
- medical consultations and case management
- family planning/contraceptive provision
- voluntary testing for HIV and AIDS
- STI screening and management
- distribution of male condoms
- conferences, debates and awareness-raising on various health issues

To create demand, the centre has established a space for young people that is equipped with teaching materials, games and audiovisual equipment. It works with a number of youth organizations such as the Collectif des chefs de class [Class Leaders Group], the Union des sages-femmes [Union of Midwives], the Association Guinéenne de Promotion de la Santé Scolaire et Universitaire [Guinean Association for the Promotion of School and University Health, AGUIPSSU] and the Cercle Scientifique Stomatologie-Pharmacie-Médecine [Scientific Association of Stomatology–Pharmacy–Medicine, CESSPHAM]. These organizations implement activities and run AYSRHR awareness and information days within the university and in the surrounding communities. Cultural and scientific activities on AYSRHR (such as quizzes) are also organized.

A number of factors were identified as contributing to the centre's success:
- its staff, who are well trained, available, have positive attitudes towards AYSRHR, and are held accountable for their performance
- strong collaborations with youth organizations that sensitize, mobilize and refer young people from the university and community to the centre
- confidentiality and privacy
- strong leadership

3.3 Creating an enabling environment

3.3.1 Leadership and advocacy

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, budgets, etc. that are impossible without high-level leadership. The interest in the demographic dividend in the region is an opportunity to integrate 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 operational levels. Since implementation and scale-up require the use of existing systems in which human and financial resources are often already limited, difficult decisions are sometimes necessary. Leadership in SDPs is also essential to change attitudes and ensure that staff devote time and provide good quality services without judgment.

Many countries have a division, unit or section on adolescent health, or a unit more specifically focused on AYSRHR. Most of these units are placed within the Directorates of Reproductive Health, Maternal and Child Health or Family Planning. These units are often weakened by limited human and financial resources and a position within the ministry structure 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.

Some advocacy priorities are common to all the countries reviewed. Although political will exists, it is hampered by the reality on the ground and financial and human constraints. Strong advocacy by TFPs and other stakeholders is essential to ensure that adolescents and youth are included in government priorities and that adequate budget allocations are made. Without a financial commitment from the State, AYSRHR programmes will not be sustainable. Advocacy should also highlight the importance of a multisectoral response and encourage the various sectors to work together.

A lack of disaggregated data affects the effectiveness of a national response to the needs of adolescents and youth. Advocacy at all levels, such as with the Minister of Health, the health information system and the District Medical Officers is necessary in order to develop and/or ensure the implementation of disaggregated indicators, the flow of data to the national level and analysis.

The cost of AYSRHR services is one of the greatest barriers to service use. Advocacy is needed to ensure free services and/or the introduction of interventions to reduce costs for young people, such as vouchers or universal health coverage that includes SRHR.

3.3.2 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 or policy can establish the rights of adolescents and youth to SRHR services.

Laws can either hinder or facilitate the provision of AYSRHR services, such as those relating to:

- the age of consent to sexual activity
- the legal age for marriage
- the age of consent and marital status requirements to access to AYSRHR services (including HIV testing, counselling and treatment, contraception and termination of pregnancy), including in schools
- parental notification and parental consent to the use of services
- confidentiality and when it may be violated (for example disclosure of sexual abuse of a minor), with whom and for what reasons
- the protection of GBV victims and
- restrictions on the provision of services to young adolescents aged 10 to 14; etc.

A review[30] in five West African countries notes that although AYSRHR services are included in policies, legislation and strategies, the legal ambiguity about the age of consent and access to contraceptives and other AYSRHR services makes service provision dependent on the provider. It may therefore be affected by the provider's prejudices.

