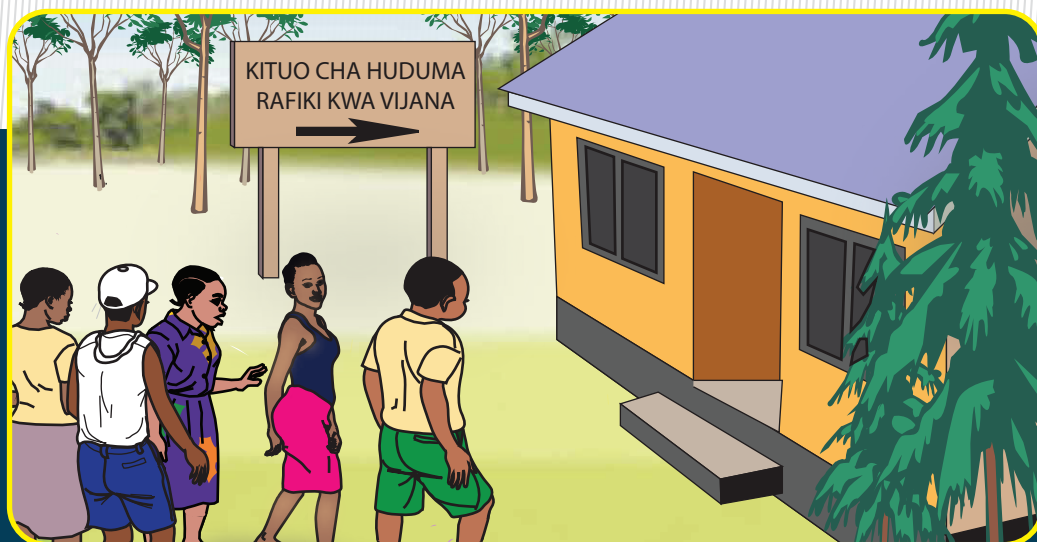




THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT,
GENDER, ELDERLY AND CHILDREN



STANDARDS FOR ADOLESCENT FRIENDLY REPRODUCTIVE HEALTH SERVICES

March 2020

THE UNITED REPUBLIC OF TANZANIA



**MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER,
ELDERLY AND CHILDREN**

Standards for Adolescent Friendly Reproductive Health Services

March 2020

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FOREWORD

The Government of Tanzania has long recognized that her adolescents and young people are the Nation's most valuable resource. The National development goals have geared towards the improvement of the quality of life of the population in general and adolescents in particular. However, the welfare of young people continues to be compromised by a number of factors such as the high rate of teenage pregnancies, high rates of STI infection including new HIV infections, Gender Based Violence, increasing Non-Communicable diseases among others. The high prevalence of unprotected sexual practices among the young people contributes significantly to the high morbidity and mortality rates in the country.

The Ministry of Health has identified Reproductive Health as a priority programme and increasing access to quality Adolescent Health services is one of the strategies to improve health of adolescents and young people and ultimately reduce the high rates of maternal mortality in Tanzania. To attain this objective, the Ministry has developed a set of standards to make easier for adolescents to obtain health services including reproductive health services. These standards outline the **minimum benchmarks and guides implementation of standards-driven approach to improve the quality of health-care services for adolescents** in the country.

The aim of these standards is to provide guidance for the assessment, certification and recognition of service delivery point providing friendly health services for adolescents. In this context, the Ministry urges all stakeholders providing health services to abreast and carefully use the National Standards for Quality Health Care Services for adolescents.

It is our expectation that these standards will significantly contribute to improving the quality and coverage of adolescent health services in our country.



Prof. Muhammad Bakari Kambi
Chief Medical Officer

ACKNOWLEDGEMENTS

The Ministry of Health, Community, Development, Gender, Elderly and Children (MOHCDGEC) developed these National Standards and Implementation Guide for Quality Health Care Services for Adolescents with the concerted efforts of different individuals and organizations interested in increasing access and availability of adolescent friendly health services, who shared their views, experiences and perceptions.

The Ministry acknowledges the World Health Organisation (WHO) for sharing the Global standards for quality health-care services for adolescents and technical support to guide implementation of a standards-driven approach to improve the quality of health-care services for adolescents in the country.

We are grateful to the Government of the United States of America through the Centre for Disease Control (CDC) and the US President's Emergency Plan for AIDS Relief (PEPFAR) for their generous technical and financial support that made development of this document possible.

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Last but not least, we are obliged for the leadership of the Reproductive and Child Health Section (RCHS) through the leadership of Dr. Ahmad M. Makuwani, the Assistant Director, RCHS, for providing leadership and guidance during the development of this document.

Dr. Leonard Subi

Director of Preventive Services

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ACRONYMS AND ABBREVIATIONS

AFHS	-	Adolescent Friendly Health Services
AGPAHI	-	Arial Glaser Paediatric Aids Healthcare Initiative
AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	Antenatal Care
ASRH	-	Adolescent Sexual Reproductive Health
BCC	-	Behavior Change Communication
CDC	-	Centres for Disease Control and Prevention
CHF	-	Community Health Fund
CPR	-	Contraceptive Prevalence Rate
EGPAF	-	Elizabeth Glacier Paediatric Foundation
FBO	-	Faith Based Organization
GBV	-	Gender Based Violence
HIV	-	Human Immunodeficiency Virus
IEC	-	Information, Education and Communication
MoH	-	Ministry of Health
MOHCDGEC	-	Ministry of Health, Community Development, Gender, Elderly and Children
NACP	-	National AIDS Control Programme
NGO	-	Non-Governmental Organization
NHIF	-	National Health Insurance Fund
PMTCT+	-	Prevention of Mother to Child Transmission
PSI	-	Population Services International
RCH	-	Reproductive and Child Health
RCHS	-	Reproductive and Child Health Section
SDP	-	Service Delivery Point
SOPs	-	Standard Operation Procedures
STI	-	Sexually Transmitted Infection
TDH-MIS	-	Tanzania Demographic and Health Survey and Malaria Indicator Survey
TDHS	-	Tanzania Demographic and Health Survey
THMIS	-	Tanzania Health and Malaria Indicator Survey
TIKA	-	<i>“Tiba kwa Kadi”</i>
UMATI	-	Uzazi na Malezi Bora Tanzania

UNFPA	-	United Nations Population Fund
UNICEF	-	United Nations Children’s Fund
VAC	-	Violence Against Children
VCT	-	Voluntary Counselling and Testing
VMMC	-	Voluntary Medical Male Circumcision
WHO	-	World Health Organization
YFS	-	Youth Friendly Services

CHAPTER 1:

BACKGROUND AND CONTEXT

INTRODUCTION

Delivery of health services to adolescents is among the priorities of the Government of Tanzania. At the global level, the 2015 Global Strategy for Women's, Children's and Adolescents' Health is essential as a front-runner platform for delivery of the Sustainable Development Goals (SDGs). At the national level, the commitment is reflected in various policy documents including The National Poverty Reduction Strategy and Vision 2025, the National Health Policy (2007), Health Sector Strategic Plan IV (2015-2020), the National Road Map Strategic Plan to Improve Reproductive, Maternal, New-born, Child and Adolescent Health in Tanzania (2016-2020), National Accelerated Actions and Investment for Adolescent Health and Well-being (2020-2024) and National Standards for Adolescent Friendly Reproductive Health Services (2005) among others.

The National Poverty Reduction Strategy and Vision 2025 notes that Tanzania needs to achieve her development breakthroughs by 2025 to become a middle-income country. Among others, this vision recognizes education as a priority. This means that, there is a need to accelerate the investments in adolescents and young people education now. By year 2025, the adolescents and young people of today will be between 25 and 35 years old. They will be the young professionals, the entrepreneurs, the farmers, teachers, nurses, social workers and doctors, the technicians and young politicians, the performers, designers and brave new thinkers, visionaries and young leaders of faith – and of course most will be parents themselves. Their ability to successfully fill these roles that are so central to national progress and development, and their capacity to avoid the pitfalls that can dim or destroy their hopes, depends a great deal on how we invest in and protect their growth and development during the coming years.

The National Health Policy (2007) notes that, reproductive health care services for all groups especially the youth and males will be improved in terms of quality

and coverage. This will include the promotion of Youth Friendly Services to facilitate increased accessibility to health information to adolescents and young people. To further enhance the focus of provision of health services to adolescents and young people, the Health Sector Strategic Plan IV (2015-2020) notes that, Adolescent Friendly Sexual and Reproductive Health Services (AFSRHS) will be expanded. During this period, the Ministry will strive to increase the level of adaptation and use of Adolescent friendly guidelines and standards, demand creation and utilization of AFSRHS. Adolescents and youth will be encouraged to access Voluntary Medical Male Circumcision (VMMC) services, STI diagnosis and treatment, condoms and other contraceptives, and HIV testing and counselling services through age-appropriate Information and Education/Behaviour Change Communication (IEC/BCC), peer education and mobilization of young people. This strategy further notes that, risks of multiple sexual partners, unprotected sex and predisposing factors such as alcohol and substance abuse, unsafe injections and unsafe blood shall be key messages in IEC and peer education. VMMC will also be considered as an entry point to engaging with adolescent boys more broadly on ASRH and HIV-related health promotion, preventive and treatment interventions and services. Peer education will be encouraged for in and out of school adolescents, in partnership with other Ministries and NGOs. The education shall target transfer of knowledge, skills and, for the sake of eliminating stigma, positive peer pressure, positive socio-cultural appeals, applied in a rights-based approach will be utilized to shape attitudes (zero-tolerance to stigma).

Other aspects of adolescent health will also be addressed through linkages with other programmes, including HIV, immunization, mental health services and school health services as avenues to expand health services and increase adolescents' access and use of health services. The strategy concludes by highlighting that Health workers will become advocates of AFSRHS. Available adolescent-friendly RHS education and service guidelines will be disseminated to health workers. Supervisors and health care providers will receive training on AFSRHS. Mass media campaign and community outreach services (providing commodities) will be enhanced to improve accessibility for all adolescents and adults in need of services. Prevention of and response to violence against women, adolescents and children will get more attention through demand creation in the community and capacity-building of health staff and ensuring services and support are provided to the survivors of violence. The strategy concludes by promising that the utilization of AFSRH services by adolescents will double during the implementation period of the HSSP V.

The National Road Map Strategic Plan to Improve Reproductive, Maternal, New-born, Child and Adolescent Health in Tanzania (2016-2020) and (2021-2025) further enhances the programming of interventions for adolescents and

young people. This strategy mission is to promote, facilitate and support in an integrated manner, the provision of comprehensive, high impact and cost effective RMNCAH and nutrition services, along the continuum of care to men, women, new-borns, children and adolescents. Focusing on adolescents, the strategy aims to strengthen and improve visibility of adolescent reproductive health services including strengthening the adolescent health programme, improving its visibility; and developing and implementing a comprehensive strategy for adolescent health.

Despite the existence of global and national policies, strategic frameworks and standards for adolescent friendly health services, there is a need to respond effectively to health needs of adolescents in the country. This group faces significant challenges including limited knowledge regarding their health, inadequate sexual and reproductive education and life skills, negative influence from harmful social and cultural practices, risky behaviours and inadequate resources for equitable delivery of adolescent friendly health services.

RATIONALE

These Standards aims to inform and assist national public health programme managers, facility managers, health-care providers, national bodies in charge of quality improvement, as well as individuals and organizations supporting their work, such as development agencies, nongovernmental organizations (NGOs) and the commercial sector. They provide guidance for provision of adolescent friendly health services in Tanzania. The eight standards address adolescent health literacy, parent and community support for adolescent, appropriate package of services, provider competencies, facility characteristics, equity and non-discrimination, data and quality improvement and adolescent participation. These standards have been developed in order to promote and maintain health for the adolescents of Tanzania relevant to their needs, circumstances, and stage of development.

The overall rationale for the National Standards addresses the importance of:

1. Informed access to adolescent-friendly health services
2. Parental, guardian, and community support through access to resources
3. Provision of comprehensive and appropriate package of services for adolescent
4. Technical skills of health service providers

5. Safe and accessible service delivery point
6. Non-discriminatory respect for the adolescent
7. Improvement of the quality of SDP data to inform policy-making
8. Engagement of adolescents in the design, planning, implementation, monitoring and evaluation of health services and decisions regarding their own care.

DOCUMENT REVIEW PROCESS

The Ministry of Health has the responsibility to provide technical guidance and direction in all health related issues in the country. The National Adolescent Reproductive Health standards review was necessary following new developments at global and regional level on issues around adolescent reproductive, in country emerging epidemiological development on diseases and health conditions and Improvement of quality standard of service delivery. Various surveys conducted in the country including national census and demographic health surveys, new national and international evidence and significant lapse of years since the initial document. The document was developed through a participatory approach involving stakeholders serving adolescents from the public sector, youth representatives, Faith Based Organizations (FBOs), national and international NGOs and the private sector.

