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**Adolescent and Youth Sexual Reproductive Health Services:**

**Rapid Assessment Report**

**Submitted to:**

 **Consortium of Reproductive Health Associations**

**(CORHA)**

**Conducted by: *DEM Institute of SD PLC***

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# Acronyms

ANC Antenatal Care

AYSRH Adolescent and Youth Sexual Reproductive health

BCC Behavioral Change Communication

BOYS Bureau of Youth and Sports

BPR Business processing Re engineering

CORHA Consortium of Reproductive Health Associations

FGAE Family Guidance Association of Ethiopia

FGDs Focus Group Discussions

FP Family Planning

FMOH Federal Ministry of Health

HC Health Center

HIV Human Immunodeficiency Virus

HMIS Health Management Information System

HO Health Officer

HR Human Resource

IEC Information Education communication

KII Key Informant Interview

MoWCA Ministry of Women and Children Affairs

OHB Oromia Health Bureau

RHB Regional Health Bureau

SRH Sexual Reproductive Health

WHO Woreda Health office

YFS Youth Friendly Services

**Acknowledgement**

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# Executive Summary

The Federal Ministry of Health (FMoH) and its partners endeavored to improve the sexual and reproductive health needs of adolescents and youth in Ethiopia. To this end, Standards on Youth Friendly Reproductive Health Services and Service Delivery Guideline and Minimum Service Delivery packages were developed to guide comprehensive Adolescent and Youth Sexual Reproductive Health (AYSRH) service delivery in Ethiopia.

Since 2006, in response to AYSRH problems, attempts were made by different stakeholders to expand Youth Friendly Services to health facilities. However, AYSRH service is not sufficiently organized in the selected health facilities for this assessment with qualified and dedicated staff, space and time.

Consortium of Reproductive Health Associations (CORHA) with financial support from the United States Agency for International Development (USAID) has carried out an assessment on AYSRH service delivery in selected health facilities in four regions (Oromia, SNNPR, Amhara and Tigray). The objective of this assessment was to explore the friendliness, quality and comprehensiveness of the service delivery at facility levels in reference to the national service standard. The assessment was carried out by DEM Institute of Social Development plc.

Data were generated from selected federal ministries and NGOs, regional health bureaus, health facilities including HEWs, youth groups and service providers at facility levels using KII, FGDs and observation using pre-developed checklists. In addition, semi-structured questions were employed to collect data from service delivery points. Friendliness of AYSRH services at facility level were measured in terms of physical settings (e.g. separate service delivery room, office facilities and recreational facilities), AYSRH competent provider (communication and rapport building), and availability of flexi time for adolescents and youth. Qualitative methods were read and re-read to develop themes and sub themes following the objectives of the study.

**Key findings of the assessment are detailed further below:**

1. **Demand creation**:Both quantitative and qualitative findings show that extensive demand creation is underway by health extension workers at community and school level while at health facility level; routine information sharing is part of service delivery. Data obtained through questionnaire (quantitative) shows that the balance between demand and supply pertaining to AYSRH services is much better in Tigray region than in the other three regions.
2. **Limited commitment for AYSRH Services:**Despite availability of guidance in the form of AYSRH strategy and minimum package of services standard, it was found that there is limited commitment at different management levels. As a result, strategies, guidelines, standards were not rolled out to the lower levels. It was indicate d by respondents that managers at regional, woreda and facility levels have limited orientation about AYSRH program and service package. Besides, it shows that financial allocation specifically for AYSRH services is insignificant at facility levels.
3. **Friendliness of AYSRH Service set up**: In this study, youth friendly SRH services are defined as services that effectively attract and meet the varying needs of young people. Thus, from the assessment it was found that service providers were not received proper or adequate training on AYSRH and dedicated to provide the service at public health facilities and youth centers. AYSRH service is provided as part of routine health care service delivery. Besides, providers were found to lack communication and reporting skills due to limited or no training specifically on adolescent and youth friendly SRH service provision. Evidence from the FMoH, on the other hand, attributes the problem to frequent staff turnover both at supervisory and service provision levels. Furthermore, the finding shows that there are no separate rooms dedicated to AYSRH program within the facilities. As a result, adolescent and youth are served as any other client despite their unique demands and interests. Besides, in the facilities, there were not recreational facilities for young people and the time for the service provision is not convenient. Most adolescents and youth are at school during working hours and facilities are closed by the time when young people are released from school.
4. **Supplies and Commodities:** Findings show that SRH commodity and supplies were not commensurate with the demand from adolescents and youths. Although there are regional variations, 48% of respondents from health facilities reported lack of adequate equipment and supplies to provide AYSRH. It was found that due to lack of consistent availability of commodities and supplies, public health facilities and youth centers advice young people to buy supplies from pharmacies.

These findings are believed to be interesting in light of what is being committed to both by government as well donors on the one hand and the growing concerns regarding AYSRH service provision on the other hand. Although there are several similar studies/assessments with recommendations, it is evident that there is no such dedicated study to pin point factors that affected provision of AYSRH at different levels. Thus, it is compelling to provide policy and program level stakeholders with expert opinion based on the key findings.

# Recommendations:

**1. Improve Commitment at different decision-making levels:** Improving commitment of decision makers, planners, and policy makers at federal, regional and woreda levels on the challenges and actions on AYSRH. Ensuring the roll out of strategic documents and packages to operational level, allocation of resources and dedication of space and convenient time for young people is an outcome of committed leadership. Thus, it is critical to improve commitment of leaders at all levels through training, consistent advocacy and evidence based discussion with concerned entities.

**2. Improve capacity of service providers and friendliness of AYSRH service:** Qualified and dedicated AYSRH service providers are believed to contribute to friendliness of services. In view of this continuous capacity building mechanism should be put in place and implemented to service providers at different levels. Furthermore, ensuring friendliness of service delivery is about improving friendliness of space and time. As it stands now there is no dedicated venue for young people within the health facilities, there is no flexi time for young people and there is no recreational opportunity while waiting for the services. Taking action to address such limitation requires structural decisions and modification of health facilities. Without strengthened commitment from decision makers, improving friendliness of space and time will not be possible. Thus, we recommend all stakeholders should advocate for this to happen and FMoH should be accountable to take such bold venture of making facilities friendly for young people.

**3. Ensure availability and adequacy of supplies and commodities:** The data pertaining to adequacy of supplies and commodities in the AYSRH facilities indicate an overall positive result, in that slightly more than three-fourth of the respondents has agreed that one can find both supplies and commodities of some quantity in the facilities. The quantitative data suggest that Amhara, Tigray and Oromia regions are in a better standing than SNNP region as far as adequacy of supplies and commodities in the AYSRH facilities. In this case, young people may not have money to buy such supplies and secondly, thus, supplies at least basic ones should be available free of charge for young people at facility level.