Most of the countries in this review have a legal framework that is conducive to scaling up AYSRHR services. Many are signatories to international conventions and campaigns such as: the Convention on the Rights of the Child; the Programme of Action of the International Conference on Population and Development (ICPD); and the African Union Commission's Campaign to End Child Marriages. AYSRHR is also aligned to national frameworks such as development plans. Nevertheless, in all countries there is a lack of harmonization between legislation and policy, a lack of implementation decrees, and insufficient knowledge and enforcement of laws and legal texts. For example, although the Reproductive Health Law in Chad was drafted in 2002, no implementing decree is in place, resulting in the non-application of the law and affecting the implementation of AYSRHR interventions.

Once laws and policies have been reviewed and any necessary changes made, they should be disseminated to providers, community and religious leaders, parents and guardians, youth and other key stakeholders to begin to address the barriers of access to and use of services.

A 'vertical' scale-up should include a review of the political and legal environment to identify potential barriers and corrective measures that may be necessary, and the development of a plan for the dissemination and enforcement of amended laws and policies.

3.4 Coordination and collaboration

Coordination and collaboration within and across sectors and with non-governmental partners is necessary at all levels: national, regional/district and operational. Within the Ministry of Health, integrating AYSRHR services into existing facilities requires internal collaboration and coordination with a number of units such as adolescent health, maternal and child health, SRHR, training (pre- and in-service), supply and stock management, the health information system, planning and infrastructure development.

Increasing access to and use of AYSRHR services requires a multisectoral response, making coordination and collaboration between relevant sectors such as education, youth, gender and social services and with various non-governmental stakeholders essential. This is particularly important in contexts with limited human and financial resources, as good coordination and collaboration can improve efficiency, reduce gaps and avoid duplication and overlap.

Coordination and collaboration are often the weak link due to the complexity and number of stakeholders working in CSE and AYSRHR. This situation may be compounded by a lack of understanding about the role of coordination and poor coordination skills. The four-country review highlights, among others, the need for:

- effective coordination
- collaboration between stakeholders to reduce duplications and address the lack of standardization (for example on provider training)
- improved collaboration between ministries to ensure synergy (for example with the education sector on school infirmaries and CSE)
- breaking down the silos within ministries and
- improved coordination between TFPs

Coordination and collaboration are essential for horizontal scale-up. The specific role of each stakeholder must be understood, and each must be held accountable. However, any collaboration will be ineffective unless the responsible unit has the authority, mandate, resources, capacity or skills to lead the coordination.

Mapping partners and stakeholders working on AYSRHR is essential in order to assess available capacities, skills and resources. This mapping, which can be part of the initial situation analysis, will identify the stakeholders, how to coordinate them and which collaborations could create synergies.

Some countries have several coordination mechanisms that cover adolescents and youth. A review of these mechanisms, including a clarification of the roles and responsibilities of all stakeholders, the development of clear terms of reference, and identification of members for each mechanism, is essential in order to improve effectiveness.

At the level of the United Nations system, several mechanisms exist to improve coordination and collaboration, such as the One United Nations initiative and the UNDAF. The French Muskoka Fund, through its inter-agency coordination and collaboration mechanism, offers a concrete example of how to improve planning and implementation and increase synergy. However, the recent increase in attention on adolescents and youth requires a clear, formalized division of labour, and increased complementarity of activities to ensure, inter alia, that there are no overlaps and that geographic coverage is equitable. Better coordination and collaboration between the United Nations, other TFPs and Government would allow resources to be pooled in order to scale up effective interventions and reduce piecemeal implementation.