The initial process involved development of a concept note and Terms of Reference (ToR) for facilitators who are to lead the process. These documents were reviewed and approved by the Technical Working Group (TWG) Lead Facilitators initiated the process of review and drafted zero draft of the document by conducting desk review of local and international documents and interview with key actors. This was refined by a series of TWG meetings and wider stakeholders review that came up with this final version.

The structure and content of these standards was adapted from WHO Global Standards for Quality Health Care Services for Adolescents, 2015.

THE PURPOSE OF THIS DOCUMENT

This document has two main purposes:

- To provide minimum requirements on key areas for adolescent health services which build on the existing health system in the country.
- To provide guidance on monitoring quality of adolescent health services

using methods and tools that are user friendly. Existing Ministry of Health, Community Development, Gender, Elderly and Children service guidelines, protocols and manuals will be used to complement the provision of quality adolescent and youth friendly health services.

BENEFICIARIES

This document is intended to guide the provision of quality health services to all adolescents in Tanzania mainland. Basically these adolescents are either in school setting or out of school. Moreover, within these population segments, there are some groups that are more vulnerable such as; orphans, street children, adolescent sex workers, adolescents with disabilities, younger adolescents 10-14 years, adolescent girls, adolescents living in high STI/HIV transmission areas e.g. mining sites and adolescents living with HIV/AIDS.

INTENDED AUDIENCE

All stakeholders and actors can utilise this document, including: Policy/decision makers at all levels, programme managers, service providers and supervisors in the government, non-government, faith-based, private organizations, Regional and Council health management teams, partners supporting health and development work in Tanzania.

GUIDING PRINCIPLES

This document has been developed based on the following eight principles.

THAT:

- Adolescents are a heterogeneous group with different needs for health information, education and services.
- Reproductive health services are a basic human right for all people including adolescents.
- The participation and involvement of adolescents in planning, implementation, monitoring and evaluation of programmes is of critical importance to ensure that their needs are fully addressed.
- Community involvement and parental support are crucial for sustainable adolescent reproductive health programmes.
- Adolescent reproductive health services should encompass promotive, preventive, curative and rehabilitative care.

- Adolescent reproductive health services must promote gender equality and equity.
- Effective and sustainable adolescent reproductive health service requires human resource development, strategic leadership, knowledge management and dissemination of lessons learnt and institutional capacity building.
- Adolescent reproductive health needs are immense and to address them holistically, special mechanisms for networking and partnerships between various stakeholders.

SERVICE DELIVERY POINTS

Adolescents can be effectively reached with the range of services described above in variety of settings and outlets. The majority of services will be provided through static facilities, which will invariably be linked to appropriate outreach activities. These include the following:

- Hospital: public, private, FBO and NGO
- Health centre: public, private, FBO and NGO
- Dispensary: public, private, FBO and NGO
- Specialized health clinics
- Community outlet: youth centres, pharmacy, community outreach (peer education, paraprofessional counselling) and shops

CHAPTER 2:

THE SITUATION OF ADOLESCENT HEALTH IN TANZANIA

According to the 2012 Population and Housing Census, the population of Tanzania mainland was estimated at 47.9 million people; and the majority (70.9 percent) live in rural areas. The population structure of the United Republic of Tanzania and that of Tanzania mainland are similar, dominated by a young population. Children age 0 to 4 constitute 16.2 percent of the population, whereas children age 0 to 14 years constitute 43.9 percent of the population; and by age 17 years, children age 0 to 17 years constitute 50.1 percent of the population. Moreover, adolescent's ages 10 to 19 years constitute 23 percent of the population whereas young people age 10 to 24 constitute 32 percent of the population.

The adolescents in Tanzania face a myriad of health and social problems. Overall, there is a slight difference in the timing of sexual debut between young women and young men age 15-24 in Tanzania. Twelve percent of young women and 13 percent of young men age 15-24 had sex before they were 15. Moreover, the median age at first sexual intercourse is 17.2 years for women, compared to 18.2 years for men. About 60 percent of women and 51 percent of men age 18-24 reported having had sex before reaching age 18. Young people who initiate sex at an early age are typically at a higher risk of becoming pregnant or contracting sexually transmitted infections than young people who initiate sex later. (TDH-MIS 2015/16). The period between first sexual intercourse and marriage is often a time of sexual experimentation. Youth are often at a greater risk of contracting sexually transmitted infections, including HIV/AIDS, and of having unwanted pregnancies during this time; they are more likely to have shorter relationships with more partners before marriage. As a result of these early sexually active and practicing of unsafe sex; adolescents become very highly vulnerable to sexual and reproductive health problems that include adolescent pregnancy and child bearing, complications of unsafe abortion, sexually transmitted infections and HIV/AIDS.

When a girl becomes pregnant, her present and future change radically, and rarely for the better. Her education may end, her job prospects evaporate, and her

vulnerabilities to poverty, exclusion and dependency multiply. During the past 5 years, adolescent pregnancy among 15-19 years has increased from 23 percent (TDHS 2010) to 27 percent (TDH-MIS 2015/16). The percentage of teenagers who have begun child bearing is higher among rural women 32 percent than urban women (19 percent), as a result, by the age of 19 years, six percent of adolescents are either mothers or are pregnant with their first child. The contraceptive prevalence rate (CPR) for modern methods among all married woman is 32 percent; whereas the CPR among all youth (15 – 24 years) is 13 percent among married adolescents (15 to 19 years). It is higher (35 percent) among unmarried adolescents. The unmet need for family planning among adolescents (15 to 19 years) was 23 percent.

Knowledge and awareness of HIV is still low among youth; (48 percent of young women and 43 percent of young men); (THMIS, 2011/12). Youth aged 15 – 24 years account for sixty percent (60 percent) of the new HIV infections in the country. Almost half of young women and one-third of young men have ever been tested for HIV and received their results (THMIS 2011/12), seventy percent (70 percent) of youth (15-24 years) are aware of at least two common HIV preventive methods (DHS 2015/16). Condom use during premarital sex is low; only 37 percent of women and 41 percent of men use a condom.

Violence against Children (VAC) and Gender Based Violence (GBV) are among factors that put adolescent girls and young women at increased risk of contracting STIs including HIV, becoming pregnant and lifelong physical, social and psychological trauma. Many adolescent girls lack a full range of opportunities and are too often devalued because of gender bias, leading them to be seen as unworthy of investment or protection. The transition into puberty and adolescence increases adolescent girl's vulnerability to VAC/GBV—including physical, emotional, and psychological abuse, rape, and other forms of sexual violence—with grave and enduring impacts on their health and well-being. Married girls may also be at a higher risk of domestic violence, either from their husbands or from their husband's family. According to the TDH-MIS 2015/16, 21.9percent and 38 percent of women aged 15-19 and 20-24 respectively have ever experienced physical violence while the same age groups 11.2 percent and 15.8 percent experienced sexual violence. Although experience of violence is higher among married women, particularly formerly married women, 16 percent of never-married women have experienced physical violence and nine percent have experienced sexual violence.

Marriage is a primary indication of the regular exposure of women to the risk of pregnancy and therefore is important for the understanding of fertility. Women tend to marry considerably earlier than men in Tanzania. Among Tanzanian youth, 23% of young women age 15-19 are already married (defined as legally

married or living together), compared to only 2% of young men age 15-19. The majority of women age 20-24 are married or living together (60%), while only 29% men age 20-24 are married or living together. Early marriage forces girls into adulthood and motherhood before they are physically and mentally mature and before completing education, limiting future options, depriving them of the chance to reach full potential, and preventing her from contributing fully to her family and community. Early child marriage is both a risk factor for VAC and a form of VAC by itself.

Access to Adolescent Friendly Health Services (AFHS) is still a challenge in the country. Studies show that only 30 percent of SDPs meet the National Standards for AFHS (UNICEF, 2011) with target to have 80 percent of health facilities providing AFHS by 2015. Parents and community support for adolescents to access available health services is very low (<20 percent) as well as limited community linkage and community outreach for provision AFHS. Poverty remains a big challenge predisposing young people to risky behaviours such as substance abuse, transactional sex and early marriages

Given the above challenges and in order to ensure that adolescent youth obtain quality health services the Ministry has developed interventions which focus the following interventional areas:

- health education along the continuum of care (before and during pregnancy, delivery and post-natal period).
- Condom promotion
- STI screening and management.
- HIV testing services and management
- Family planning services including condom use and emergency contraception
- Care during pregnancy
- Care during delivery including post abortion care and emergency obstetric care
- Care during the post-partum period
- Immunization services
- Addressing gender based violence issues
- Substance abuse
- Mental health and other health related issues

According to the TDH-MIS 2015-16, utilization of ANC services among adolescents was low and only 49 percent made four or more ANC visits. The prevalence of anaemia among pregnant adolescents 15-19-year was 47 percent; whereas the uptake of TT2+ among adolescents was 74 percent. Adolescent child bearing poses health risks for both mother and child, and adolescent are prone to a number of complications during and after delivery. These complications include toxemia, haemorrhage, anaemia, infection, malnutrition, cephalopelvic disproportion, vesico- or recto-vaginal fistula, and low birth weight. Some of these complications may result into perinatal and maternal mortality.

These standards aim to ensure that the above-mentioned challenges including low coverage of service utilization are addressed by the stipulated interventions and are delivered according to adolescents needs.

CHAPTER 3:

NATIONAL STANDARDS AND CRITERIA

STANDARD 1 – ADOLESCENTS' HEALTH LITERACY

Standard statement: The health management systems ensures that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.

Rationale for Standard 1

Evidence suggests that adolescents do not have adequate health literacy to enable them to gain access to, understand and effectively use it in ways that promote and maintain their good health. Health literacy is critical to empowerment and includes, among other things, the timely recognition of the need for health or other services; the ability to seek advice and care, including successfully making appointments; and the ability to navigate through the sometimes-complicated system of services available. Yet, adolescents often are not aware of what health or other services are being provided (e.g. educational and vocational support, drug and alcohol counselling, legal and social support), where they are provided and how to obtain them (WHO, 2011a; WHO, 2014a).

The Ministry of Education Science and Technology have significant contribution to adolescents' health literacy. Strengthened collective effort, among ministries working with young people, health SDPs and health service providers play an important role in provision of information and education on health to targeted group. Adolescents value the active listening skills of health service providers and the clarity and amount of information provided to them. Adolescents' positive experience of care depends also on the availability of updated IEC/BCC materials with health information in the waiting room, including television or games. Standard No. 1, therefore, stresses the importance of health education within the health facility and beyond where adolescents and youth can be reached and through individual behaviour-oriented communication that will develop adolescents' skills and knowledge, and their efficacy to act on their knowledge,

in order to maintain good health.

The national standards for adolescent friendly reproductive health services had a standard statement “*All adolescents are able to obtain sexual and reproductive health information and advice relevant to their needs, circumstances and stage of development.*” However, there is still a problem in attaining the required adolescent health literacy.

- Most of the adolescents obtain information on health from unreliable sources and hence make risky choices
- Most of the adolescents do not have access to appropriate information to prepare them to cope with changes that take place in their bodies, health and development.
- Adolescents are experiencing gender-based violence resulting from inadequate or comprehensive sexuality education and life skills.
- Service providers are not adequately oriented on the provision of health information, education including counselling and psychosocial services in non-judgmental and friendly manner
- Most of the SDPs do not have adequate and appropriate IEC/BCC messages and materials that are specific for adolescent health issues and needs

Measurable criteria of Standard 1

Input criteria	Process criteria	Output criteria
1. The health facility has a sign-board indicating operating hours and range of services offered. 2. The health facility has in the waiting area up-to-date information, health education, communication messages and audio-visual materials specifically developed for adolescents. 3. Health-service providers have competencies to provide health education to adolescents and to communicate about health and available services (health, social and other services). 4. The health SDPs has community health workers that are trained to conduct health education for adolescents in the community. 5. The health SDPs has a plan and/or involvement of community health workers in activities to promote health and increase adolescents' use of services.	6. Health-service providers provide age and developmentally appropriate health education and counselling to adolescent clients and inform them about the availability of health, social services and other services. 7. Outreach activities to promote health and increase adolescents' use of services are carried out according to a plan in a SDPs.	8. Adolescents are knowledgeable about health. 9. Adolescents are aware of what health services are being provided, where and when they are provided and how to obtain them.

Intent of Standard 1

Health education is carried out in both the health facility and the community (see Standard 2). Informational materials use a language, format and comprehension level appropriate to adolescents of various age groups, relevant to their needs, circumstances and stage of development. This will help adolescents to have better understanding of the available health services.

The information should clearly be communicated about types of services, health-service providers and working hours of the facility. In addition, adolescents are informed about other services available in the community, such as social services, shelters, recreational services, vocational training services or services provided by agencies that finance care or provide transportation. The facility, thus, maps other service providers, governmental and NGOs, and community agencies that can serve adolescents, and develops a network of services and referrals with them.

STANDARD 2 – PARENTS AND COMMUNITY SUPPORT

Standard statement: The health SDP implements systems to ensure that parent, 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.