1. **Introduction**

In Ethiopia, young people 10-29 years of age account for 42% of the total population and are the single largest group in the country (CSA, 2007). In recognition of such realities the national youth and educational policies focused on how to reach young people in Ethiopia with relevant services. Yet, characteristically there is wide range of variation in terms of age, sex, schooling, residence, needs etc posing opportunities and challenges to programs designed for young people. Based on available evidence the 10-14 years brackets are the most neglected in adolescent and youth focused SRH service.

* 1. **Adolescents and Youth Sexual and Reproductive Health Challenges**

Studies show that adolescents and youth in Ethiopia are prone to various forms of SRH problems including: early marriage, sexual coercion, female genital cutting, unplanned pregnancies and abortion and sexually transmitted infections including HIV. Recent studies that focused on higher learning institute students revealed that one third of university students have had sexual experience. Of these, nearly two third were found to have sexual experience already before joining the university which evidences that SRH problems manifest early on and calls for interventions at early adolescence (NEWA, 2009 and Desalegn et.al., 2011). The consequences of such sexual engagement early on, is apparent including abortion, exposure to HIV infection, school dropout etc.

Although availability of abortion service for young people needs to be further studied, there is widespread concern on abortion likely due to unsafe sex among young people. Distant data from 2002 that was generated from young people from all over the country documented that abortion as the most widely reported SRH problem among adolescents and youth (FHI Youth-net, 2002). More recent report from FGAE has further revealed that in 2011, the organization has planned to provide safe abortion service to 25,000 women in its service delivery points. However, at the end of the year it reached over 32,000 women of whom 70% were less than 25 years of age (FGAE, 2011). This is further corroborated by Ipas study that reported unplanned pregnancy and abortion to be common among unmarried in-school girls (Takeleet.al. 2012).

HIV infection has been recognized as one of the critical challenges for adolescents and youth in Ethiopia. Available report shows that some youth are engaged in multiple sexual partners and with older men for financial gains, which put them at higher risk of HIV infection (UNAIDS 2008, WHO 2006). Nonetheless, given they are engaged in unsafe sex as evidenced above, their level of HIV infection needs more focused study. For the sake of this assessment however, this is one of the problems that affect the healthy life of young people in Ethiopia.

* 1. **Adolescent and youth Friendly Health Services provision**

In order to shade light on the adolescent and youth friendly health service provision in Ethiopia, it would be useful to provide frame of reference within which this could be understood.

Firstly, adolescence is a period of transition and experimentation. In many countries young people between the age of 15 and 19 have practiced sex for the first time and begin to adapt behavior that will have profound effect on their future health and development. Thus, young people (10 - 24) need information, life skills and access to services for a healthy transition to adulthood.

Secondly, young people are an important resource for the future of their country and there is a need to invest in their health and development so that they are able to fully participate and contribute to their country’s development endeavor.

Thirdly, as enshrined in the Convention of the rights of the child (UN 1989), young people have rights to participate in decisions and actions that affect their lives, and to develop roles and attitudes compatible with responsible citizenship.

Following such general basis for the understanding of youth friendly health services, essential packages of Youth Friendly Health Services were delineated to include:

1. Provides services supported by the existing national policies and processes that give due attention to the rights of the youth
2. Appropriate health services that cater to the RH needs of the youth are available and accessible,
3. The service outlets have physical environment and are organized in a conducive way for the provision of youth friendly health services,
4. The service outlet has drugs, supplies and equipment necessary to provide the essentials service package for youth friendly health care,
5. Information, education and communication (IEC)/ Behavioral Change and Communication (BCC) consistent with minimum service package.
6. The service providers in all service outlets have the required knowledge, skills and positive attitudes to effectively provide youth friendly RH services.
7. Youth receive an adequate psychosocial and physical assessment and individualized care based on the national standard case management guidelines/ protocols.
8. The necessary referral linkage is made and ensures continuity of care for youth.
9. Youth participate in designing and implementing youth friendly services and mechanisms are created to enhance the participation of parents and members of the community to contribute towards a sustainable YFS services in their receptive localities.

In addition to these, the current adolescent and youth health strategic document of Ethiopia (2016-2020) included nutrition, non-communicable diseases, and GBV in to the package (FMoH, 2016).

1. **Objectives of the Assessment**

**2.1. General objectives:** The general objective of the study is to explore friendliness of AYSRH services that meets the national standards in terms of quality and comprehensiveness.

**2.2. Specific Objectives**

1. Explore the availability and use of AYRH strategy and standards on AYRH in visited facilities
2. Identify the availability of providers trained on AYRH in visited facilities
3. Explore availability of supplies and commodities for AYRH service provision at service delivery points
4. Identify the level of support and commitments that the RHBs have made towards AYRH service expansion
5. Describe demand creation works implemented this far
6. Methods of Data collection and Analysis

**Study sites**

Four regions (Oromia, Tigray Amhara, and SNNPR) were included in the assessment as per agreement reached at the study-planning meeting between the Consultants and CORHA. The study sites were purposively selected. Accordingly, a total of 10 sites in the four regions were covered in the assessment.

**Data Collection**

Both quantitative and qualitative tools were developed to collect relevant information for the different groups (young people and health extension workers at community level, service providers at health facility level in selected facilities, AYSRH focal persons at federal and regional levels and selected CSOs working with and for adolescent and youth SRH) were identified.

**Questionnaire:** Quantitative data were gathered from 41 respondents using questionnaire containing more than 20 items. The items raise questions about AYSRH services, the respondents’ awareness of the AYSRH strategy and standards, demand and supply of the service provision, service providers’ competencies and skills, refresher training or orientation, availability of supplies and commodities, support and follow-up of the RHBs and demand creation works.

**FGDs:** Specific question guides were developed and administered to youth groups in the respective sites. In more than 4 sessions 24 youth groups were participated in FGDs

**Key informant interviews (KII):**Using checklists AYSRH focal persons at federal, regional and woreda levels, Ministry of Youth and Sport, CSOs working with and for youth: CORHA, FGAE, Hiwot Ethiopia, Maries topes were involved in the study.

**Observation:** This was made in order to find out the availability of the necessary documents, supplies and commodities as well as the physical setting of the health facilities on the basis of a checklist.

 The recruitment of six interviewers/enumerators was based on experience in data collection and using qualitative and quantitative tools in similar areas. A half day training/orientation was provided for data collectors to establish common understanding on the objectives and assessment tools; and procedures of data collection including observance of ethical issues.