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4

Conclusions and Recommendations

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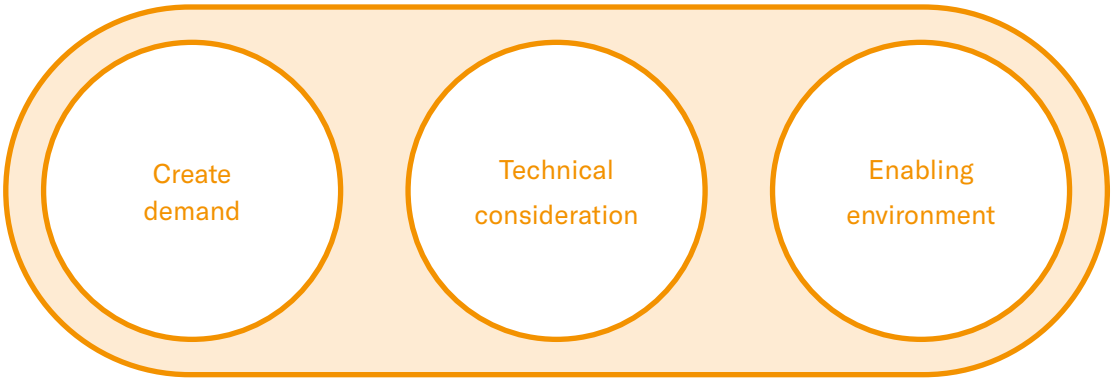
An effective response to young people's needs relies on simultaneous and synergistic actions to improve the quality of and access to services through amongst others training and supervision of providers; creating demand; and ensuring an adequate and regular supply and effective management of SRHR commodities (condoms and other contraceptives, medicines and equipment).

The evidence base on AYSRHR has demonstrated what is effective and should be scaled up (CSE and health services adapted to the needs of adolescents and youth), and what is not (youth centres, peer educators and ad hoc public meetings). Nevertheless, some interventions considered less effective continue to be implemented and supported. Proven ones tend not to be scaled up (for example CSE, integrated services), often due to high costs and the time required for scaling up. The scaling up of effective interventions as well as their quality in the long-term is affected by a lack of attention and resources from partners and Government.

At the global level, a number of partners are working to share and disseminate promising practice on adolescent and youth health, for example through the AA-HA guidelines for countries. However, more efforts are now needed to improve planning and implementation at the national level. UNFPA is well placed to support countries to analyse the situation, identify priorities and develop costed action plans based on proven effective interventions. The key considerations for the provision and scale-up of AYSRHR services can be grouped under three main headings: technical considerations, demand creation and an enabling environment.

Key elements for the implementation and scale up of AYSRHR services



4.1 Technical considerations

Defining priorities and development of an implementation plan

Current situation	Impact	Required action
Most countries have policies, strategies and plans that cover adolescents and youth. **Most do not have a costed action plan** that details the necessary actions and timelines for scaling up AYSRHR services nationally. Several countries are in the process of finalizing their RMNCAH Plan and all include young people. Some, such as Guinea, are at the costing phase.	Countries implement activities from their strategies according to the financial resources at their disposal. Most often, this funding comes from TFPs and is therefore dependent on their interests and priorities. This situation does not allow a country to put in place a comprehensive response in the short, medium and long term.	**Support the development of a COSTED implementation and scale-up plan for AYSRHR services** (integrated into the RMNCAH Plan or another plan, or as an independent plan, depending on the national context), as well as the development of a national (and international) resource mobilization plan to ensure long-term sustainability.

UNFPA is committed to supporting countries, depending on their context, to:

- analyse the different technical considerations
- map partners and stakeholders working on AYSRHR to assess available capacities, skills and resources, as well as to support the development of coordination and collaboration mechanisms (identifying stakeholders, how to coordinate them, and which collaborations can create synergies)
- develop an action plan that should include at a minimum the recommended methodology and strategies (including for monitoring and evaluation); an analysis of the processes required for progressive implementation (a timeline for activities); the objectives; the roles and responsibilities of all stakeholders and the most appropriate coordination and collaboration mechanisms; a description of the actions required at the national, provincial/district and operational levels; and an estimate of costs, current available funding, and possible resource mobilization strategies