Rationale for Standard 2

Parents, guardians, family, community and religious leaders play an important role in supporting adolescents to access and use services. Evidence suggests that without gatekeepers' (see Glossary) support, adolescent health programs are not successful (WHO, 2014a; Denno DM et al., 2015). In many countries, unmarried adolescents have little support from parents and community to access and use sexual and reproductive health services (Chandra-Mouli et al., 2014). Parent and community support was one of the national standards that scored very low (YFS Assessment Report 2015/2016). This shows disconnection between community and parental support for adolescent access to health services. Some of the gaps identified were:

- Parents and communities are not adequately equipped and empowered to prepare their children for adult living due to changes in traditional systems of socializing young people for adult hood.
- Communities and parents have limited access to information and not adequately oriented on emerging sexual reproductive health as well as other health issues concerning adolescents.

This standard, set expectation for the level of support from parents, guardians and other community members for adolescents to use health services

Measurable criteria for Standard 2

Input	Process	Output
10. Health-service providers have competencies and support materials to communicate with parents, guardians and other community members and organizations about the value of providing health services to adolescents. 11. The SDP has an updated list of agencies and organizations with which it collaborates to increase community support for adolescents' use of services. Service providers should sensitize Community members including parents to form support groups (e.g. Para-professional counsellors, Peer educators) for sexual and reproductive health on provision to adolescents in the community 12. The health SDPs has a plan for outreach activities and/or engagement of community health workers in activities to increase gatekeepers' support for adolescents' use of services	13. The health SDP engages in partnerships with adolescents, gatekeepers and community organizations to develop health education and behaviour-oriented communication strategies and materials and plan service provision. 14. Health-service providers inform parents/guardians the provision of sexual and reproductive health services to adolescents in the community. 15. Health-service providers and/or community health workers inform parents/guardians and teachers during school meetings about the value of providing health services to adolescents. 16. Health-service providers and/or community health workers inform youth and other community organizations about the value of providing health services to adolescents.	17. Gatekeepers and community organizations support the provision of health services and their utilization by adolescents.

Intent of Standard 2

The health management system informs community members about the value of providing health services to adolescents either during visits to the SDP or

through outreach. However, merely informing community members about the importance of adolescents' use of health-service services is not enough. To ensure that parents, guardians and other community members support all adolescents – married and unmarried, younger and older – to use the health services they need, it is essential that the health facility engage in partnerships with community members and organizations to develop health education and communication strategies and materials, to get their buy-in and to plan service provision. Involving adolescents in this work is also essential.

STANDARD 3 – APPROPRIATE PACKAGE OF SERVICES

Standard statement: The SDPs provide a package of information, counselling, diagnostic, treatment and rehabilitation health services that fulfil the needs of all adolescents. Services are provided in the SDP and through referral linkages and outreach.

Rationale for Standard 3

Adolescents requiring services that are not provided at one SDP is likely to affect future of accessibility for adolescent friendly health services will. Evidence suggests that important causes of mortality and morbidity, and their risk factors, do not get sufficient attention in primary care nor in many initiatives labelled “adolescent-friendly”, which often focus on a limited range of issues, such as sexual and reproductive health. For example, mental health problems, which are the main cause of illness and disability among adolescents, are often neglected (WHO, 2014a).

Other problems that do not get sufficient attention relative to the burden of disease the causes may include nutrition, substance use, intentional and unintentional injuries, mental illness, Gender Based Violence limited coverage of human papilloma vaccine, and chronic illness. Sexual and reproductive health, including STI, HIV and pregnancy in adolescents, remains a critical health concern in the country; however, it is important that other contributors to the burden of disease be adequately addressed.

Comprehensive means not only that care responds to the full range of health problems, but also that care for any condition encompasses, in a coherent way, health promotion and prevention, as well as diagnosis and treatment, rehabilitation or referral (WHO, 2015b).

Evidence shows that health services are often clinically oriented and opportunities for preventive interventions are frequently overlooked. Further, health-service

providers often do not have clear guidance as to which services are important to provide to their adolescent clients.

In Tanzania, knowledge of the fertile period is very low for both young women and men in the country. Only 18percent of young women and 13 percent of young men age 15-24 correctly identify the fertile period as halfway between two menstrual periods (TDH-MIS 2015/16).

- Overall, 27percent of adolescent women age 15-19 are already mothers or are pregnant with their first child (TDHS 2015-16).
- Although ANC services from skilled health service provider to women age <20 is high (98.5percent), there is still a gap in attendance of all four ANC visits (48.9percent), protection against tetanus (74.4percent), delivery by a skilled attendant (68.2percent) and delivery in the SDP (64.1percent)
- Comprehensive knowledge of HIV is still low among youth (48 percent and 43 percent of young women and men respectively) (THMIS, 2011/12). The proportion of comprehensive knowledge among women and men increases with age and educational attainment.
- Among unmarried young women, use of a condom at sexual intercourse is higher especially at age 18-19 years. Older unmarried young men (age 20-24) are more likely to use a condom during sexual intercourse than younger unmarried men (age 15-19). Condom during sexual intercourse increases with age for young men and with education for both young women and young men (THMIS 2011/12).
- Prevalence of stunting among adolescents is high, reaching 70 percent at 13 years. Prevalence of anaemia among 15-19 years old was 42percent in 2010, a decline from 49 percent in 2004/05. (UNICEF, 2011). According to THMIS 2015/16 10.4 percent of adolescents aged 15-19 years have moderate Anaemia.

Intent of Standard 3

Health service for adolescents encompasses a range of services such as information, counselling, diagnosis, treatment, rehabilitation, referral and service. The package of services offered in the SDP should reflect the health-service needs of adolescents in the community. While priorities might vary geographically, from community to community, adolescents need range of health service. Therefore, it is very important that the SDP determine exactly what services are to be offered on-site and what services are to be made available through referral and outreach.

Successful care requires a close interrelationship between the network of

services within and outside the health sector. Within the health sector, strong links between the health SDP and the community served by the facility should exist, as well as between various levels of the health- service system and between various specialties.

Measurable criteria for Standard 3

Input	Process	Output
18. National policies and guideline are in place that define the required package of health information, counselling, diagnostic, treatment and rehabilitation to enable provision of services.	21. SDP provide the required package of health information, counselling, diagnostic, treatment, and rehabilitation services in the facility and/or in community settings, in line with policies, guideline and procedures.	23. The health facility provides a package of health services that fulfils the needs of all adolescents in the facility and/ or through referral, linkages and outreach.
19. National Policies and SOPs are in places that identify and direct health facilities to develop action plans for provision of adolescent health services in the health facility and in community settings such as peer groups, youth centers and schools.	22. Ability of SDP to refer adolescents to the appropriate service and level of service according to National Policies, SOPs, Protocols and procedures	
20. National Policies, SOPs, and guideline, Job Aids, protocols are in place that describes the referral system including linkages to services within and outside the health sector, including provisions for transition service for adolescents with chronic conditions.		

STANDARD 4 – PROVIDERS’ COMPETENCIES

Standard statement: Health-service providers demonstrate the technical competence required to provide effective health services to adolescents. Both health- service providers and support staff respect, protect and fulfil adolescents’ rights to information, privacy, confidentiality, non-discrimination, non- judgmental attitude and respect.

Rationale for Standard 4

Health-service providers' attitudes, knowledge and skills are the core of quality service provision. Guideline-driven care is central to young people's positive experience of care. Yet, many health-service professionals report insufficient knowledge on technical competence in adolescent-specific aspects of health promotion, disease prevention and management. Many providers do not feel confident to communicate effectively about issues such as domestic and school violence, family or intimate partner relationships, and nutrition or substance use (WHO, 2012, 2014, 2015).

Studies conducted in the country shows poor score in providers' competency. During assessments of adolescent services using the National standards for Adolescent Friendly Health services, the competency score ranged from 9 percent to 39 percent. The studies also show that almost all of the facilities didn't refer adolescent even during a situation where the facility has no skilled personnel, drugs or supplies to manage the problem presented (MoH YFHS Assessment report 2014). In addition, health-service providers' own attitudes and beliefs may lead them to discourage the use of certain services or to withhold certain services from adolescents – for example, refusing to provide contraception to unmarried sexually active adolescents (Chandra-Mouli et al., 2014).

Provider biased preference advocating girl's abstinence and condom use for boys. (Tanzania PSI Human Centered Design Insights 2016) Insufficient respect in clinical practice for adolescents' rights to information, privacy, confidentiality, non-discrimination and non-judgmental attitudes is a major barrier to adolescents' use of services (WHO, 2014a). Therefore, developing technical competencies in adolescent health service, there is a need to assess and, where needed, change providers' attitudes towards adolescents and their right to quality health care (WHO, 2015a).

Intent of Standard 4

Standard four sets the expectations for the technical and attitudinal competencies that are required by providers for effective care, including competencies related to a human rights-based approach to adolescent health service. Importantly, the latter also applies to support staff. Health-service providers should be competent not only in managing adolescents in specific clinical situations, but also in demonstrating awareness of one's own attitudes, values and prejudices that may interfere with the ability to provide confidential, non-discriminatory, non-judgmental and respectful service to adolescents.

In order to have technical competence, the health management system need to

ensure that the number, qualifications and skill mix of staff is adequate to deliver the required package of adolescent health services. To maintain acceptable staff performance, the health management system need to ensure up-to-date management of conditions, teach new skills or new aspects of equipment and procedures, to provide opportunities for in-service training and other education. In situation where there is no knowledgeable health service provider in adolescent health service, the facility uses flexible learning opportunities such as seminars, supportive supervision, case reviews, access to online information resources and distance learning to maintain staff performance.

Measurable criteria of Standard 4

Input	Process	Output
24. Health-service providers and support staff of the required manning levels are in place 25. Health-service providers have the technical competencies necessary to provide the required package of services including referral and linkage. 26. Health-service providers have been trained and retrained on the importance of respecting the rights of adolescents to information, education, privacy, confidentiality and provide health service that is respectful, non-judgmental and non-discriminatory manner. 27. Providers' obligations and adolescents' right are clearly displayed in the health facility.	31. Health-service providers follow evidence-based guidelines and protocols in delivering service to adolescents. 32. Health-service providers and support staff relate to adolescents in a friendly manner, and respect their rights to information, education, privacy, confidentiality, non-discrimination, non-judgmental attitude, and respectful service.	33. Adolescents receive effective and comprehensive health services. 34. Adolescents receive services in a friendly, supportive, respectful, non-discriminatory and non-judgmental manner, and know their rights in health service. 35. Adolescents receive accurate, age-appropriate and clear information to facilitate informed choice.

Input	Process	Output
28. Up-to-date decision support tools (guidelines, protocols, algorithms) that cover topics of clinical care in line with the package of services are in place.		
29. A system of supportive supervision is in place to improve health-service providers' performance.		
30. A system of continuous professional education that includes an adolescent health-service component is in place to ensure lifelong learning.		

STANDARD 5 – FACILITY CHARACTERISTICS

Standard statement: The SDP has a welcoming environment, sufficient space, convenient operating hours, and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents according to national policies and guidelines.

Rationale for standard 5

Evidence suggests that the process of care can be confusing and even overwhelming for an adolescent. Convenient operating hours (e.g. outside of school hours) and flexible appointment procedures (e.g. the possibility of a consultation without an appointment) are important for adolescents' access to services. The facility's physical environment (cleanliness, design features that enable privacy and confidentiality) is a characteristic highly valued by adolescents. Adolescents may not use the facility if they perceive it to be equipped inadequately, or lack the necessary drugs and supplies (Ambresin A-E et al., 2010, 2012).

In Tanzania, studies show that only 30percent of health SDPs meet the national standards for AFRHS (UNICEF, 2011). The target was to have 80 percent coverage of health facilities providing AFRHS by 2015 that is the target currently maintained for the National Reproductive Maternal New-born Child Adolescent Health (One Plan II, 2016/2020). In addition, only 60 percent of the health facilities are open for services for 7 days in a week (MOHSW YFHS Assessment report, 2015). National

studies also showed that majority of health facilities had adequate supplies of contraceptives (90 percent), ARV drugs (84 percent) and STI drugs (81 percent).

However, health facility system in the country faces the following issues:

- Existing protocols and procedures do not clearly stipulate how adolescent confidentiality and privacy should be ensured.
- The supervision mechanism at all levels is weak; service provision to adolescents is one of the areas that are not adequately addressed and implemented.
- Most SDPs currently providing sexual and reproductive health services are not organized to meet the needs of adolescents.
- Services are limited in terms of affordability, accessibility and acceptability

Intent of Standard 5

Standard five emphasize the importance of the organizational and design features of the facility that are important to provide accessible, efficient, and safe clinical care in a secure and supportive environment. The standard has three elements:

- Operating hours and an appointment system to meet the needs of adolescents
- The importance of design features and national policies to maintain privacy and confidentiality.
- The importance of having systems to ensure adequate equipment, drugs and supplies.

To make the service process continuous for the adolescent, the facility takes actions to support an adolescent-focused process such as:

- The operating hours are convenient for adolescents, providers, parents and community
- Service may be provided on an appointment basis or a walk-in basis
- The adolescent appointment and registration processes are respectful of the adolescent's time and are designed to minimize waiting times.