**Data Analysis**

The **quantitative data** which were gathered through the questionnaire were first entered into the SPSS software, cleaned and edited in preparation for analysis. The data were then analyzed using mainly descriptive statistics (including percentage, mean and standard deviation) but also inferential statistics (paired sample t-test and Pearson r) to examine differences between mean scores and associations between a pair of ratings pertaining service provision for boys and girls.

The transcribed qualitative data were read and reread following key themes were defined: awareness on existence of AYSRH strategy, demands on AYSRH, friendliness of service, availability of supply and commodities. Friendliness was measured based on whether services are effectively attracting young people; meet the varying needs of young people comfortably and responsively and succeed in retaining these young clients for continuing care, flexi time and recreational services (Pathfinder International, 2003). Data were categorized under these themes and interpreted accordingly.

**Ethical issues**: Formal letter written from CORHA to regional Health Bureaus was used as an entry point. During the interviews, explanation was given about the purpose of the assessment and how the result may help in improving AYSRH service provision. Assurance was given that their identifiers will not be used in the report. In the report no personal identifier is used and selected verbatim that represent-shared findings are quoted with reference to a region instead of specific setting to maintain anonymity of the information**.**

**Limitations of the Assessment**

The assessment covers limited geographic areas (regions and woredas) and target groups only in those settings. This may affect generalization of the finding, although our expert opinion is that the findings mirror realities on ground.

1. **Findings/Results**
	1. **Awareness and Availability of the AYSRH Strategy and Service Standards**

Data generated from health facilities using self-reported questionnaire on service providers’ awareness of the AYSRH strategy and standards showed that 25 (62.5%) of the respondents are aware of the strategy, 15 (37.5%) are not. To examine whether there is a difference among the four regions in the respondents’ awareness, the data are further disaggregated by region as shown in the table 1 below. The data clearly show that there are regional differences in the proportion of respondents who reported to have been aware of the strategy. That is, Oromia and SNNP appear to be in a better standing than Amhara and Tigray in terms of the proportion of respondents who reported to have the awareness.

**Table 1. Proportion of Respondents who are and who are not aware of the Strategy and Standards by Region**

|  |  |  |
| --- | --- | --- |
| **Region** | Aware of the strategy and Standards | Not aware of the strategy and standards |
| N | % | N | % |
| Amhara | 3 | 42.9 | 4 | 57.1 |
| Oromia | 11 | 78.6 | 3 | 21.4 |
| SNNP | 9 | 69.2 | 4 | 30.7 |
| Tigray | 2 | 33.3 | 4 | 66.7 |
| Total | 25 | 62.5 | 15 | 37.5 |

Participants at facility level unanimously indicated that AYSRH services especially at public health facilities are not guided by AYSRH strategies and protocols. Facilities provide AYSRH services as part of the routine health care with no particular focus on AYSRH.

Information from participating non-governmental organizations, (FGAE, Hiwot Ethiopia and Marie Stops International - Ethiopia), show that they were well aware of the national AYSRH strategy and they all have their own internally developed service provision standards on the basis of the national strategy. They indicated that there is no specific AYSRH plan at Health Centers as well as Woreda Health Offices level.

Despite such evidences at operational level, participants from Federal Ministry of Health and Regional Health Bureau firmly argued that the strategy was advocated and disseminated to regional, wereda and facility levels to facilitate implementation of AYSRH program. However, it was found that they attribute claims at wereda and facility level to continuous staff turnover and perhaps those who participated in the assessment are yet junior ones. “*An effort has been as much to ensure all decision makers at different levels and providers know about the strategy and minimum standards. Unfortunately those who are involved in such advocacy forums have left and that it is not surprising the new ones may not know about the strategy and standards”.*

Data generated from health facilities using self-reported checklist revealed consistent findings as was from the interview where there is limitation in awareness about AYSRH strategy and standards.

With regard to the existence of copies of AYSRH strategy at Woreda, health center and youth center, FGD report reveals that their knowledge is limited to hearing about the existence of the strategy than its contents. One of the respondents argued that; “*Although I believe that awareness about AYSRH is important, there is no effort to inform us. There is no training to planners as well as providers. So, even if I heard about the strategy, I do not know what it constitutes. In view of this, I do not see what support and guidance we could offer to young people at facility level”* (Amhara).

This implies that awareness should be accompanied with clear direction and guidance on how to make the best use of it in terms of implementation. This calls for strong leadership with focus on providing clear guidance and the required technical support.

* 1. **Availability of AYSRH Services in the Facilities**

The data in the table 2 below indicate that some of the services (e.g., HIV/AIDS prevention, condom, pregnancy prevention, STI prevention, and counseling) are available in almost all the facilities visited. The other services (e.g., sexual abuse and violence service, drug abuse service, STI testing and pregnancy testing) are also available in the majority of the facilities. But the majority (24) of the respondents did not respond to this particular question possibly because they have low awareness on VCT services.

**Table 2. Respondents’ Views on the Availability of AYSRH Services in the Facilities**

|  |  |
| --- | --- |
| Service | Is the service provided in the facility? |
| Yes  | No  |
| Counselling | 39 | 2 |
| Pregnancy prevention | 40 | 1 |
| HIV/AIDS prevention | 41 | 0 |
| STI prevention | 40 | 1 |
| Sexual abuse and violence service | 31 | 9 |
| Drug/Substance abuse service | 27 | 12 |
| Condom | 41 | 0 |
| Pregnancy testing | 26 | 15 |
| STI testing | 28 | 13 |
| VCT | 14 | 3 |

A follow-up question aimed to secure the respondents’ views on whether the facility provides the AYSRH services according to the standard. The responses indicate that seven respondents did not answer this question possibly because they don’t know the standards or perhaps because they don’t consider the standards when providing the services. Among the remaining 34 respondents, 85 percent answered in the affirmative suggesting that AYSRH services are provided according to the standards. Only 15 percent admitted that service provision is not according to the standard.

A further item in the questionnaire asked the respondents to rate the supply meeting the needs of adolescents and youth (or demand). In response, only 43.9 percent indicated the supplies are adequate in terms of adolescents’ needs of demand. However, the majority of respondents were of the opinion that supply is neither adequate (48.8%) nor consistent (7.3%) with the adolescents’ needs or demand. Examination of regional differences indicate that except in Amhara region where a great majority (85.7%) of the respondents judged the supply to be adequate, in the remaining regions (Oromia, 66.7%; SNNP, 69.2%; and Tigray, 50%), the majority rated the supply to be inadequate or not consistent with the demand. All health facilities involved in the assessment claimed to have prevention services especially awareness creation interventions at different levels.