Service delivery points and the package of services offered

Current situation	Impact	Required action
The countries reviewed provide services through a combination of different SDP models, and all advocate for the integration of AYSRHR into existing public health structures. Currently, the capacity of health facilities to provide quality AYSRHR services is low in all documented countries. The service package differs depending on the type of SDP and the level at which it is offered.	An integration of AYSRHR services may require a reorganization of how a health facility is run. Needs change and a single model is not effective, the service package must be adapted to age, gender, marital status, etc. This is not always the case.	**Identification of the combination of SDP models** required in the short, medium and long term for a sustainable scale-up. **Development of a minimum package of AYSRHR** services to be implemented at each level of the health system, and for each SDP model (taking into account that young people's needs are not homogeneous needs). Identification of providers (midwife, nurse, CHW, etc.) and the services for which they will be responsible (all services, contraceptive/family planning services only, pregnancy, GBV, etc.) **Identification of the number and type of human resources required and their training needs.**

- Using the most recent evidence base for action, UNFPA will support countries that request assistance to perform a situation analysis, identify the most appropriate combination of SDP models, and develop the package of services to be offered within the different SDP models dependent on the level at which services are offered (mobile, clinic, reference hospital, etc.).

- UNFPA is committed to supporting (within its resources) the implementation of AYSRHR services, as well as assisting in the identification of providers training requirements, the development and implementation of training (pre- and in-service) on adolescent and youth health, and the development and implementation of formative supervision and support systems.

Setting standards

Current situation	Impact	Required action
Three out of four countries in the review and the majority of countries in the region have developed standards for AYSRHR or health services adapted to the needs of adolescents and youth. However, some were developed several years ago and should be revised to ensure they are in line with the most recent WHO guidelines. **Implementation of standards is limited.** Often implementation is incomplete and stops at dissemination. Very few providers are trained and even fewer receive support to improve their performance.	Standards are not implemented properly, providers are not sufficiently equipped to provide quality services, and standards may not be in line with the most recent WHO guidelines.	**The development or revision of norms and standards by type of SDP. Standards** should define the skills and attitudes needed by providers, as well as requirements for infrastructure, transport, equipment and technology, medicines and commodities (including family planning), human resources, etc. The development (or revision) and dissemination of decision support tools for AYSRHR providers.

↪ UNFPA is committed to supporting countries to develop or revise norms and standards and decision support tools.

Training and supervision of service providers

Current situation	Impact	Required action
All the countries reviewed implement in-service training activities, but none have integrated AYSRHR into the pre-service training programme of the various types of providers. Very little standardization of training by the different training providers. Few staff are trained and often the quality of service provision is inadequate. The four countries are far from achieving national coverage of provider training. Rural and hard-to-reach areas have received less training. **Supervision and support to providers, although demonstrated as essential, are identified as a weakness in many countries.**	Training requires not only the development of skills and knowledge, but also a change in negative attitudes. This is not always the case. Various TFPs support the training of service providers, each focusing on their priority topics.	**Development and standardization of pre- and in-service training programmes that include a values clarification methodology.** Better coordination of stakeholders to enable standardization, improved content and a reduction in AYSRHR training costs, and to avoid duplication and ensure better and more equitable geographic coverage. **Development of formative supervision and provider support systems.** **Integration of AYSRHR into providers' job descriptions.**

UNFPA is committed to supporting countries to:

- standardize in-service training and ensure better coordination among stakeholders to reduce AYSRHR provider training costs, avoid duplication, and ensure better geographical coverage
- integrate and standardize AYSRHR training into pre-service training programmes of public and private institutions for all health-care providers that will be in contact with young people
- as part of the SWEDD project, support the development of regional centres of excellence for the pre-service training of midwives and the establishment of a midwifery degree. These centres are an opportunity to integrate adolescent and youth health into pre-service training programmes
- improve formative supervision and support to providers through the development of supervision systems; the identification of context-specific provider support activities; the training of supervisors; and the provision of resources for implementation