The SDPs plans and implement actions to manage the physical environment to ensure that it is clean, safe and accessible to all adolescents. Maintaining privacy and confidentiality is a matter of staff attitudes, but it is also a matter of how the SDP is designed. Design features that enable privacy, confidentiality and safety include the following:

- Offices/examining rooms are designed to ensure privacy for patients during clinical examinations and treatment.
- Adequate hand hygiene facilities are located in or adjacent to the office/exam room.
- Adequate seating is provided in the waiting room for normal patient flow, in a manner that ensures privacy of communication with reception staff.
- The premises, fittings, and furniture are kept clean and in good repair, meeting standards for lighting, heating, ventilation, and infection control.
- The SDPs provide for safe storage and disposal of clinical waste and potentially infectious waste that require special disposal, such as sharps/needles and other disposable equipment that may have been exposed to body fluids.
- Security is provided to assure the safety of the environment, the premises and offices/exam rooms.

In addition to design features, policies and procedures are in place that maintain adolescents' confidentiality at all times (except where staff are obliged by legal requirements to report incidents such as gender based violence including sexual assaults, road traffic accidents or gunshot wounds, to the relevant authorities). Policies and procedures address:

- registration – information on the identity of the adolescent and the presenting issue are gathered in confidence; consultation – confidentiality is maintained throughout the visit of the adolescent to the point of health service delivery (i.e. before, during and after a consultation); record-keeping – case-records are kept in a secure place, accessible only to authorized personnel; the facility also considers unauthorized access to electronically stored information and implements processes to prevent such access;
- Disclosure of information – staff do not disclose any information given to or received from an adolescent to third parties such as family members, schoolteachers or employers, without the adolescent's consent.

The SDPs implement actions for inspecting, testing, and maintaining medical equipment and documenting the results. The SDP has a system for procurement and stock management of the medicines and supplies necessary to deliver the required package of services to adolescents.

Measurable criteria of Standard 5

Input	Process	Output
36. National policies, guidelines and procedures are in place, including assigned responsibilities across health-service providers and support staff, to ensure a welcoming and clean environment, minimize waiting times and ensure convenient operating hours and flexible appointment procedures. 37. The SDPs has basic amenities (electricity, water, sanitation and waste disposal). 38. National policies, guidelines and procedures to protect the privacy and confidentiality of adolescents are in place. Both health-service providers and support staff know them as well as their own roles and responsibilities. 39. A system of procurement and stock management of the medicines and supplies necessary to deliver the required package of services is in place. 40. A system of procurement, inventory, maintenance and safe use of the equipment necessary to deliver the required package of services is in place.	41. Health-service providers offer consultations during hours that are convenient to adolescents, parents and communities with or without an appointment. 42. Health-service providers and support staff follow National Policies Guidelines and procedures to protect the privacy and confidentiality of adolescents. 43. Medicines and supplies are in adequate quantities without shortages (stock-outs), and are equitably used. 44. The equipment necessary to provide the required package of services to adolescents is available, functioning and equitably used.	45. The SDP has convenient operating hours, appointment procedures and waiting times kept to a minimum. 46. The SDP has a welcoming adolescent user friendly and clean environment. 47. Adolescents accompanied by relatives/parents receive private and confidential health service at all times during the consultation process. 48. The SDP has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.

STANDARD 6 – EQUITY AND NON- DISCRIMINATION

Standard statement: The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual behaviour, disabilities and other characteristics.

Rationale for Standard 6

Most people including adolescents are not aware of their reproductive rights; rights to information, education and health services as stipulated in various national policies and guidelines.

Evidence suggests that some groups of adolescents within the community may fall outside the planning and service delivery system because they are less visible, are socially marginalized or stigmatized or do not have advocates. For example, unmarried adolescents may be stigmatized if they seek contraceptive, STI, HIV testing and ART services. In addition, out-of-pocket payments that have a limiting effect on access to services for any population group may have a disproportionate effect on adolescents because of their limited access to cash and dependence on family resources (WHO, 2014; 2015).

It is expected that once the rights are known, adolescents will seek and demand for health services, providers will render the services effectively, and significant others will support and facilitate the availability and access to these services.

Intent of Standard 6

This standard stresses the importance of providing equitable service so that all adolescents, not just certain groups, are able to obtain the health services they need. It stresses that equity concerns all dimensions of quality of care outlined in these standards. That is, equity is observed not just in the levels of service use by various groups of adolescents, but also in, for example, the level of respect, application of technical competence, use of medicines and technologies, engagement in the services process and its planning and monitoring that various groups of adolescents experience.

The SDP works collaboratively with other agencies and health-service providers to identify vulnerable group(s) of adolescents in families and community, understand the needs of these groups, and engage them in the planning, implementation, monitoring and evaluation of health services. The SDP provides equitable care and treatment for adolescents with the same health problems and service needs. Providers use guidelines and protocols that ensure a high level of client services that is applied to all adolescents in an equitable manner and without discrimination. Clinical and managerial leaders plan and coordinate policies and procedures to ensure equity, monitor that this equity is observed at all times and to take remedial actions when necessary. The SDP has policies and procedures for services that are free at the point of use, or affordable, to adolescents.

Measurable criteria of Standard 6

Input	Process	Output
49. National policies, guidelines and procedures are in place stating the obligation of service delivery staff to provide services to all adolescents irrespective of their ability to pay, age, sex, marital status, schooling, sexual behaviour or other characteristics. 50. National Policies, guidelines and procedures are in place for services that are free at the point of use, or affordable of adolescent. 51. Health service providers and support staff are aware of the national policies, guidelines and procedures, and Knows how to implement them, when serving adolescents. 52. Commitment of policy to provide services to all adolescents without discrimination by decision makers, health facility in charges, supervisors, and health service providers at all level of SDPs are in place and displayed prominently in the health facility. 53. Health-service providers know who are the vulnerable groups of adolescents in families and community.	54. Health service providers and support staff demonstrate the same friendly, non- judgmental and respectful attitude to all adolescents, regardless of age, sex, marital status, sexual behaviour, cultural background, disability or any other reason. 55. Health service providers provide services to all adolescents without discrimination, in line with policies and procedures. 56. The SDP engage vulnerable group(s) of adolescents in the planning, implementation, monitoring and evaluation of health services, as well as provision of selected health- services	57. All adolescents – irrespective of their ability to pay, age, sex, marital status, education, sexual behaviour or other characteristics – report similar experiences of health service. 58. Vulnerable group(s) of adolescents are involved in the planning, implementation, monitoring and evaluation of health services, as well as provision of selected health- service.

STANDARD 7 – DATA AND QUALITY SERVICE IMPROVEMENT

Standard statement: The health SDP collects analyses and uses data on service utilization and quality of service, disaggregated by age and sex, to support quality improvement. Health SDP staff is supported to participate in continuous quality improvement.

Rationale for Standard 7

Effective policy-making for adolescent health service and programme design requires strategic information on the health-related behaviours of adolescents and about available health services. Data that come from routine SDP data collection and SDP assessments of services and service quality are extremely important. Through facility-level registers health management information systems (HMIS) collect data that includes client information about age, sex, presenting problem, diagnosis and services provided. In addition, data on quality of service, even if they exist, often lack a focus on adolescent-specific elements of quality. Measuring the quality of health services for adolescents, based on nationally developed standards, have shown greater utilization of improved quality services (WHO, 2014, MoH YFHS Assessment Report 2015/2016).

Measurable criteria for Standard 7

Input	Process	Output
59. A system is in place to collect data on service utilization that is disaggregated by age, sex and other socio-demographic characteristics as relevant.	64. The SDP collects data on service utilization disaggregated by age and sex, and conducts regular self-assessments of quality of service.	68. Facility's reports to districts include data on cause-specific utilization of services by adolescents that is disaggregated by age and sex.
60. Health-service providers are trained to collect and analyses data to inform quality improvement initiatives.	65. Health-service providers and support staff use data on service utilization and quality of service for action planning and implementation of quality improvement initiatives.	69. Facility's reports to districts on quality of service have a focus on adolescents.
61. Tools and mechanisms for self- monitoring of the quality of health services for adolescents are in place.	66. Health-service providers and support staff receive supportive supervision in areas identified during self-assessments.	70. Health SDP staff feels supported by supervisors and motivated to comply with the standards.
	67. Good performance is recognized and rewarded	

62. Mechanisms are in place to link supportive supervision to priorities for improvement as identified during the monitoring of the implementation of standards.	.	
63. Mechanisms are in place for reward and recognition of highly performing health-service providers and support staff.		

Intent of Standard 7

This standard, therefore, stresses the importance of the facility's actions to collect analyses and use data on cause-specific service utilization and quality of service, disaggregated by age and sex to support quality improvement. To monitor equity, it might be necessary to disaggregate data by other important characteristics such as school enrolment or marital status. However, it has been reported that asking an adolescent about, for example, marital status might, in some cultures, be perceived as a barrier to service use, and grounds to deny services to unmarried adolescents. The advantages and disadvantages of collecting information on certain socio-economic characteristics should be carefully weighed. The SDP understands that aggregate data are an important part of the facility's performance improvement activities; it provides a profile of the SDP over time and allows benchmarking and the comparison of the facility's performance with the performance of other similar facilities. For example, dissemination of good practices and lessons learnt could be organized at all levels (national, regional, districts and community).

The aggregation and analysis of data and information and planning of subsequent improvements frequently requires knowledge and skills that most staff does not have or do not use regularly. Thus, staff involved in these processes need to be provided with the training and tools to manage, display, and report data and information on adolescents in a useful and informative manner. They also need appropriate technological support. Mechanisms are in place not only to support data collection and analysis, but also to support health-service providers and support staff to use data for action planning and implementation. Improvement

is assigned to individuals or a team, any needed training is provided, and information management or other resources are made available. Once an improvement initiative is planned, data are collected to demonstrate that the planned change was actually implemented and was an improvement.

Staff motivation to participate in quality improvement may depend on a number of factors, including factors outside the control of SDP managers or health systems. However, actions such as supportive supervision or reward and recognition of highly performing staff will help to drive a culture that engages in health improvement initiatives.

STANDARD 8 – ADOLESCENTS’ PARTICIPATION

Standard statement: Adolescents are engaged in the design, planning, implementation, monitoring and evaluation of health services and in decisions regarding their own care as well as in certain appropriate aspects of service provision.

Rationale for Standard 8

Adolescents have the right to participate in decisions that affect their lives. The meaningful involvement of adolescents is an integral component of effective adolescent health service. It is essential that their engagement is encouraged and supported by facility staff and health committee. There are a number of ways that adolescents can be engaged, all of which can influence both the quality of services provided as well as health outcomes. Adolescents have important contributions to make in the policy-making, planning, implementation and monitoring of services provided in the community. Furthermore, if is empowered and given the opportunity, adolescents could be effective peer educators, counsellors, trainers and advocates.

Adolescents usually have the best knowledge about their own lives and their needs, and they have the capacity to identify approaches or solutions that will best adapt a health-service solution or management option to their personal circumstances. Ignoring participants will be limited in number, thus, it will be equally important to activate youth to hold representation position in the health facility committee and by soliciting information from other agencies and organizations in the community. In addition, the perceptions of current and potential adolescent clients in the community are very important. Solicitation can be through individual interviews, focus groups, surveys, or other means, and is done on a regular basis. The SDP has a process to receive, analyses, and use this information to influence its programmes and services. (Ambresin A-E et al., 2012).

Adolescents have the right to participation in the processes of their own care including contributing in decision during design, planning, implementation, monitoring and evaluation of health services; Unless the adolescent lacks decision-making capacity, or the decision-making capacity is delegated by law to a third party. Hence, the SDPs should support and promote adolescent's engagement in all aspects of health service delivery including developing and implementing national policies, guidelines and procedures to enable them make an informed choice on their health and development. A choice made by an adolescent regarding elements of his/her care is a result of adequate, appropriate and clear information in order to understand the nature, risks and alternatives of a medical procedure or treatment and their implications for health and other aspects of the adolescent's life. In some situations, a documented consent for a procedure or treatment is required. The facility has policies and procedures on how to handle an informed consent, and makes sure the providers know and respect them.

Finally, the facility engages adolescents in selected aspects of service delivery such as peer education, training and advocacy. In order to participate in a meaningful way, adolescents should be empowered to do so effectively.

Adolescent views regarding their own care can lead to disengagement (e.g. Discontinuation of a treatment) and loss to follow-up; In turn, upholding adolescents' participation in their own care supports the provision of sustainable, acceptable, locally appropriate and more effective solutions, which ensures that more adolescents will seek and remain engaged in care.

Measurable criteria for Standard 8

Input	Process	Output
71. The governance structure of the facility includes adolescents. 72. There is a policy in place to engage adolescents in service design, planning, monitoring and evaluation.	75. The health facility carries out regular activities to identify adolescents' expectations about the service and to assess their experience of care, and it involves adolescents in the design, planning, monitoring and evaluation of health services.	78. Adolescents are engaged in design, planning, monitoring and evaluation of health services. 79. Adolescents are engaged in decisions regarding their own care.