It was found out that demand creation intervention works have been undertaken by all weredas and health centers. Among such interventions are, school based youth dialogue, and community level awareness creation by Health Extension Workers are the major ones. Adolescent and youth sexual reproductive health service provision is reported in all health centers involved in the study. While contraceptive service is reported as available in all health facilities during the assessment, additional SRH services that were available for young people include the pregnancy testing, STI testing, counseling and post abortion care.

As detailed in table 3 below 15 (37%) of the respondents claim that pregnancy testing service are not available at health center level with the worst case in those facilities from Tigray and relatively better performance in those focus facilities in SNNP. Further disaggregation by wereda shows that pregnancy-testing service was not available at Biftu Health Center in Adama, DebreBerhan Health Center, Hawassa-Millenium Health Center and Yirgalem Town Health Center.

Finding shows that 28(68.3%) of the respondents said that there are STI services in the health facilities included in this study. Relatively more facilities involved in the assessment from Oromia and SNNPR provide the service while service provision is very weak in the focus facilities in Tigray region.

Post Abortion Care service is provided in most of the facilities. Fifty six percent of the respondents pointed out that post abortion care service is available in their respective facilities although still non-negligible health facilities do not provide the services due to lack of relevant training among others.

Table 3: Response on Availability of services on STI, Pregnancy Testing and Post Abortion

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Type of service | Amhara | Oromia | SNNPR | Tigray | Total |
| STI diagnosis and testingYesNo | 4 (57.1%)3 (42.9%) | 11 (73.3%)4 (73.3%) | 9 (69.2%)4 (30.8%) | 3 (30%)7 (70%) | 60%40% |
| Pregnancy testingYesNo | 3 (42.9%)4 (57.1%) | 11 (73.3%)4 (73.3%) | 7 (53.9%)6 (46.1%) | 4 (40%)6 (60%) | 55.6%44.4% |
| Post Abortion CareAvailableNot availableDon’t know | 4 (57.1%)3 (42.9%)0 | 12 (80%)3 (20%)0 | 7 (53.9%)6 (46.1%)0 | 3 (30%)5 (50%)2 (20%) | 57.8%37.8%4.4% |

Finding on counseling services show that 39 (86.7%) of the participants reported on availability of counseling service. However availability of such service is found to be relatively better in participating health centers in Oromia and SNNPR as shown in the figure below.

Fig 1: Counseling service in participating health facilities in the four regions

While public health facilities are not adequate in SRH service delivery for young people NGO run facilities and youth centers were better positioned in providing SRH services for young people. However, it was found that, youth centers did not have clear direction and resources in terms of trained providers and supplies to meet the needs of young people. Some youth centers were found to provide opportunities for young people to meet and share experiences, study and recreate. It was found that service provisions at youth centers are often limited in type and consistency of service availability. Quantitative data mentioned above shows that services like condom distribution, information, and edutainment services on SRH are available at the youth centers. One of the youth center attendants stated that, *“Young people usually come to the health center mainly for recreational purpose. In connection to this, they would love to obtain such services as family planning and termination of pregnancy which may not be available in youth centers”* (Young person, Oromia). Unfortunately most youth centers do not have referral linkages with health facilities for SRH services.

Respondents were asked to rate the availability of types of services in their respective facilities. The results are summarized in the table below in the form of frequencies.

**Table 3. Frequency of Respondents’ Ratings of Service Availability**

|  |  |
| --- | --- |
| **Type of Service** | **Ratings of Availability of Services** |
| Not Available at all | Rarely Available | Available  | Abundantly or Excessively Available |
| Basic SRH services  | 1 | 1 | 29 | 10 |
| Family planning services | 3 | 2 | 13 | 23 |
| Safe abortion services | 15 | 1 | 11 | 14 |
| Post abortion health care services | 15 | 1 | 11 | 12 |

According to the data in the table, a great majority of the respondents rated basic SRH and family planning services available or abundantly or excessively available. The ratings, however, slightly favor family planning services because more respondents rated the availability of family planning services as abundantly or excessively available. The data pertaining to safe abortion and post abortion health care services are more negative than the ratings of basic SRH and family planning services in that not a small proportion (36.6%) of the respondents confirmed that both services are not available at all in their respective facilities. This rating (that is not available at all) is more or less distributed the same way across the regions though the rating for Tigray is slightly higher. That is, safe abortion and post abortion health care services are not available in some parts of the four regions but this is slightly more so in Tigray than in the other regions.

Along with the above four items, the respondents were asked to rate the service providers’ skills to properly approach and treat the youth and adolescents coming to the facility and the service provision’s attractiveness and friendliness to young people. In both cases, the ratings were very positive. A great majority of the respondents (95% for the first item and 90% for the second item) rated the skills of service providers and friendliness and attractiveness of the service provision very favorably.

* 1. **Adequacy of AYSRH Service Provision for Boys and Girls**

Four questions in the questionnaire asked the respondents to rate (excellent, good or poor) four kinds of services (Basic health care services, life skills education services, counseling services and family planning services) provided to boys and girls. The average of the respondents’ ratings across the four items for boys and girls is summarized in the table below. Higher mean score indicates better service provision.

Table 4. Descriptive Statistics for Respondents’ Ratings of Services for Boys and Girls

|  |  |  |  |
| --- | --- | --- | --- |
| Service for Whom | N | Mean | SD |
| For Boys | 38 | 2.1316 | .5475 |
| For Girls | 38 | 2.2303 | .4979 |

Examination of the data pertaining to service provision for boys and girls indicate that the respondents’ ratings of service provision for boys and girls are highly correlated (r = .864, p = .001). Examination of differences between the two mean scores using a paired-sample t test also produced statistically significant difference in favor of the service provision for girls. That is, the service provision for girls is significantly better than that of boys (t = -2.071, df = 37, p = .045).

Further analysis of the corresponding mean scores for the four regions showed that in three of the regions (that is, Amhara, SNNP and Tigray), there was no statistically significant difference (p > .05 in each case) between the ratings of service provision for boys and the ratings of service provision for girls. In contrast, the difference in ratings of service provision for boys and girls was statistically significant for Oromia region.

The respondents were also asked to rate whether young people (boys and girls) have equal rights to various recreational activities or youth centers (e.g., playing outdoors, indulging in sports). In response, only 7 percent of the respondents rated it excellent whereas 49 percent rated it poor. In fact 44 percent of the respondents rated the condition to be good. In short, the result points to the need for more work in this area.

A final item further asked the respondents to rate the adequacy of services to prevent HTPs to which 15.4 percent of the respondents rated the adequacy excellent whereas another 15.4 percent rated the same to be poor. Rejecting the two extreme ratings, more than two-thirds (69.2%) of the respondents rated the adequacy of services to prevent HTPs good. In sum, despite the ratings of some of the respondents, a large percentage (84.6%) of the respondents rated favorably (excellent or good) the services aimed at preventing HTPs).