Social and behaviour change communication

Situation	Recommendations for UNFPA
Improving access to and use of AYSRHR services depends not only on the systems in place in SDPs, but also on the environment in which young people live and interact. To protect young people's SRHR, it is essential to create demand, provide information and knowledge, and change societal attitudes and behaviours (e.g. gender inequalities; sociocultural barriers; preconceptions about contraceptives and their side effects; providing a rationale to parents for taking their children to services). SBCC activities are being implemented in all countries. The C'est la Vie ! project, which is active at the regional level and in some countries, contributes to SBCC campaigns. **To date, none of the countries in the review has implemented a national SBCC campaign.**	UNFPA will support the development and implementation of SBCC activities, for example by supporting initiatives such as linking CSE to AYSRHR services, orienting young people towards services, supporting the implementation of CSE in- and out-of-schools, and through other activities to develop their skills and reach adolescents and youth with information.

Commodities and supply chain management

Situation	Recommendations for UNFPA
The provision and scale-up of AYSRHR services will result in an increased need not only for equipment and technology, but also for condoms, family planning products and medicines. **All the countries in the review and a large number of countries in the region report weaknesses in the functionality of their commodities supply, storage and distribution systems, resulting in stock-outs in health facilities.**	In most countries in the region, UNFPA is already active in this area. However, it will be necessary to take into account the increased need for commodities, and improve coordination and communication between the different UNFPA teams (Youth, SRHR, etc.), and with the different sections of the Ministry of Health.

Monitoring and evaluation

Situation	Recommendations for UNFPA
All the countries in the review and a large number of countries in the region report weaknesses in their monitoring and evaluation system and a lack of data disaggregated by age, sex, marital status and other indicators. The lack of data is more significant for adolescents aged 10–14 and unmarried adolescents.	Support the integration of adolescent and youth-specific indicators into existing information management systems (identification of needs and necessary changes to systems such as forms, training on new indicators, dissemination of system changes, etc.). UNFPA's support for strengthening a country's data systems (such as DHIS 2 or the population census) is an opportunity to integrate adolescent- and youth-specific aspects or indicators, or at least to identify how specific indicators could be integrated in the long term.

4.2 Demand creation

Sensitization, participation and empowerment of adolescents and youth

Global experience shows that adolescent and youth participation in the development, implementation and evaluation of, and advocacy for, AYSRHR improves the effectiveness of interventions. All the countries in the review have youth organizations that are active on SRHR, either through peer educators or focusing on advocacy. However, this sector is more developed in some countries (for example Senegal) than in others.

- UNFPA will continue to build the capacity of adolescents and youth and their organizations in countries where they are weak, in order to improve young people's participation in the development, implementation and evaluation of, and advocacy for, AYSRHR interventions.
- To this end, UNFPA will need to invest more to ensure that all young people are included in activities, including through capacity development, training and the establishment of inclusive spaces for effective participation.
- Adolescents and youth are not a homogeneous group and do not have the same AYSRHR needs. Too often the voices heard are those of educated youth (with very few young adolescents) from urban areas. This group does not necessarily represent those from poor rural areas, who are likely to have different needs. UNFPA assistance should ensure that a diversity of voices are heard, covering both sexes and a variety of ages, contexts (urban and rural), educational levels, socioeconomic levels and so forth.

- Investments in research and evaluation on the meaningful participation of adolescents and youth are needed to identify effective or promising interventions.

All the countries in the review are implementing empowerment projects. These projects are often coupled with awareness-raising on SHRH. Youth centres are present in all countries and most of them train peer educators and implement various activities. However, the evidence base shows that youth centres and peer education have generally not been effective,[31] and are not cost-effective, scalable and sustainable. **The allocation of funds for youth centres to provide AYSRHR services should therefore be discontinued.** However, in countries that have received significant human and financial investment, the centres could be repurposed and be used, inter alia, to develop social connectedness and support young people's development and empowerment.