73. Health-service providers are aware of laws and regulations that govern informed consent, and the consent process is clearly defined by facility policies and procedures in line with laws and regulations. 74. Health service providers and significant others are well prepared for adolescents and youth involvement and participation	76. Health-service providers provide accurate and clear information on the medical condition and management/ treatment options, and explicitly take into account the adolescent's decision on the preferred option and follow-up actions. 77. The health facility carries out activities to build capacity of adolescents, health providers and significant others in selected aspects of service provision as well as adolescents-adult partnership.	80. Adolescents are engaged in certain aspects of health- service provision.
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Intent of Standard 8

This standard emphasizes three important areas for adolescents' participation. First, it highlights adolescents' participation in the design, planning, monitoring and evaluation of health services. Second, it stresses adolescents' participation in decisions regarding their own care. Third, it emphasizes adolescents' participation and engagement in selected aspects of service provision. Health-service providers have an obligation to make sure that opportunities are available for adolescents to exercise these rights.

To ensure adolescents' participation in the design, planning, monitoring and evaluation of health services, the facility regularly solicits adolescents' perceptions of its services. Including adolescents in the governance structure of the facility is one way to understand their perceptions of its services.

CHAPTER 4:

IMPLEMENTATION GUIDE

ACTIONS AT NATIONAL LEVEL

Governance

Review policies, laws and systems, and modify existing ones when necessary

Comprehensive package of services:

- i. Define the required package of health information, counselling, diagnostic, treatment and care services for adolescents based on up-to-date evidence on mortality, morbidity, health-related behaviours, risk and protective factors and social determinants affecting adolescent health;
- ii. Review policies and laws and modify them as necessary to enable the provision of the defined comprehensive package of health services for adolescents;
- iii. Review policies and modify them as necessary to suit needs of ensure planned transition from child-cantered to adult- cantered health service for adolescents with chronic conditions that mandates coordination and joint planning at all levels.

Financial protection:

Design and implement measures of adolescents' financial protection (e.g. waivers, vouchers, NHIF, CHF/TIKA, exemptions from or reduced co-payments) so that health services are free at the point of use or affordable to adolescents.

Confidentiality:

Review national policies and laws to include provisions on:

- Clear and unambiguous indication of situations when confidentiality could be breached (e.g. disclosure of sexual abuse, significant suicidal thoughts or self-harm or homicidal intent), with whom, and for what reasons;
- Clear standard operating procedures (SOPs) in situations when confidentiality might be breached due to legal requirements;
- Clear requirements that in all other circumstances, health facility in charges, service providers and support staff are to maintain the confidentiality of their adolescent clients;
- Clear requirements that a consultation with an adolescent client accompanied by parents/ guardians should routinely include time alone with the adolescent;
- Clear procedures to be about clients is not disclosed to third parties, and that personal information including client records are held securely; and
- Requirements for the organization of the physical space of the facility and actions to ensure visual and auditory privacy during registration and during consultation with a service provider.

Age of consent

Examine and potentially revise current policies for age of consent in order to reflect current WHO recommendations;

- Give clear and unambiguous indication of situations when an informed consent is required, the legal age of adolescents' consent for key clinical situations and procedures, and from whom the consent should be obtained if the adolescent is below the legal age of consent for a given situation/procedure;
- Adopt flexible policies to allow adolescents in specific groups or situations to be considered "mature minors";
- Include SOPs for obtaining informed consent;
- Emphasize that in all cases, whether or not the consent of the parent/guardian is required, the voluntary, adequately informed, non-forced and non-rushed assent of the adolescent should be obtained;
- Communicate that in all situations, whether or not a documented consent by the adolescent is required, adolescents should be given full, unbiased and clear information on the nature, risks and alternatives of a medical procedure or treatment and their implications to enable adolescents' participation in their own care and the communication of their choices.

Equity

Review national policies and laws and modify them as necessary to ensure that they do not restrict the provision of health services to adolescents; make sure that policies state the obligation of health service providers to provide services to all adolescents irrespective of their ability to pay, age, sex, marital status, schooling, sexual behaviour or other characteristics.

Participation

Review policies and laws and modify them as necessary to ensure that adolescents are engaged in designing, planning, implementation, monitoring, evaluation and provision of services; ensure that national directive(s) that establish the policy for the governance of health-service facilities make provisions for the inclusion of adolescents in the governance structure.

Welcoming services

Review existing policies to include provisions on

- Ensuring convenient operating hours for the adolescent population and reducing waiting time;
- Ensuring a welcoming and clean environment (seating area is comfortable and clean, drinking water is available, educational materials are available, toilets are clean and functioning, surrounding area is clean);
- Ensuring privacy at all stages of the Health services process.
- Health management information system (HMIS): Review the HMIS, including data collection and reporting forms and reporting requirements to ensure that all data are collected in a single age and are disaggregated by sex and 5-year age groups with focus to 10 to 24 years
- Communicate national, policies and laws and latest revisions to regional managers and for regional-level actions.
- Communicate policies and laws, including the latest revisions on:
 - Equitable service provision to adolescents and financial protection measures;
 - The age of consent; Confidentiality; Adolescents' participation in designing planning, implementation, monitoring, evaluation and provision of services;
 - The organization of welcoming services (e.g. optimizing operating hours and waiting time, ensuring privacy, maintaining a clean

environment), and request the development of local procedures to implement the policies.

- Communicate the importance of:
 - Adopting a human rights-based approach in the health - services for all adolescents regardless of their socio-economic status by;
 - Involving adolescents in designing and assessing health services;
 - The special role that confidentiality plays in adolescents' willingness to use services, and the importance of informing them about confidentiality and applying facility procedures to maintain it
 - Respecting privacy at all stages of the adolescents' consultation process, and applying facility procedures to assure privacy, and
 - Planned transition from child-cantered to adult-cantered health service for adolescents with chronic conditions.

Advocate with other sectors and wider society to ensure their support for key policies

- Communicate the rationale for providing health services to adolescents in the mass media and in meetings with national-level representatives of other sectors (e.g. education) and civil society institutions.
- Raise awareness in national meetings and in the mass media about national policies on adolescents' financial protection and other policies that protect adolescents' rights to receive quality services irrespective of their ability to pay, age, sex, marital status, schooling, race/ethnicity, sexual orientation or other characteristics.
- Communicate about adolescents' rights to confidentiality to confidentiality and privacy in the mass media and in meetings with national-level representatives of other sectors (e.g. education) and civil society institutions.
- Inform the wider community about the package of health services that should be made available to adolescents.
- Develop or review, as appropriate, norms, standards and standard operating procedures and make them known and available in the districts
- Adopt national standards for quality health services for adolescents.

- List the health services from the defined package that are to be provided to adolescents within the health facility and in the community, and develop guidelines/SOPs on how to implement the package.
- List the health services that are to be provided at each level of service (e.g. primary level, secondary level and referral level), and develop SOPs for the referral system to ensure compliance.

Develop or review, as appropriate, information and training materials, practice guidelines and other decision support tools in adolescent health service.

- Develop or adapt materials from locally or internationally available information and educational materials for adolescents, parents, and guardians and other community members and organizations to inform them about the value of providing health services to adolescents. Liaise with non-governmental organizations (NGOs) working on adolescent health issues in the country to explore whether the informational/educational materials they produce could be disseminated to the districts (after adaptation, if required).
- Develop or adapt materials using age-appropriate visual and audio aids on key medical conditions, their management and treatment options for adolescents and send them to the districts. Liaise with NGOs providing health-service services to adolescents in the country to explore whether the materials they produce on selected conditions could be disseminated to the districts (after adaptation, if required).
- Develop or adapt evidence-based decision support tools (guidelines, protocols, algorithms, job aids) for adolescent health-service conditions and situations as required by the defined package of services.
- Ensure that these decision support tools are included in teaching/learning materials and activities.
- Develop or adapt tools for supportive supervision and distribute them to districts and health facility in charges.
- Ensure an adolescent health focus in national reports
- Ensure that national reports on cause-specific utilization of services include a focus on adolescents.

Ensure that other national reports (e.g.

- Demographic and Health Surveys, Behaviour Surveillance Surveys, quality of service evaluations) have a focus on adolescents
- Conduct data synthesis, monitoring and evaluation activities at the national level and use national data to stimulate local actions.

- Communicate to district officials
- the importance of using data for action planning and implementation of quality improvement initiatives;
- The requirements for district-level responsibilities in monitoring and evaluating the implementation of standards (e.g. monitoring visits to facilities and periodic district-level evaluations).
- Communicate to districts who are the vulnerable group(s) of adolescents based on national data and encourage district- and local-level analysis of vulnerable groups of adolescents.
- Issue a directive that: Establishes that self-assessments of the quality of service for adolescents are a mandatory part of the routine functioning of primary service facilities, and includes recommended timing and various roles and responsibilities; includes the provision that identification of adolescents' expectations about the service and assessment of their experience of care are part of the self-assessment.
- Develop and endorse tools to monitor the implementation of national standards for quality health-service for adolescents.
- As part of periodic nationwide evaluations of the implementation of standards: Analyses national data on adolescents' experience of service; Analyses national data on vulnerable adolescents' experience of service; Evaluate compliance with evidence-based guidelines and protocols and the impact on adolescent health. Provide feedback to districts in each of these areas and support them in taking corrective actions.
- Conduct periodic evaluations of equity in adolescent health service, provide feedback to districts and facilities, and implement national- level corrective actions to increase equity.
- Set up a system to reward and recognize highly performing districts, facilities, health-service providers and support staff, and inform districts.
- Communicate to district officials the importance of recognizing and rewarding well-performing facilities and staff, and do so using a combination of extrinsic (e.g. financial rewards), and intrinsic rewards (e.g. professional education activities).

Workforce capacity

Define core competencies in adolescent health development, develop and implement competency-based training programs in pre-service and continuous professional education

- Define the core competencies required by the service providers in adolescent health and development in key areas (communication, basic concepts in adolescent health and development, policies and laws that affect adolescent health-service provision, quality standards for health-service services, technical competencies regarding clinical service in specific clinical situations).
- Set up a system for continuous professional education in adolescent health service including a combination of traditional learning methods (e.g. face-to-face trainings, seminars, case- reviews, participation in conferences, with innovative ways to access teaching expertise and materials (e.g. e-learning, self-learning by accessing electronic databases).
- Develop and implement competency-based training programmes in adolescent health and development in pre-service and continuous professional education in adolescent health information, counselling, diagnostic, treatment, service and rehabilitation for priority conditions.
- Ensure that a human rights-based approach to adolescent health service, including preventing discrimination, is addressed in both pre-service and continuous professional education training, handbooks and training materials.
- Request that districts regularly identify training needs in core competencies in adolescent health and development at the district level and conduct competency-based in-service trainings in adolescent health.
- Ensure that training and orientation materials on adolescent health and development and a human rights-based approach to adolescent health service are available at the district level.
- Ensure that training and orientation on data collection and analysis to inform quality improvement actions are available at the district level.
- Organize trainings on the safe use of equipment, or support district managers to organize such trainings.
- Set up a system for supportive supervision in adolescent health service
- Set up a system for supportive supervision in adolescent health-service (Standardized supportive supervision checklist to be in place) (including peer, supervisor and external assessment) and emphasize the educational, problem-solving and non-punitive nature of it. Ensure that supportive supervision is linked to priorities for improvement as identified during the monitoring of the implementation of standards and that feedback to staff is provided (on site feedback verbal and written

feedback).

- Make sure the system of supportive supervision is extended to community health workers and other community health workers involved in providing information and services to adolescents.
- Coordination, Monitoring and Evaluation. Establish a multi-disciplinary and Multisectorial coordinating committee for Adolescent friendly services will support implementation at all levels. The standardized tool for monitoring and evaluation will be disseminated and used at all levels.
- Ensure an adolescent health focus in job descriptions and policies on skill mix
- Include competencies in adolescent health and development in job descriptions as relevant, and ensure that objectives, responsibilities, authority and lines of accountability within job descriptions include a focus on adolescents.
- Define the skill mix in adolescent health service of teams at different levels of the health-service system, identify district staffing needs, and deploy staff to facilities to ensure the necessary skill mix.

Financing

Mobilization of funds from the national budget and other sources to ensure the provision of a comprehensive package of services to adolescents.

- MoHCDGEC Work with the ministry of finance and other relevant ministries and partners so that budget allocations are adequate to enable the provision of the defined package of adolescent health services.
- Develop and implement advocacy strategies targeting policy and decision makers to advocate for more funding for adolescent sexual reproductive health
- MoHCDGEC Make the national package of adolescent health services an instrument to guide purchasing decisions and benefit packages, with due attention to preventive services.
- Finance continuous professional education activities
- Allocate funds to ensure continuous professional education activities in adolescent health and development at the district level.
- Allocate funds for capacity building, as part of the continuous professional education of health facility in charges and health-service providers, in using decision support tools for various adolescent health-service

conditions and situations as required by the defined package of services.