* 1. **Friendliness of AYSRH service delivery**

In this study, youth friendly SRH services are services that effectively attract young people; meet the varying needs of young people comfortably and responsively; succeed in retaining these young clients for continuing care. The quantitative finding of this assessment shows that sexual reproductive health services are not friendly in most of the facilities visited. Observation data and FGDs with young people revealed that neither dedicated rooms for young people nor recreational opportunities within public health facilities are found in most of visited health facilities. Furthermore, lack of flexi time for young people and trained and dedicated SRH service providers were rarely found in all facilities visited.

As regards to the dedicated rooms, one of the young girls who participated in FGD explained the problem that *“The health center is not conducive for us. We prefer not to be seen by our parents, relatives, or neighbors when we enter into the health center for service. There is no separate entry that we could not be easily spotted if we go there. So, the health center is not friendly for young people”* (young girl, Oromia).

However, only in one of the visited public Health centers AYSRH services were provided in a separate room and there were copies of AYSRH strategy and standard on AYSRH and Service Delivery Guideline (Minimum service package). Yet, this health center itself is not as friendly as expected since there are not recreational facilities in its compound and there are not trained health service providers.

* 1. **Health Care Providers’ Competencies and Skills**

The service providers’ competencies and skills were also other areas that the questionnaire focused on. In particular, the respondents were asked to indicate whether all, some or few of the service providers have the competencies and skills to provide health education to adolescents among other things. The responses are summarized in the following table.

Table 5. Health Care providers’ Competencies and Skills

|  |  |  |
| --- | --- | --- |
| **Respondents’ Ratings** | **N** | **Percent** |
| All of them are competent. | 19 | 46.3 |
| Some of them are competent. | 18 | 43.9 |
| Few of them are competent. | 4 |  9.8 |
| TOTAL | 41 | 100.0 |

As shown above, the views are divided nearly equally between the first two options: all of them are competent and some of them are competent. In addition, about one in 10 respondents indicated that only a few are competent. According to the respondents’ views, it is safe to infer that not all health care providers are competent. And this points to the need for conducting regular refresher training. According to most respondents’ opinions presented in the table below, unfortunately, refresher training or orientation appeared to be a rare phenomenon.

*Table 6. How often do service providers receive refresher orientation/training?*

|  |  |  |
| --- | --- | --- |
| **How often?** | **N** | **Percent** |
| Regularly |  4 |  9.8 |
| Intermittently |  7 | 17.1 |
| Rarely | 17 | 41.5 |
|  Not at all (Missing) | 13 | 31.7 |
| TOTAL | 41 | 100.0 |

Fig 3: Availability of dedicated and trained AYSRH service providers

The figure depicts that trained and dedicated providers are relatively missing in participating health facilities from SNNPR, Oromia and Amahara regions in all woredas under study. In connection to this, one of the KII participants pointed out that, “We were not trained in school on how to provide AYSRH service. Besides, there is no one specifically tasked to provide AYSRH for young people in this health center” (Health Officer, Oromia).

Although in-service refresher trainings were available service providers are not fully benefited from this as it depends on decision maker’s commitment and willingness to AYSRH services at facility level. Accordingly, providers in participating facilities from Amhara and Tigray regions did not obtain any refresher training. Coupled with consistent staff turnover, thus availability of trained and dedicated providers is an exception in most cases in participating facilities. As few as one in five public health centers were found to have one staff trained on AYSRH in the facility. Key informants have unanimously explained that there is limited opportunity for in-service training on AYSRH services and even those who were trained are expected to provide general services to all clients including young people. Regional Health Bureau respondents explained that a number of in-service training on AYSRH are in place but since there is limited human resource in the area, trained people are engaged in providing general health services than AYSRH in most cases.

* 1. **Availability of Supplies and Commodities**

The respondents were asked in the questionnaire to rate the availability of supplies (e.g., condoms, family planning and STI pills) and commodities (e.g., tables, chairs, beds) for service provision in the AYSRH service centers. The responses are summarized in the following table.

Table 6. Adequacy of Supplies and Commodities

|  |  |  |
| --- | --- | --- |
| **Item** | **Adequate** | **Not Adequate** |
| N | Percent | N | Percent |
| Supplies | 31 | 75.6 | 10 | 24.4 |
| Commodities | 31 | 75.6 | 10 | 24.4 |

The data pertaining to adequacy of supplies and commodities in the AYSRH facilities as presented in the above table indicate an overall positive result in that slightly more than three-fourth of the respondents have agreed that one can find both supplies and commodities in adequate quantity in the facilities. When disaggregated by region, the data indicate that about 38 percent of the respondents from SNNP region acknowledged that both supplies and commodities are inadequate in their facilities while the proportions of respondents in the other three regions who gave the same response are much lower (Amhara, 14%; Oromia, 27%; and Tigray, 33%). Taken together, the quantitative data suggest that Amhara, Tigray and Oromia regions are in a better standing than SNNP region as far as adequacy of supplies and commodities in the AYSRH facilities are concerned.

The respondents were also asked about whether supplies and commodities are provided to the center without interruption. In response, 70 percent of the respondents were of the opinion that they have been receiving supplies and commodities without interruption whereas 30 percent of the respondents felt otherwise. A follow-up question asked the respondents how often they face shortages of supplies and commodities to which only 22.5 percent of the respondents answered not at all. In contrast, more than three times as many (that is, 75 percent) respondents admitted that they face shortages sometimes.

* 1. **Support and Commitment of the RHBs to Expand AYSRH Services**
1. ***Limited Commitment for AYSRH Services***

The translation of the AYSRH strategy and related frameworks into practice requires strong government commitment and leadership at all levels. This includes putting the system in place with allocation of the required resources accompanied with strong monitoring and evaluation. This study has clearly depicted that strategic documents that are expected to guide programming and intervention at facility and community level did not roll out to operational levels to the expected standard of efficiency. Perhaps in connection to frequent staff turnover, most of those at wereda health office and health facility level are not well acquainted with the AYSRH strategy. On the other hand, relatively speaking, NGOs working with and for adolescents and youth are relatively better informed about adolescents and youth strategic plan of the recent past. Lack of financial resources allocated for AYSRH program, and limited support and guidance from federal and regional structures to the facility levels makes AYSRH service provision weak at all levels. Although there are useful lessons at different levels, drawing on such lessons and scaling up remains a critical issue since there is no responsible entity to pull such resources and disseminate for wider use.