Comprehensive sexuality education

Research shows that awareness of SRHR is insufficient. Quality comprehensive sexuality education (CSE) is much more effective. Most countries in the region are implementing projects, either on sexuality education or life skills education. In addition, several countries in the region have begun to identify the key components of a quality CSE and to develop and implement activities for a gradual scale-up. No country has a nationally scaled-up CSE programme in- and out-of-school. Currently, most Governments in the region do not have the human, financial and technical resources to implement CSE on a national scale.

- UNFPA is committed to supporting (within the limit of its resources) the development and implementation of quality CSE in- and out-of-school[32] (for more details, please refer to UNFPA WCARO's regional report on CSE).

Information and communication technology

Governments and 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. Many countries in the region have free telephone hotlines on AYSRHR (for at-risk children) or on GBV. Community radio and television are also successfully used in the region (for example C'est la Vie !). Other ICTs, such as social networks, are used by youth organizations and NGOs in a number of countries, but very few government projects are implemented through social networks.

- As an increasing number of adolescents and youth have access to ICTs and use them as a source of information, the use of ICTs (radio, television, SMS, Internet, etc.) and especially social networks is recommended, depending on the country context. UNFPA support for young people's empowerment and participation should include capacity-building on the use of ICTs and the allocation of resources to support ICT project implementation. To ensure representation, a broad range of young people (and not just urban youth) should be targeted. In addition, support for regional and national programmes such as *C'est la Vie !* will contribute to SBCC campaigns.

MUSKOKA Guinea © Vincent Tremeau

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

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. All countries in the review have initiated activities with religious and community leaders. Other strategies such as community mobilization, parent-child communication programmes and training of influential community members in advocacy and communication on AYSRHR are needed and are being implemented in the region.

↪ Promoting the engagement of religious and community leaders is a key UNFPA strategy in the region and should continue to be a priority.

Referral systems to service delivery points

Information on the package of services offered and where to access it is essential to increase use. Information can be disseminated through national IEC/SBCC campaigns, integration into CSE in- and out-of-schools (information on SDPs services and a referral system), and various activities. School clubs in the four countries are often used to convey information and organize awareness-raising events, sometimes with the support of health-care providers. Peer educators also disseminate information in the community, youth centres and schools. In addition, ICTs are an effective and inexpensive mechanism for transmitting this information. Several countries in the region are experimenting with activities to strengthen links between different sectors (for example education and health) to create demand.

↪ UNFPA should support or conduct research to identify the most effective referral systems, and in particular how to improve collaboration between the health and education sectors.

4.3 Creating an enabling environment

Government ownership and leadership are essential for the implementation and scale-up of AYSRHR services. Depending on the country context, this **may require changes in policy, laws, budgets** and so on that are impossible without high-level leadership. Leadership and ownership are also needed at the **provincial/district and operational levels**. Although there is strong political will in all countries reviewed, this has not always been translated into concrete actions.

Institutional context

All the countries in the review have a division, unit or section on adolescent health, or a unit more specifically focused on AYSRHR. Most of these units are placed within the Directorates of Reproductive Health, Maternal and Child Health or Family Planning. These units are often weakened by limited human and financial resources and a position within the ministry structure 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. The low priority placed on AYSRHR by the Ministry of Health (in some cases) highlights the need for advocacy and the importance of political commitment and government leadership.

- UNFPA should support countries (as appropriate) to identify the human resources and skills required for the effective implementation of AYSRHR services, including within ministries.
- If a unit exists, establish the authority, mandate, resources, capacity and/or skills required to scale up and coordinate AYSRHR services.

Legal and political context

Most of the countries in this review have a legal framework that is conducive to scaling up AYSRHR services. Nevertheless, in all countries there is a **lack of harmonization between legislation and policy and insufficient knowledge and enforcement of laws and legal texts**, which affect the implementation of AYSRHR interventions. Laws can either hinder or facilitate the provision 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 or policy can establish the rights of adolescents and youth to AYSRHR services.