- Allocate funds to support the activities necessary to implement the system for supportive supervision in adolescent health service (e.g. training of trainers, travels).
- Allocate funds for printing and other dissemination means of decision support tools.
- At national level allocate fund for development and inclusion of ARH competency based pre-service training
- Finance quality improvement initiatives in adolescent health service.
- Allocate funds to implement national quality standards, 2 and to implement reward and recognition actions of highly performing districts.
- Make funds available to enable districts to support health-service facilities in implementing actions to improve the quality of health service of adolescents, based on findings of self-assessments.
- Finance the production of information and education materials for adolescents and community members
- Communicate with districts to identify their needs for information and education materials for adolescents and community members, and allocate sufficient funds for their production.

Drugs, Supplies and Technology

Advocate with districts to ensure the equitable use of the drugs, supplies and technologies in the care of adolescents.

- Communicate to district managers the importance of the equitable provision of medicines and supplies, with special regard to adolescent clients, and the importance of taking corrective actions in the event of inequitable use (e.g. denying adolescents certain methods of contraception).
- Communicate to district managers the importance of equitable use of medical equipment and technology, with special regard to adolescent clients, and the importance of taking corrective actions in the event of inequitable use (e.g. denying adolescents access to sophisticated equipment).

ACTIONS AT REGIONAL LEVEL

The national standards for adolescence align with existing health administrative structures mechanism whereby the regional level authorities are responsible to translate the national actions at district levels. Some of the action includes:

- Translate national, policies and laws and latest revisions, to district managers and request district-level actions.
- Advocate with district managers to ensure their ownership and support for support and implement the national standards
- Oversee health service provider competencies in adolescent health and development through deployment of qualified staffs, supportive supervision and on job training
- Negotiate allocation of funds from the national budget to ensure the provision of a comprehensive package of services to adolescents.
- Communicate to district managers the importance of the equitable provision of medicines and supplies with special regard to adolescent clients, and the importance of taking corrective actions in the event of inequitable use (e.g. denying adolescents certain methods of contraception).
- Inform districts about the latest requirements for reporting, and send updated data collection and reporting forms.
- Ensure that districts make display boards with policies and procedures on equitable (including free or affordable) service provision for adolescents and distribute them to facilities.
- Inform districts and facilities that the visible display of adolescents' rights in the health facility is mandatory.
- Inform district managers about the package of health services that should be made available to adolescents.
- Advocate with district managers to ensure their ownership and support for key policies

ACTIONS AT DISTRICTS LEVEL

Governance

Communicate national policies, laws and latest revisions to SDP in charges and encourage facility-level actions

Communicate to SDP policies and including the latest revisions, on

- equitable service provision to adolescents and financial protection measures;
- The age of consent and confidentiality;
- Adolescents' participation in designing, planning, monitoring and evaluation of health services;
- The organization of welcoming services (e.g. optimizing operating hours and waiting time, ensuring privacy, maintaining a clean environment); and encourage the development of standard operating procedures to implement the national standard.
- Inform SDP in charges about the defined package of health information, counselling, diagnostic, treatment and health services for adolescents.
- Ensure that SDP in charges receive the guidelines/SOPs regarding which health services are to be provided to adolescents within the health facility and in the community.
- Ensure that SDP in charges receive the documents on referral policies within and outside the health sector and the SOPs to implement them.
- Inform SDP in charges about mandatory visible display of adolescents' rights in the health-service facility.
- Inform SDP in charges about the latest requirements for HMIS, and send updated data collection and reporting forms.
- Ensure that SDP in charges are aware of national policies and standard for the provision of adolescents' health service and communicate the importance of doing so.
 - Communicate the need for district officials and health facility in charges to take actions to help inform adolescents about the range of health services that are provided in the facility.
 - Communicate the importance of local actions (e.g. modifying operating hours to meet the needs of specific groups of adolescents) to make services welcoming and accessible.
 - Communicate the need for district officials and health facility in charges to identify and engage in formal and informal partnerships with key community organizations to increase community support for adolescent use of services.
 - Communicate to district officials and health facility in charges about the importance of outreach activities that:

- inform schools, youth and other community organizations about the value of providing health services to adolescents through outreach;
- Reach vulnerable groups with information and services by trained community health workers;
- Reach out the selected groups of adolescents in the community with selected health services (e.g. some aspects of antenatal care) and commodities (e.g. iron and folic acid tablets).
- Communicate to districts the importance of involving adolescents, including vulnerable groups, in the planning, monitoring and evaluation of health services, as well as in certain aspects of health-service provision (e.g. outreach health education, counselling and training).
- Communicate the importance of routine information from districts on cause-specific utilization of services by adolescents, and the role of an adolescent health focus in district and facility-based registers.
- Communicate the importance of routine facility- level assessment of the quality of services for adolescents and periodic evaluations at the district level.

Advocate with SDP in charges to ensure their ownership and support for key policies

- Communicate to SDP in-charges and staff the importance of:
 - protecting adolescents' rights to receive quality services irrespective of their ability to pay, age, sex, marital status, schooling, sexual behaviour or other characteristics; Involving adolescents in designing and assessing health services; The special role that confidentiality plays in adolescents' willingness to use services, and the importance of informing them about confidentiality and applying facility procedures to maintain it; Respecting the privacy at all stages of the adolescents' health service, including during appointments, and of applying facility procedures to assure privacy; and

Planned transition from child-cantered to adult- cantered health service for adolescents with chronic conditions. (E.g. acquired HIV in child hood)

- Communicate to SDP in-charges the importance of local actions to help inform adolescents about the range of health services available (e.g. putting up a notice board), and to organize welcoming services

(e.g. modifying working hours to meet the needs of specific groups of adolescents).

- Communicate to SDP in-charges about the importance of outreach activities that:
 - Inform schools, youth and other community organizations about the value of providing health services to adolescents through outreach
 - Reach vulnerable groups with information and services by trained outreach workers
 - Reach selected groups of adolescents in the community with particular health services (e.g. some aspects of antenatal care) and commodities (e.g. iron and folic acid tablets)
 - Working with NGOs in the community that could engage selected adults or adolescents to provide health services and commodities to adolescents in the community.
- Communicate the importance of routine information from health facilities on cause- specific utilization of services by adolescents, and the role of an adolescent health focus in facility-based registers.
- Communicate to SDP in-charges the importance of routine facility-level assessment of the quality of services for adolescents.

Advocate with other sectors and wider society to ensure their ownership and support for key policies

- Communicate the rationale for providing health services to adolescents in meetings with district-level representatives of other sectors (e.g. education) and civil society institutions.
- Communicate what health services are provided, where and when they are provided, and how much they cost: in the mass media (where possible); In meetings with representatives of other sectors (e.g. education) and civil society institutions
- Raise awareness in the media about national policies on adolescents' financial protection and other policies that protect adolescents' rights to receive quality services irrespective of their ability to pay, age, sex, marital status, schooling, race/ethnicity, sexual behaviour or other characteristics.
- Communicate about adolescents' rights to confidentiality and privacy in mass media, and in meetings with district-level representatives of other sectors (e.g. education) and civil society institutions.

Support SDP in-charges to implement key policies and to translate them into facility SOPs

- Work with SDP in-charges to identify which groups of adolescents to reach with services in the community, where to reach them, and what health services and commodities to reach them with.
- Support SDP in-charges to increase compliance to SOPs for referrals (e.g. facilitate access through referral linkages to services that are not available locally).
- Support SDP in-charges in translating policies on equity and financial protection into local SOPs.
- Support SDP in-charges in translating the policies on confidentiality and privacy into local SOPs.
- Support SDP in-charges in translating the policy on informed consent into local SOPs.
- Make display boards with policies and procedures on equitable (including free or affordable) service provision for adolescents and distribute to facilities.
- Encourage SDP in-charges to create local processes for involving adolescents in designing, assessing and providing health services, and to have a plan on how to engage adolescents.

Ensure the availability of information and educational materials at the district level

- Arrange for the delivery of information and educational materials obtained from national officials or NGOs to facilities, and/or liaise with NGOs working in the district to explore whether the materials they produce could be disseminated to health-service facilities (after adaptation, if required).
- Arrange for the delivery of information materials on key conditions and their management options obtained from national officials or NGOs to facilities, and/or liaise with NGOs in the district that provide health-services to adolescents to explore whether the materials they produce on selected conditions could be disseminated to the facilities (after adaptation, if required).
- Ensure district reports capture health services provided to adolescents
- Ensure that district reports on cause-specific utilization of services and quality of service include a focus on adolescents including very young adolescents.¹

- Conduct data synthesis and monitoring and evaluation activities at the district level and use national and district data to stimulate local actions
- Orient SDP in-charges to the national policy for self-assessment of the quality of adolescent health service, and communicate to SDP in-charges the importance of using data for action planning and implementation of quality improvement initiatives.
- Orient SDP in-charges to the importance of identifying adolescents' expectations about the service and assessing their experience of service as part of facility self-assessment.
- Make sure tools for self-assessment, including tools to assess adolescents' expectations about the service and their experience of service, are known to SDP in-charges, and available in facilities.
- Monitor the implementation of policies regarding the provision of the defined package of services for adolescents within the health facility and in community settings and the compliance with SOPs.
- Monitor the implementation of referral policies at the district level and compliance with SOPs.
- Analyse district data to assess equity in adolescent health service, provide feedback to SDP in-charges and support them in taking corrective actions.
- Conduct periodic visits to facilities to monitor the implementation of measures for financial protection of adolescents as stipulated in national policies and laws (e.g. vouchers, exemptions from co-payments).
- As part of periodic evaluations of the implementation of standards:
 - analyse district data on adolescents' experience of service, including the experience of service in subgroups of adolescents (e.g. in vulnerable groups), provide feedback to facilities and support them in taking corrective actions;
 - Assess compliance with evidence-based guidelines and protocols, provide feedback to health facility in charges and health-service providers and support them in taking corrective actions.
- Evaluate the quality of outreach activities in the district and support SDP in-charges in taking corrective actions.
- Conduct a district analysis of who are the vulnerable groups of adolescents, share this information with health facility in charges and encourage local analysis to identify vulnerable adolescents in the local communities.

- Develop and share with SDP in-charges a list of organizations working with adolescents in the district and catchment areas of the district's health facilities.
- Take district-level actions to implement the system for reward and recognition of highly performing facilities, communicate to SDP in-charges the importance of recognizing and rewarding well-performing health-service providers and support staff, and do so using a combination of extrinsic (e.g. financial rewards), and intrinsic rewards (e.g. professional education activities).

Workforce capacity

Plan capacity-building activities at the district level

- Inform SDP in-charges and staff about national policies concerning training in adolescent health and development.
- In consultation with SDP in-charges, identify training needs and develop a district plan for health-service provider training in adolescent health information, counselling, diagnostic, treatment and health services.
- In consultation with SDP in-charges, identify training/orientation needs and develop a district plan for health-service provider training in human-rights based approaches to adolescent health service.
- Work with SDP in-charges to determine staff training needs in safe use of equipment.
- Inform SDP in-charges and staff about the availability of trainings in key areas of adolescent health and development (e.g. Management of priority conditions, human rights-based approaches to adolescent health service), and their schedule.
- Conduct capacity-building activities in adolescent health service and support SDP in-charges in doing so.
- Organize competency-based trainings in key areas of adolescent health and development (e.g. management of priority conditions, human rights-based approaches to adolescent health service) as part of continuous professional education.
- Ensure that training and orientation materials on human rights-based approaches to adolescent health-service are available to SDP in-charges.
- Conduct training/orientation for SDP in-charges on quality improvement in the field of adolescent health service, including using data collection tools, data analysis and action planning.

- Provide orientation to SDP in-charges on using new forms and reporting.
- Support SDP in-charges to conduct trainings for community health workers in adolescent health- related topics (e.g. allocate funds for trainings and develop training materials).
- Sensitize SDP in-charges on the importance of supporting health-service providers and support staff to respect the rights of adolescents to information, privacy, confidentiality, and of health service that is provided in a respectful, non- judgmental and non-discriminatory manner.
- Organize trainings in the safe use of equipment.

Implement a system of supportive supervision in adolescent health service at the district level

- Support SDP in-charges to implement a system of supportive supervision in the functioning of the health-service facility.
- Encourage SDP in-charges to prioritize the need for supportive supervision based on the findings from the self-assessments of the quality of health-service services in the facilities.
- Distribute tools for supportive supervision to SDP in-charges.

Ensure that decision support tools are available in health-service facilities and providers know how to use them

- Liaise with SDP in-charges to conduct periodic assessments of health-service providers' needs for decision support tools, and inform national authorities about priority areas.
- Distribute decision support tools (guidelines, protocols, algorithms, job aids) to health-service facilities, and organize trainings.
- Financing
 - Allocate funds for the provision of a comprehensive package of services in adolescent health service
 - Allocate, or use funds allocated at the national level, to enable district facilities to provide the defined package of health-service services to adolescents.
 - Finance continuous professional education activities
 - Allocate funds, or use funds allocated at the national level, to conduct competency-based trainings and other continuous professional education activities in adolescent health and development at district level.
 - Allocate funds, or use funds allocated at the national level, for printing

and other dissemination means of decision support tools to facilities.