Respondents at federal and regional level have made efforts to roll out AYSRH to facility level following the strategic document and minimum package of services. Weredas and facilities are also encouraged to draw AYSRH plans and allocate resources for this. However, this has remained to be challenging. Majority of the participants at this level (three in four) pointed out that shortage of budget to implement AYSRH is an outstanding problem. Participants at wereda health office and health center level on the other hand argue, they do not have detailed information about the strategy and the package. Most of the respondents indicated that they neither participated in the preparation of the strategy nor obtained training on the strategy itself. One of the participants emphasized that, “*We were told about the strategy in one of the review meetings. However, we were not told its details and how to implement*” (KII, Oromia). As a result the level of guidance and support to health facilities from wereda health office remains limited. Facilities follow their own routine service delivery modality and young people are also provided SRH services as any other client. One of the participants under scored that, “*For us here in this facility we have shortage of rooms and we do not have provider assigned for AYSRH service. I am surprised to hear that we are expected to provide dedicated service to AYSRH, which to me is a dream”* (KII, Tigray).The major support by wereda health office was found to be routine supportive supervision at health centers, where AYSRH service provision is checked at facility level. Such supervision is said to facilitate and improve SRH service delivery for young people. Yet, such claims by regional and wereda health office that supportive supervision facilitates and improves AYSRH service delivery at facility level, this is not uniform in all the facilities nor changes follow supervision. One of the participants argued that, *“We have not seen any change in the provision of AYSRH at health facility level since RHB visited this facility last year”* (KII, SNNPR).

1. ***Allocation of Fund and Human Resources for the AYSRH Facilities***

The respondents were asked through the questionnaire to evaluate the adequacy of the fund and human resources that are allocated by the RHBs for the AYSRH facilities given the scope of work, the volume of work and the demand. The table below contains summary of the responses.

Table 7. Adequacy of Fund and Human Resources Allocation

|  |  |  |
| --- | --- | --- |
| **Item** | **Adequate** | **Not Adequate** |
| N | Percent | N | Percent |
| Fund | 8 | 19.5 | 33 | 80.5 |
| Human Resources | 15 | 36.6 | 26 | 63.4 |

As can be seen from the data in the table, a great majority (80.5%) of the respondents affirmed that their facilities do not have adequate fund allocation in view of the scope of service they provide. Despite the overall negative rating of the fund allocation, there were of course some respondents particularly from Oromia (40%) and Amhara (29%) who believed that the fund allocated to their facilities is adequate. This could be attributed to apparent differences in the demand of adolescents/youth for AYSRH services across facilities or woredas. In some woredas where there is much demand for the services, the funding could be judged inadequate, On the other hand, in woredas where there is limited demand of the services for one reason or another, the fund allocation could be judged adequate.

The results are generally in the same direction for human resources allocation as well where 63.4 percent of the respondents judged the allocation inadequate. Disaggregating the respondents’ ratings by region, one can see that human resources allocation is much more inadequate in Amhara (100%), SNNP (77%) and Oromia (53%) regions than it is in Tigray (17%) region.

Taken together, both fund and human resources allocation in the AYSRH facilities appear to be inadequate in all the regions with the exception of Tigray where the human resources allocation is judged by most respondents to be adequate. The fund allocation in particular is judged to be inadequate in all regions with the exception of a few facilities in Oromia and Amhara regions. In addition to rating the adequacy of the fund and human resources allocation, the respondents were also asked to rate directly the level of support and follow-up of the RHBs in strengthening the AYSRH services in the facilities. The ratings are summarized below.

Table 8. Level of Support and Follow-up of the RHB in Strengthening the Facility

|  |  |  |
| --- | --- | --- |
| **Level of Support and Follow-up** | **N** | **Percent** |
| High |  6 | 14.6 |
| Medium | 15 | 36.6 |
| Low |  7 | 17.1 |
| Not at all (Missing) | 13 | 31.7 |
| TOTAL | 41 | 100.0 |

One can observe from the data in the above table that the respondents’ ratings of the RHB’s support and follow-up are mixed. That is, whereas about 51 percent of the respondents rated the support and follow-up favorably (that is, high or medium) the remaining 49 percent rated the support and follow-up negatively (that is, low or not at all). Region-wise comparisons indicate that while the majority of respondents from Tigray (66.7%) and Oromia (60%) regions rated the level of support and follow-up of the RHB favorably, the majority of respondents from SNNP (61.5%) and Amhara (57.1%) regions rated the same negatively. Taken together, the RHBs’ support and follow-up with a view to strengthening the AYSRH facilities appears to be better in Tigray and Oromia regions than it is in Amhara and SNNP regions.

* 1. **Demand Creation Works Implemented Thus Far**

The questionnaire queried respondents about whether there are mechanisms put in place to promote the AYSRH services. In response, a large proportion (87.8%) of the participants agreed that such mechanisms are put in place. A follow-up question which asked the respondents to indicate the specific mechanisms used to promote the AYSRH services produced responses that indicate the use of poster and flier, campaigns, orientations and more importantly a combination of them all.

A question further asked the respondents as to which one, demand or supply, is more available in their respective facility. Except a few (10.3%) respondents who confirmed that the supply is higher, a large proportion of them confirmed that the demand is higher (56.4%) or that there is a balance between the demand and supply (33.3%). In this connection, examination of regional differences show that in Tigray region, a larger proportion (83%) of the respondents confirmed that there is a balance between demand and supply. The corresponding proportions of respondents from the other regions who confirmed that the demand and supply are balanced are far lower (Amhara, 14%; Oromia, 38%; and SNNP, 15%). In summary, according to the data obtained through questionnaire, the balance between demand and supply pertaining to AYSRH services is much better in Tigray region than in the other three regions. For a large percentage of the respondents in Amhara (71%) and SNNP (85%) regions, in particular, the demand is higher than the supply.

A related question also queried about how often awareness raising or sensitization works/activities were undertaken to create demand within the last one year. The responses clearly showed that a great majority of the respondents confirmed that such activities were undertaken either regularly (58.5%) or intermittently (29.3%). Only a small proportion (10.2%) of respondents from Oromia and SNNP indicated that such demand creation activities as awareness raising or sensitization works are rare. In short, most respondents were of the opinion that awareness raising activities were undertaken either regularly or intermittently.