UNFPA commits to support (dependent on needs and available resources):

- a review of the legal and policy environment of countries in order to identify barriers to implementation and identify any corrective measures that may be necessary (for example implementing decrees)
- the dissemination and enforcement of amended laws and policies

Coordination and collaboration

AYSRHR requires a multisector response. Intra- and intersectoral coordination and collaboration with governmental and NGO partners (at all levels: national, regional/district and operational) are therefore essential for scale-up. The review noted weaknesses in coordination and collaboration in each country, often due to the complexity and number of stakeholders working on CSE and AYSRHR, but also in some cases due to the responsible unit not having the authority, mandate, resources, capacity and/or skills required to lead coordination.

UNFPA will support (dependent on needs and available resources) a review of existing coordination mechanisms, with a view to streamlining them and ensuring they are adapted to their role. If necessary, UNFPA can play a lead role in establishing or strengthening these mechanisms, including coordination. An effective system requires clarification of the roles and responsibilities of all stakeholders, the development of clear terms of reference and the identification of appropriate members for each mechanism.

Within the United Nations system, several mechanisms exist to improve coordination and collaboration, such as the One United Nations initiative and the UNDAF. The French Muskoka Fund, through its inter-agency coordination and collaboration mechanism, offers a concrete example of how to improve planning and implementation and increase synergy. However, partners' growing focus on adolescents and youth requires a clear, formalized division of labour and increased complementarity of activities. This would ensure, inter alia, that there are no overlaps and that geographic coverage is equitable. Better coordination and collaboration within the United Nations system, other partners and Government would allow resources to be pooled to support the scale-up of effective interventions, and would reduce piecemeal implementation.

Advocacy

As the lead agency of the United Nations system on AYSRHR, UNFPA has a major role to play in improving advocacy at the regional and national levels. Advocacy needs will depend on the national context. Nevertheless, some priorities are common to all. Although political will exists in most countries, it is hampered by the reality on the ground and by financial and human constraints. To overcome this, strong advocacy by TFPs and other stakeholders is essential to ensure that adolescents and youth are included in government priorities and that adequate budget allocations are made. Without a financial commitment from the State, programmes addressing the health needs of young people will not be sustainable. Advocacy should also highlight the importance of a multisector response and encourage different sectors to work together.

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The limited availability of disaggregated data (see recommendations on monitoring and evaluation) affects the effectiveness of a national response to the needs of adolescents and youth. Advocacy at all levels (such as with the Minister of Health, the health information system, District Medical Officers) is necessary to develop and/or implement disaggregated indicators, and ensure data is transferred to the national level and analysed.

The cost of AYSRHR services is one of the greatest barriers to service utilization. Advocacy around free services is necessary, but this is not a realistic or sustainable option in some contexts. Each country will therefore need to identify initiatives or systems to reduce costs for adolescents and youth such as coupons, public-private partnerships, or universal health coverage that covers SRHR.

Each country in the review implements interventions to improve access to and use of quality AYSRHR services. None of the countries have achieved national scale-up and most require technical and financial support from TFPs. UNFPA has a long history of working on AYSRHR and continues to strengthen its interventions and support to Governments in this area. UNFPA, in coordination with other United Nations organizations and TFPs in each country, therefore has a major role to play.

UNFPA will assist countries through technical assistance, using its contacts in various sectors and with different stakeholders (Government, CSOs, TFPs and so on) to create linkages and facilitate a multisectoral response. UNFPA's resources will not cover all the priorities listed above, given that it already implements a number of key interventions that are not mentioned here. Country offices will therefore have to decide on their positioning and priorities, based on UNFPA's in-country comparative advantage and the priorities of the Government and other TFPs.