- Allocate funds, or use funds allocated at the national level, for in-service training of health- service providers in using decision support tools for various adolescent health-service conditions and situations as required by the defined package of services.
- Allocate funds or use funds allocated at the national level, to conduct trainings of SDP in-charges on how to provide supportive supervision in adolescent health service to health- service providers and support staff.
- Finance quality improvement initiatives in adolescent health service
- Allocate funds, or use funds allocated at the national level, to support facilities to implement actions to improve the quality of health service to adolescents based on findings of self-assessments or external assessments.
- Allocate funds, or use funds allocated at the national level, to reward and recognize highly performing facilities, health-service providers and support staff.

Finance the production of information and educational materials for adolescents and community members

- Communicate with facilities to identify their needs for information and education materials for adolescents and community members, and allocate sufficient funds, or use funds allocated at the national level, for their production.
- Drugs, supplies and technology
- Send checklists for basic amenities, drugs, supplies and technology to SDP in-charges
- Give SDP in-charges the list of basic amenities that facilities need to have to provide the defined package of health services.
- Give SDP in-charges the list of medicines and supplies that facilities need to have to provide the defined package of health services.
- Give SDP in-charges the list of equipment, with maintenance and safe use requirements that the facility need to have to provide the defined package of health services.
- Work with SDP in-charges to determine the facility's needs in drugs, supplies and technology and ensure that the needs are met
- Work with SDP in-charges to determine what basic amenities are

required (one time or recurring).

- Work with SDP in-charges to determine what quantities of medicines and supplies are required on a monthly/quarterly basis.
- Work with SDP in-charges to determine what equipment and maintenance are required on a monthly/quarterly basis.
- Work with SDP in-charges to obtain the equipment and maintenance services required by the district in a timely manner.
- Work with SDP in-charges to obtain the medicines and supplies required by the district in a timely manner.
- Work with SDP in-charges officials to estimate the basic amenities required by the district and ensure that they are put in place in a timely manner.
- Advocate with SDP in-charges to ensure the equitable use of the drugs, supplies and technologies in the health services for adolescents
- Communicate to SDP in-charges the importance of equitable use of medicines and supplies with special regards for adolescent clients, and the importance of taking corrective actions in the case of inequitable use (e.g. denying adolescents certain methods of contraception).
- Communicate to SDP in charges the importance of equitable use of medical equipment and technology with special regards for adolescent clients, and the importance of taking corrective actions in the case of inequitable use (e.g. denying access to sophisticated equipment).

Send checklists for basic amenities, drugs, supplies and technology to health facility in charges

- Give SDP in-charges the list of basic amenities that facilities need to have to provide the defined package of health services.
- Give health facility in charges the list of medicines and supplies that facilities need to have to provide the defined package of health services.
- Give SDP in-charges the list of equipment, with maintenance and safe use requirements, which the facility need to have to provide the defined package of health services.

Work with SDP in-charges to determine the facility's needs in drugs, supplies and technology and ensure that the needs are met

- Work with SDP in-charges to determine what basic amenities are required (one time or recurring).

- Work with SDP in-charges to determine what quantities of medicines and supplies are required on a monthly/quarterly basis.
- Work with SDP in-charges to determine what equipment and maintenance are required on a monthly/quarterly basis.
- Work with SDP in-charges to obtain the equipment and maintenance services required by the district in a timely manner.
- Work with SDP in-charges to obtain the medicines and supplies required by the district in a timely manner.
- Work with SDP in-charges to estimate the basic amenities required by the district and ensure that they are put in place in a timely manner.
- Advocate with SDP in-charges ensuring the equitable use of the drugs, supplies and technologies in the health services for adolescents.
- Communicate to SDP in-charges the importance of equitable use of medicines and supplies with special regards for adolescent clients, and the importance of taking corrective actions in the case of inequitable use (e.g. denying adolescents certain methods of contraception).
- Communicate to SDP in-charges the importance of equitable use of medical equipment and technology, with special regards for adolescent clients, and the importance of taking corrective actions in the case of inequitable use (e.g. denying access to sophisticated equipment).
- Put in place a system of procurement and stock management of the medicines and supplies necessary to deliver the required package of services
- SDP in-charges approved lists of medicines and supplies that are needed to provide the defined package of health services.
- SDP in-charges work with health-service providers and support staff to put in place a system to ensure that stocks of medicines and supplies are adequate at all times.
- SDP in-charges organize regular replenishment of medicines and supplies.
- Put in place a system of procurement, inventory, maintenance and safe use of the equipment necessary to deliver the required package of services.
- SDP in-charges have lists of equipment, with maintenance and safe use requirements that is needed to provide the defined package of health services.

- SDP in-charges Work with service providers and support staff to put in place an inventory system to review the availability and state of equipment (e.g. functionality and good order of pieces).

ACTIONS AT FACILITY LEVEL

Governance

Communicate national policies and laws, standard operating procedures, and latest revisions, to facility staff

- Facility in-charges communicate to facility staff policies and laws, their latest revisions, and recommended procedures on equitable service provision to adolescents and financial protection measures;
 - Informed consent; confidentiality and privacy
 - Adolescents' participation in planning, monitoring, evaluation and provision of services
 - And the organization of welcoming services (e.g. optimizing operating hours and waiting time, ensuring privacy and maintaining a clean environment)
 - The planned transition from child-cantered to adult-cantered health service for adolescents with chronic conditions.
- Facility in-charges make available in the facility printed copies of national policies and laws concerning adolescents' financial protection and other measures for equitable service provision.
- Facility in-charges ensure that the guidelines/SOPs regarding which health services are provided in the health facility and/or in community, settings are in place and known to staff.
- Facility in-charges ensure that service providers and support staff are aware of the referral policy within and outside the health sector and the SOPs to implement it.
- Identify community resources and build partnerships for advocacy and service provision for adolescents
- Facility in-charges identify key community organizations in the catchment area, and engage in formal and informal partnerships with them to increase their support for adolescent use of services, to develop health education and communication strategies and materials and to plan service provision.

- Facility in-charges inform/share with facility staff the list of key partner agencies and organizations to increase community support for adolescent use of services.
- Facility in-charge and staff identify NGOs, which could engage selected adults and adolescents to provide health services and commodities to adolescents in the community.
- Facility in-charges work with health-service providers and local services within and outside the health sector to develop referral protocols to locally available services.
- Facility in-charges work with staff, community members and community organizations to identify vulnerable adolescents in their communities, and make sure that facility staff is aware of these groups.
- Facility in-charges work with service providers and support staff to develop a plan on how to engage adolescents in the planning, monitoring and evaluation of facility services, and service provision.
- Facility in-charges establish, in consultation with local community and facility staff, the process of inclusion of adolescent(s) in the governance structure of the facility.
- Facility in-charges work with service providers and support staff to identify and draw adolescents employed by organizations working with young people or volunteers from the community into the planning, monitoring and evaluation of facility services and service provision.
- Facility in-charges and health-service providers work with adolescents employed by organizations working with young people or volunteers from the community to draw upon their ideas and suggestions for designing health service provision and to involve them in assessing and providing health services.
- Advocate with facility staff, other sectors' services and the wider community to ensure their ownership and support for the implementation of key policies
- Facility in-charges communicate to staff the importance of providing evidence-based information to adult visitors about the value of providing health services to adolescents, and monitor these activities as part of supportive supervision and self-assessments.
- Facility in-charges communicate the importance of, and orient health-service providers and support staff in, respecting the rights of adolescents to information, privacy, confidentiality, participation, and health service that is provided in a respectful, non-judgmental and non-

discriminatory manner.

- Health-service providers encourage adolescents to read information on their rights and communicate to them about their rights to confidentiality and privacy.
- Facility in-charges communicate to health-service providers and support staff the importance of providing services to all adolescents without discrimination. Facility in-charges work together with facility staff to raise adolescents' awareness of financial protection measures and other policies that protect adolescents' rights to receive quality services without discrimination.
- Facility in-charges communicate to health-service providers the importance of routine information collection in the health facility on cause-specific utilization of services by adolescents and the role of an adolescent health focus in facility-based registers.
- Facility in-charges communicate to facility staff the importance of using data on adolescent health-service for action planning and implementation of quality improvement initiatives.
- Develop or adapt, as appropriate, national standard operating procedures to implement key policies
- Facility in-charges ensure the display of boards in the facility about adolescents' rights; Policies and procedures on equitable (including free or affordable) service provision for adolescents.
- Facility in-charges work with service providers and support staff to develop local SOPs including the designation of responsibilities among staff in applying policies on: the financial protection of adolescents; confidentiality; informed consent; and Planned transition from child-centered to adult-centered health service for adolescents with chronic conditions.
- Facility in-charges work with service providers and support staff to develop SOPs in applying policies on the equitable provision of services to adolescents and ensure that service providers and support staff know their responsibilities and know the SOPs about equity in adolescent health service (e.g. Facility in-charges orient newly employed personnel).
- Facility in-charges work with service providers and support staff to develop SOPs, with assigned responsibilities across health-service providers and support staff, to ensure a welcoming and clean environment and to find local solutions to minimize waiting times.
- Facility in-charges work with service providers and support staff to

determine whether and how the working hours could be modified to take into account the needs of specific groups of adolescents.

- Facility in-charges work with service providers and support staff to determine what could be done to optimize the organization of the physical space of the facility to ensure both visual and auditory privacy in the facility.
- Facility in-charges work with health-service providers to identify ways to involve adolescents, including vulnerable group(s) of adolescents, in the designing, planning, implementation, monitoring and evaluation of health services.

Supply facility staff with information and training materials, practice guidelines and other decision support tools

- Even if no materials are obtained from district officials, Facility in-charges work with health- service providers to ensure that appropriate clippings from newspapers and magazines, and handmade materials are displayed for information and education for adolescents, parents and other community members.
- Facility in-charges ensure that information materials on key medical conditions and their management/ treatment options for adolescents are available to health-service providers and used to enable adolescents' decisions on the preferred options and follow-up actions.

Ensure facility reports include adolescent health information: Health service providers collect data that includes information about adolescents' age, sex, presenting problem, diagnosis and services provided through facility-level registers.

- Facility in-charges collate facility data in reports to districts in a way that preserves age- and sex- disaggregated data, including for very young adolescents.
- Monitor the implementation of quality standards in the facility and use data to stimulate actions
- Facility in-charges monitor and evaluate the scope and quality of health education and counselling activities conducted by facility staff (e.g. during the supportive supervision visits and self- assessment surveys).
- Facility in-charges monitor the implementation of the plan for outreach activities by both health- service providers and trained community health workers, evaluate the quality of outreach activities, and take corrective actions as necessary.

- Facility in-charges monitor compliance with local referral protocols and take corrective action as necessary.
- Facility in-charges monitor the provision of the package of defined services within the health facility.

As part of self-assessment of the quality of service provided in the facility, Facility in-charges do the following;

- Collect SDP data on compliance with quality standards provide feedback to SDP staff and take corrective actions.
- monitor whether or not medicine and supplies are equitably used (e.g. identify situations when medicines and supplies were denied for non-medical reasons);
- Ensure Medical equipment and technology are equitably used (e.g. identify situations where adolescents were denied access to expensive technology); and take corrective actions should such events occur.
- Ensure that tools for self-assessment, including tools to assess adolescents' expectations about the service and their experience of health services, are known to SDP staff, available and used for monitoring of the quality of health service for adolescents.
- In collaboration with facility health-care providers and support staff, health facility in charges establish a local process to translate the findings of self- assessments into an action plan for quality improvement.
- Assign roles and responsibilities of staff for the implementation of proposed actions and monitor implementation.
- Implement SDP - level action plans for reward and recognition of highly performing staff.

Workforce capacity

Plan capacity-building activities for SDP staff facility in charge should:

- Identify training needs of SDP staff in key areas (e.g. communication for adolescent health, adolescent health information, counselling, diagnostic, treatment and care; using decision support tools such as guidelines and protocols for various adolescent health-service conditions and situations; and a human-rights- based approach to adolescent health service).
- Inform districts about the training needs of staff in the SDP and coordinate with district authorities to ensure that service providers are trained according to their needs.

- Ensure that health service providers and support staff are trained in the safe use of equipment.
- Ensure health service providers participation in continuous education in adolescent health service and in supportive supervision.
- Ensure that supportive supervision activities, such as peer and supervisor assessments are carried out regularly and are informed by the findings of SDP self- assessments of the quality of health-service services in the SDP.
- Communicate to health service providers that supervisory visits are not merely administrative events, and not intended to be fault finding or punitive, rather they are intended to be supportive, educational and aimed at problem solving.
- Ensure that the systems for supportive supervision are extended to community health workers and other community health workers involved in providing information and services to adolescents.
- Ensure that reports from supportive supervision sessions are used to identify needs for improvement.
- In collaboration with district officials, Facility in-charges ensure that staff access continuous education activities that include a combination of traditional learning methods (face-to-face trainings, seminars, case-reviews, participation in conferences) and innovative ways to access teaching expertise and materials (e.g. e-learning, self-learning by accessing electronic databases).
- Ensure that service providers have up-to-date decision support tools (guidelines, protocols, algorithms) that cover topics of clinical care in line with the package of services in place in the SDP.
- Conduct capacity-building activities
- Provide orientation to relevant staff on using new HMIS forms and reporting.
- Work with health-service providers to identify and train community health workers to enable them to conduct health education for adolescents in the community.
- Work with Health-service providers to train adolescents to provide selected services (e.g. Outreach health education, counselling and peer learning sessions).