1. **Discussion and Conclusion**

The results pertaining to the frequency or proportion of service providers who are aware of the AYSRH strategy and standards indicate that the majority (62.5%) reported to have known the strategy and standards. This result can be seen as something positive for more than half of the service providers are knowledgeable of the strategy. The substantive issue, however, is not proportion or percentage but whether the services can be provided in a fair and ethical manner by people who don’t know the strategy or the standards. The question, therefore, is would it be acceptable to expect people who don’t know the strategy or the standards to provide youth friendly services in an ethical manner? In principle, it would be far better to make all service providers aware of the strategy and standards if we want them to provide youth friendly services. The quantitative finding also depicted that AYSRH service provisions at health facilities remain satisfactory except for family planning. Although there are some endeavors to integrate AYSRH service in to youth centers and there are some NGO-run facilities that have implemented AYSRH service provision, this remains few in coverage and depends on availability of support. Based on the findings, the following are key conclusions:

* 1. **Demand and supply gap:** Although further study should be carried out to determine the type of awareness creation endeavors and tools used at different levels to improve young people’s awareness on AYSRH, finding shows relatively better awareness and consequently demands for the services. Nonetheless, there is limited response to such demands at facility level. Although contraceptive services, pregnancy testing, STI testing, PAC and counseling services were found to be available at facility level, such services were found to be inconsistent and often not up to expectations.
	2. **Compromised friendliness of AYSRH Service:** Absence of AYSRH friendly service was assessed in terms of a) physical settings (e.g. separate room for AYSRH service delivery b) trained and dedicated provider (well versed with AYSRH and be able to communicate with young people) c) timing (availability of flexi time for adolescents and youth). Finding generally shows that AYSRH service provision is not friendly although one or the other component is relatively better in one health facility than the other. It is however obvious to note that public health facilities are weak in their friendliness to young people as compared to NGO-run facilities and youth centers due to weak or absence of all the indicators measured above. Services are provided along with all other clients in the same venue, which is found to be embarrassing for young people.
	3. **Limited availability of Supplies and Commodities:** The findings show that SRH commodity and supplies were not commensurate with the demand from adolescents and youths. Although there are variations between regions and facilities, adequacy and persistent availability of services was found to be common problem. Such problem compel providers to refer young people pharmacies and drug shops which in itself is not feasible given young people do not have money to buy such supplies.
1. **Recommendations**

Generally, AYSRH service provision with the expected standard of friendliness is yet grey and a lot more is expected to be done beyond drawing strategic plan and development of minimum service package. Based on the findings, the following key recommendations were drawn that may help to reinvigorate AYSRH in Ethiopia.

On the basis of evidences generated from this assessment, the following recommendations were put forward aimed at influencing strategies and programs.

* 1. **Strengthen Commitment at decision making level:** There is a need to increase commitment of the concerned bodies at the federal, regional and woreda levels for effective planning, implementation and follow up of adolescent and youth reproductive health services. Especially, in light of the new AYSRH strategy (2016-20), well versed leadership commitment is required to roll out the program to clients at all levels. Thus, leaders of the health sector at all levels have to be oriented and equipped with the new strategy and what it encompasses. Furthermore, government as well as donors should allocate resources for AYSRH program
	2. **Improve demand creation work:** This study shows thatawareness raising activities were undertaken either regularly or intermittently for demand creation. Thus, although current demand for AYSRH is said to be fairly high, there is a need to carry out a study on how HEWs and facilities reach out to young people and with what tools. Based on the findings, it is important to define context informed AYSRH demand creation approach and tools for young people in school, at community level and when they come to health facility.
	3. **Ensure friendliness of service delivery points:** In view of providing friendly services, context informed mechanism should be developed to avail friendly SRH services for adolescent and youth. Perhaps introducing flexi time, improve friendly service delivery rooms including waiting place with recreational facilities, opening separate entry to health facilities and training of providers on AYSRH and communication skills would improve friendliness of service delivery. As it stands now it may look like a huge task. However, taking this as a challenge and being convinced that there are easy ways by leaning from existing experiences is a starting point. Further implementation of friendly service delivery could be facilitated with modification of existing structure and internal working procedures.
	4. **Ensure adequate comprehensive youth health Supplies and Commodities**

Youth centers and health facilities are expected to provide AYSRH services of all types included in the minimum package. As it stands now services are erratic and at times absent due to lack of relevant supplies and equipment. It is important to ensure AYSRH commodities and supplies are part of the supply chain management plan and timely refilling of such supplies and ensuring free access to young people is critical.

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# Annexes

**Annex 1: Interview questions for Federal and Regional Counterparts**

*Instruction:* The purpose of the interview is to collect data so as to find out the existing situating ( status) of adolescent an d youth sexual reproductive health services in selected facilities so as to improve the services. You are kindly requested to respond to the questions and provide relevant information on the basis of the existing situation in your Woreda/Facilities.

Personal Information

1. Region\_\_\_\_\_\_\_\_\_\_\_\_\_\_Woreda\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Professional Background\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Name of Health Center\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Responsibility in the Organization/unit/HC
6. Sex\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Educational level\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Service year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Objective 1. Determine the availability and use of AYRH strategy and

standards on AYRH in visited facilities

Macro level (Federal, Regional, Coordination ...)

1. Can you please tell me which policies and strategies are of use for AYSRH? How has these policies and strategies contributed to improved AYSRH programming? At your organization, do you have strategies developed for improved AYSRH?
2. Please describe the existing Adolescent & Youth Reproductive Health Services Policy, Strategy and operational framework.?
3. What roles did young people have in the development of the policies and strategies?
4. How participatory was the development of the policy & the strategy and what was the contribution of the stakeholders in this regard ?
5. How are the programmes/activities of the various stakeholders coordinated and whose responsibility is it?
6. What are the things that need to improve in terms of coordination among stakeholders in AYSRH?
7. Describe the system/mechanism in place to monitor and evaluate the implementation of the policy and the strategy
8. Describe what system is in place for coordination and networking in providing comprehensive SRH services to the youth
9. What needs to improve at policy and strategy level for an improved AYSRH in terms of coordination, leadership, funding, institutional commitment, etc?

Objective 2. Find out the availability of providers trained on AYRH

in visited facilities

Facility checklist for HR, supplies, equipment including referral

|  |  |  |
| --- | --- | --- |
| Types of YSRH resources at facility level |  |  |
| HR (list... per guideline) |  |  |
| Equipment (list... per guideline) |  |  |
| Supplies (list... per guideline) |  |  |

1. Describe if the existing human resource capacity (at the facility level) is in line with the expected level of competency.
2. Discuss what mechanisms are in place for the provision of capacity building refresher/ on-job training for service provides at the facility level
3. How is the performance of service providers assessed against the standard and whose responsibility is it?
4. What are the challenges in this regard and what strategies do you propose to address the challenges

Objective 4. Establish the support and commitments that the RHBs have made

towards AYRH service expansion

1. Please describe the readiness and willingness of the RHBs in providing technical support to the AYSRH services providers as and when required.
2. To what extent do the regional RHB experts respond to the issues and concerns of the health facility with regards to AYSRH services?
3. Discus how frequently the regional HB staff make supportive supervision to the the adolescent and youth sexual reproductive health services and describe what support the Regional Health Bureaus provide to the Health Facilities.
4. What are the challenges in this regard and what strategies do you propose to address the challenges