The French Muskoka Fund (Fonds Français Muskoka– FFM) has provided stable funding for eight years and will be renewed for a new five-year cycle (2018–2022). Denmark's entry into the mechanism was also announced in 2018, with the intention of strengthening the AYSRHR component. FFM represents an opportunity for AYSRHR programmes in the region for the following reasons:

- AYSRHR is a funding priority.
- As an inter-agency mechanism, it creates synergies by building on each agency's mandate and comparative advantage (WHO for standards and norms, UNICEF for the focus on the school environment, UNFPA for the implementation of services adapted to young people and CSE, and UN-Women to support demand creation, especially for girls, and gender mainstreaming. In addition, all agencies support community mobilization).
- FFM's strategic focus includes CSE, services adapted to the needs of young people and SBCC.
- Created to support implementation, the mechanism enables effective coordination between the United Nations organizations and Governments.

Each office should review (if it has not already done so) its AYSRHR activities and ensure that they are aligned to the latest research on what does and does not work in terms of improving AYSRHR, while taking into account the mandate and activities of other TFPs. This would not require a major evaluation of all projects, but rather a review of activities and the country programme's objectives, and a judgment as to whether these interventions will achieve those objectives, and if not which interventions would be more cost-effective. This is particularly important given the current global context in which financial resources for SRHR and HIV and AIDS are decreasing. Global research has demonstrated the importance of faithfully implementing and scaling up proven strategies. Unfortunately, the considerable demands of implementation mean that it is rarely properly carried out. This fact needs to be taken into account when preparing or revising country programmes.

ANNEX – Promising practices

UNFPA's strategy of supporting different aspects of AYSRHR simultaneously, such as creating demand, increasing the number of SDPs, improving the quality of services (for example, through training) and providing commodities (equipment and contraceptives).

One size does not fit all. Segmentation of the target population is essential to develop effective messages and interventions. Such segmentation is necessary for different factors, such as age, sex, marital status, adolescents, youth, parents and leaders, and should be done for IEC/SBCC, demand-creation activities and the package of services.

Linking AYSRHR services to CSE is more effective.

AYSRHR interventions are more effective when adolescents and youth participate in their development, implementation, evaluation and advocacy.

The integration of HIV, SRHR and contraceptive/family planning services can increase effectiveness.

Mobile/outreach strategies can increase usage in part thanks to their ease of access and free services. Although mobile strategies are not currently sustainable, they represent short- and medium-term strategies to improve access to and use of SRHR services, including AYSRHR.

Non-governmental providers that implement AYSRHR interventions often have young people's trust and offer services tailored to their needs.

The strategy implemented by some countries and NGOs to train providers, set up a supervision and support system, ensure product availability, create a user-friendly space with SRHR resources and a facilitator, ensure free access for young people and implement demand-creation activities in the community, is a model that has been successful when faithfully implemented.

School and university infirmaries can reduce some barriers such as access and cost (services and contraceptives are free). The availability of contraceptives and STI management in school infirmaries has been demonstrated as an effective strategy (such an in Côte d'Ivoire).

Awareness and approval of and support for AYSRHR services and CSE must be strengthened among adolescents and youth, their tutors and religious and community leaders to have an impact on the use of such services.

A combination of SDP models for AYSRHR is essential for scaling up.

Partnerships between the public sector, the private sector, NGOs and TFPs help to increase the number and quality of SDPs.

The development of a minimum package of services to be implemented at each level of the health system and for each SDP model is essential to standardize services, allocate responsibilities and ensure accountability.

Training that goes beyond the development of skills and knowledge and begins to change negative attitudes (for example, through a values clarification methodology) is more effective.

Different techniques can be used to improve training outcomes, such as training providers and young people jointly.

Referral systems to AYSRHR services are essential. All AYSRHR interventions, regardless of their primary objective (CSE, youth empowerment, etc.), should identify and communicate the nearest and most appropriate SDP and the services they offer.

Given existing sociocultural barriers, UNFPA's work with religious and traditional leaders is essential.

The provision and scale-up of AYSRHR services is impossible without government ownership and leadership.

The region's interest in the demographic dividend is an opportunity to integrate AYSRHR into Governments' agendas and budgets and to justify the implementation of interventions by the relevant ministries.

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