Plan staff profile and manage staff time to enable the implementation of key policies

- Facility in-charges provide up-to-date job descriptions for health-service providers, support staff, and ensure that they understand the objectives, responsibilities, authority and lines of accountability in relation to adolescent health service.
- Based on the needs of the local adolescent population, Facility in-charges identify the skill mix in adolescent health service required in the facility's health team, and coordinate with district officials to deploy staff to the SDP to ensure the necessary staffing profile and skill mix.
- Facility in-charges plan time for selected staff members to be involved in outreach work.
- Facility in-charges allocate staff time for training of community health workers.

Financing

Inform district officials about SDP needs to enable allocation of funds for key activities

- Facility in-charge inform district officials about the financial or other support that the SDP requires from the district to implement selected actions and use allocated funds to implement them.

Medicine supplies and technology

Ensure that basic amenities in health facilities are in place and functioning. Facility in charge should:

- Have nationally approved lists of medicine, supplies, medical equipment, with maintenance and safe use requirements that is needed to provide the defined package of health services.
- Allocate responsibility to health-care providers and support staff to review the basic amenities in line with SOPs, and ensure that they are in good order.
- Organize regular servicing/repairs of basic amenities and medical equipment.
- Put in place a system of procurement and stock management of the medicine and supplies necessary to deliver the required package of services
- Put in place a system of procurement, inventory, maintenance and safe use of the equipment necessary to deliver the required package of services

- Work with service providers and support staff to put in place an inventory system to review medicine and supply stock, availability and state of equipment (e.g. functionality and good order of pieces)
- Advocate and communicate to SDP staff the importance of equitable use of medicine, supplies, medical equipment, and technology with special regard to adolescent clients.

CHAPTER 5:

TOOLS FOR MONITORING IMPLEMENTATION

Monitoring and Evaluation of RMNCAH activities including those for Adolescent Health Services will aim to provide reliable information on progress towards the achievement of planned interventions; and to document insights into past and existing initiatives and assist in the planning for future interventions. This guide contains a set of eight tools to conduct quality and coverage measurement surveys to collect data about compliance with standards. The tools are designed to gather information about standards' criteria from key informants (facility managers, health-care providers, support staff, adolescent clients, adolescents in the community, gatekeepers in the facility, gatekeepers in the community - community members, parents, community leaders), as well as from direct observation of the care process. Facility compliance with quality standards will be reflected in the aggregate scores per each standard (out of 100%). Tracking the progress in the standards' implementation can be conducted at four levels, namely: facility, council, region and national. There are several steps to consider in the planning, implementation and analysis of the results of the quality and coverage measurement surveys:

1. determining the scope of the assessment,
2. forming and training the assessment team,
3. planning the time and resources,
4. pre-testing the data collection instruments,
5. collecting, scoring, summarizing and disseminating data, and
6. planning for improvements.

Routine monitoring

Monitoring of the standards' implementation should take place as a continual process to inform quality improvement in adolescent health care at the facility level. It can be done by way of self-assessment or external assessments (e.g.

monitoring visits from the district). Full-scale assessments that measure all the criteria for each of the standards are desirable, however, they are resource consuming and can only be performed once every few years. It is important, however, that regular monitoring of quality is performed at the facility level to ensure that corrective actions are timely. It is thus advisable whenever desirable and feasible, to select a short list of criteria (e.g. 2–3 criteria per standard) and identify corresponding indicators for quarterly or semiannual routine monitoring, while deciding to monitor the compliance with the entire list of criteria less often. The choice of the criteria for the limited monitoring could be based on a number of considerations, for example:

- criteria that are judged as the most essential for standard implementation, or
- criteria that address the most problematic areas as shown by the situation analysis and/or a previous assessment, or criteria that were agreed upon between a number of facilities to enable horizontal comparisons.

A good practice is to space out the completion of the questionnaires over the entire implementation period between quality improvement meetings, preferably quarterly. At the same time, it is recommended to interview one or two clients per day rather than try to fill in all 80 questionnaires in one or two weeks before the quality improvement meeting. National Level experts from MOHCDGEC will provide technical inputs on the mechanisms for conducting these monitoring activities.

Periodic evaluation

Evaluation of the implementation of quality standards for adolescent health care is the periodic assessment of the overall process of implementation to inform District Council and national-level actions. This includes not only the benchmarking of the performance of individual facilities against the standards, but also the assessment of reasons for under-performance, as well as lessons learnt from champion institutions. Evaluations are, therefore, important to identify the support that facility staff and facility managers may need from the national and district levels to improve performance. In addition, if a standard or its criteria no longer reflect a relevant problem or current health-care practice, it should be revised. Evaluations are important, therefore, to identify changing priorities and the need for standards' revision. The below table summarizes the scope, methods and expected frequency of the standards' monitoring and evaluation activities at the facility, district and national levels. These periodic evaluations will be facilitated by National Level experts from MOHCDGEC.

Activity	Level/Expected Frequency	Description of the method and scope of the monitoring and evaluation activity
Routine monitoring	Facility/every 3 months (quarterly)	Self-assessments using self-assessment tools to monitor a short list of indicators on a limited number of priority criteria (e.g. those criteria that scored least in the previous assessment, or criteria that are considered most essential). Questionnaires could be completed routinely or on a weekly basis, and every 3 months' data should be analyzed and discussed in facility meetings to identify actions for improvements. Focus of the self-assessments may periodically change depending on the progress the facility makes against selected standards and criteria.
	Facility level every 3–6 months	Supportive supervision sessions by the facility manager or District Council Managers using the client-provider interaction tool. Based on the results of self-assessment, the facility manager may identify problematic areas and focus on those during supportive supervision visits.
	Council level every 6 months	Monitoring visits by District Council Managers or National Level Managers to the facility using a short list of indicators on a limited number of priority criteria in priority facilities (e.g. the least performing facilities).
Periodic evaluations	District Council level every 2–3 years	The scope of the evaluation is to assess District Council performance against all standards and criteria, and to assess the status of the implementation of District Council level actions. A baseline survey before standards implementation might provide useful information for comparison. Depending on the feasibility, the assessment could be done in a representative sample of District Council facilities, or in all facilities in the district. The information will be gathered through quality and coverage measurement surveys using standards monitoring tools and key informant interviews. Other sources will be used to gather information about the status of the implementation of the district level actions outlined in the implementation plan, reasons for delayed implementation and factors linked to good progress.

Activity	Level/Expected Frequency	Description of the method and scope of the monitoring and evaluation activity
	Regional and National level every 4–5 years	The scope of the evaluation is to assess national progress against quality standards, and to assess the status of the implementation of national- and district-level actions. A baseline survey before standards implementation might provide useful information for comparison. The assessment might be done in selected District Councils according to defined criteria or in all District Councils, but within each of the selected District Council the assessment should be conducted in a representative sample of facilities. The information will be gathered through quality and coverage measurement surveys using the standards monitoring tools. Key informant interviews and other sources will be used to gather information about the status of the implementation of national- and district-level actions outlined in the implementation plan, reasons for delayed implementation and factors linked to good progress.

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GLOSSARY OF TERMS

Term	Explanation
Adolescent participation in health services	The adolescent provides their views and advice to service providers to make decisions about all aspects of health service.
Adolescent rights in provision of health services	- The adolescent decides which family member and friends, if any, participate with him or her in the health service process. - Adolescents' involvement in health service is respected whether or not the adolescent has a legal capacity for decision-making. - An adult's judgment of an adolescent's best interests cannot override the obligation to respect all rights of adolescents as stipulated in the national policies and laws on the Rights of the Child. - The health management system supports and promotes adolescent involvement in all aspects of health services by developing and implementing related policies and procedures.
Adolescents, youths and young people	The Tanzania National Youth Policy defines youth as all persons aged 15 to 35 years. According to the World Health Organization (WHO) and as adapted by Tanzania, adolescence is defined as all persons of 10 to 19 years; and youths 15 to 24 years; and young people 10 to 24 years of age.
Advice	Information given to influence action, in this document advice will focus on promoting adolescent actions for positive behaviour change.
Appropriate	Relevant services provided to adolescents as per specific needs and circumstances (age, sex, marital status and socio-economic situation, etc.).

Term	Explanation
Behavioural Change Communication	Is an interactive process of any intervention with individuals, communities and/or societies (as integrated throughout the program) to develop communication strategies that target to promote positive behaviours which are appropriate to their settings. Pyramid of developing BCC involves identifying risk factors, target group, desired behaviour and attitude changes, message, communication channel & media and pre-testing.
Circumstance	A state/situation that someone finds himself/herself in, that can influence adolescent behaviour.
Community Support	People living in a given locality take part in/contribute to actions aimed at empowering adolescents to obtain sexual and reproductive health services.
Competency	Ability to make correct informed decisions due to sufficient knowledge.
Comprehensive care	Care that responds to the full range of health problems of an individual or in a given community – is widely recognized as key to the overall quality of care (WHO, 2015b).
Curative health services	Measures that are undertaken to correct conditions or diseases
Development	A process of change during which adolescents undergo physiological and psychological maturity that influence their behaviour
Early Marriage	Early marriage is defined as a formal marriage or informal union where one or both parties is under the age of 18.
Equity	The absence of avoidable or remediable differences among population groups, defined socially, economically, demographically, or geographically.
Female Genital Mutilation/Cutting	Refers to all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons. Is typically carried out on young girls between infancy and adolescence, and occasionally on adult women.
Gatekeepers in the community	Influential persons such as political and administrative leaders, religious leaders, youth association leaders, women leaders, teachers, social workers and any significant others in that community.

Term	Explanation
Health literacy	The cognitive and social skills that determine the motivation and ability of an adolescent to gain access to understand and use information in ways that promote and maintain good health.
Information	A package of messages or ideas that can influence behaviour or actions
Management	Is a science and art, which uses various methods and tools to improve the performance of a system
Management System	Is the organization of a set of units to perform a specific function (or functions) effectively and efficiently to achieve a desired outcome
Met need for family planning	Proportion of demand for family planning satisfied through the use of contraception.
Outreach	Any health-related activity coordinated by the health system that takes place off-site to reach the intended audience (outside the health facility premises).
Parental support	Assistance given by fathers, mothers, guardians or other household members to enable access to appropriate SRH services.
Perception	How an individual is made to feel.
Policies	Guiding principles on how an organization should operate by focusing on its vision and mission.
Preventive health services	All measures that are undertaken to attain good health and inhibit occurrence of diseases
Promotive health services	All actions that will enable and empower individuals to maintain good health
Quality improvement	Systematic and continuous actions that lead to measurable improvement in health services and the health status of targeted patient groups
Quality of health services	WHO has defined quality dimensions for adolescent health service: available, accessible, acceptable, appropriate, equitable and effective.
Quality standard	A statement of a defined level of quality in the delivery of services required to meet the needs of intended beneficiaries.
Quality	Ability of a product or service to satisfy needs of a specific customer that is achieved by complying to established requirements and standards.
Rehabilitative services	Corrective measures of disabilities and conditions in order to restore better health

Term	Explanation
Reproductive health	State of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health is the ability to have a satisfying and safe sex life, capability to reproduce, freedom to decide if, when and how often to reproduce.
Required knowledge and skills	Both theoretical and practical technical aspects of promotive, preventive, curative and rehabilitative health that relate to adolescents. This includes interpersonal communication skills
Attitude towards adolescents	A person's views (values and beliefs) about a thing, process or person, which influence behaviour. For the standard, a positive attitude is non-judgmental and allows adolescent to receive health information, education and services with empathy for the situation she/he is in.
Right are observed	This is when the service providers and significant others conform to the rights of adolescents to get information, services, or both in relation to reproductive health.
Rights on Sexual and Reproductive Health	These are rights specific to personal decision-making and behaviour on reproduction including access to reproductive health information, privacy, guidance from trained personnel and obtaining reproductive health services free of discrimination, coercion, or violence in their sexual life.
Rights	Something that an individual or a population deserves, which they can legally and justly claim
Provision	Be able to assist service providers in provision of adolescent sexual reproductive health services by giving guidance, advice, financial, materials and human support that they need.
System	Consists of sets or units organized in such a way that, they work together effectively and efficiently to perform a specific function or functions.
Total demand for family planning	Women with unmet need and met need together constitute the total demand for family planning, which can be categorized based on whether the need is for spacing or limiting births

Term	Explanation
Unmet need for family planning	Percentage of women of reproductive age, either married or in a union, who have an unmet need for family planning. Women with unmet need are those who want to stop or delay childbearing but are not using any method of contraception (UN.org)
Youth friendly services	Are services that all adolescents are able to obtain, and these services should meet adolescents' expectations and needs, and improve their health.