Objective 5. Describe demand creation works implemented this far

1. What means do you use to raise the awareness of the youth and adolescents on ASRH and increase demand in this regard?

2. Discuss if the demand for services is increasing or decreasing from time to time? Discuss the reasons.

4. What are the challenges in this regard and what strategies do you propose to address the challenges?

**Annex 2: Questionnaire for Service Providers**

**Instruction:** *The questions are meant to collect information on the friendliness of Adolescent and Youth Sexual Reproductive Health Services at the Health Facility level. You are required to administer the questions in a couple – one of you asking and the other taking notes. Please put the questions in a clear statement so that the interview can easily understand and provide clear responses.*

2.1. Personal Information

1. Region\_\_\_\_\_\_\_\_\_\_\_\_\_\_Woreda\_\_\_\_\_\_\_\_\_\_\_\_
2. Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Professional Background\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Name of Health Center\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Responsibility in the H. Facility
6. Sex\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Educational level\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Service year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.2. Questions on the Services

2.2.1. Are Service providers well aware of the availability and use of of Adolescent& Youth Reproductive Health Services Strategy and standards in the Woreda/Facility?

1. Yes

2. No

2.2.2. Which services are provided in your facility?

2.2.2.1. Counseling services are available: 1. Yes 2.No

2.2.2.2. Pregnancy prevention: 1. Yes 2. No

2.2.2.3. HIV/AIDS prevention: 1. Yes 2. No

2.2.2.4. STI prevention: 1.Yes 2. No

2.2.2.5. Sexual Abuse & Violence service 1. Yes 2. No

2.2.2.6. Drugs and Substance abuse Service 1.Yes 2. No

2.2.2.7. Condom: 1. Yes 2. No

2.2.2.8. Other SRH Issues – list them\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Testing

2.2.2.9. Pregnancy testing 1. Yes 2. No

2.2.2.10. STI testing: 1. Yes 2. No

2.2.2.11. VCT: 1. Yes 2. No

Other tests available, list them

2.2.3. What do you use to provide those…?

1. Yes
2. No (state the reason)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.2.4. How do you rate the supply meeting the needs of adolescents and youth /demand?

1. Adequate
2. Inadequate
3. Not consistent

2.3. Find out the availability of providers trained on AYRH

in visited facilities

2.3.1. Health-care providers have competencies and the required skills to provide

health education to adolescents and to communicate about health and

available services (health,

social and other services).

1. All of them
2. Some of them
3. Few of them

2.3.2. How often are service providers given refresher orientations/trainiungs?

1. Periodically/Regularly

2. Intermittently

3. Rarely

4. Any other idea (discuss)

2.3.2. What other means of capacity building supports are provided to the services

providers? State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.3. Find out availability of supplies (Condoms, Family planning & STI pills, etc.) and commodities (tables, chairs, beds, etc.) for AYRH service provision at

service delivery points.

2.3.1. There are adequate supplies in the facility

 1. Yes

2.No

3. If no, explain why not

2.3.2. There are adequate commodities in the Facility

 1. Yes

2.No

3. If ‘No’ state why not\_\_\_\_\_

2.3.3. Are the supplies and commodities provided to the Centre without

interruption?

 1. Yes

 2. No

 3. If ‘No’, state why not\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.3.4. How often do you face shortages of supplies and commodities?

1. Frequently

2. Sometimes

3. No shortage at all

2.4. Establish the support and commitments that the RHBs have made towards

AYRH service expansion

 2.4.1. Does the/your Facility have adequate fund allocation in view of the scope of

service?

1. Yes

2. No

2.4.2. Is the Human resource allocation adequate in terms of the volume of work

and the demand?

 1. Yes

 2. No

2.4.2. How do you rate the support (in terms of technical, close follow up) of the RHB in terms of strengthening the

Facility?

1. High

2. Medium

3. Low

4. None

2.5. Describe demand creation works implemented this far

 2.5.1. Are there mechanisms in place to increase the promotion (making the service known to the community in general and adolescent and youth in particular) of the service?

 1. Yes

 2. No

2.5.2. If ‘Yes’, what are the mechanisms to increase the demand side?

 1. Poster and flier distribution

 2. Awareness raising campaigns

 3. Orientations and sensitisations

2.5.3. Which one of demand and supply is more available in your Health Facility?

1. The Demand

2. The Supply

3. The two match

2.5.4. How often were awareness raising /sensitisation works activities undertaken

to create demand within the last one year?

1. Regularly
2. Intermittently
3. Rarely

*Put your Rating for the items in the following table:*

1=Not Available At All 2=Rarely Available 3=Available 4=Abundantly Available 5=excessive 6=Don’t know

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| SN | Activity  |  | Rating |
|  | Rate the availability of the following services in your Facility  | 1 | 2 | 3 | 4 | 5 | 6 |
| 1 | Basic SRH services (counseling,  |  |  |  |  |  |  |
| 2 | Family planning services (i.e. birth control, pre-conception counseling, etc.) |  |  |  |  |  |  |
| 3 | Safe Abortion services |  |  |  |  |  |  |
| 4 | Post Abortion health care services |  |  |  |  |  |  |
| 5 | The service providers have the skills to properly approach and treat the youth and adolescents coming to the facility |  |  |  |  |  |  |
| 6 | The services provision is attractive and friendly to young people |  |  |  |  |  |  |
| 7 | Please discuss any problem or issues in relation to the service providers |  |  |  |  |  |  |
|  | 1= Excellent 2= Good 3= poor  |
|  | How do you rate the adequacy (including availability and access) of the following services for young people in your Facility?  |
| 1 | Basic Health care services | 1 | 2 | 3 |  |
| For Boys |  |  |  |
| For Girls |  |  |  |
| 2 | Life Skills Education Services |  |  |  |
| For Boys |  |  |  |
| For Girls |  |  |  |
| 3 | Counseling services provided by healthcare providers |  |  |  |
| For boys |  |  |  |
| For Girls |  |  |  |
| 4 | Family planning services |  |  |  |
| For boys |  |  |  |
| For Girls |  |  |  |
| 5 | Post abortion health care services |  |  |  |
| 6 | Have equal rights to various recreational activities or youth centers (e.g. playing outdoors, indulging in sports etc.) |  |  |  |
| 7 | Is there any service to prevent HTPs in your health services or area? |  |  |  |

**Annex 4: FGD Questions for Adolescent and Youth Groups**

**Instruction:** *The questions are meant to collect information on the friendliness of Adolescent and Youth Sexual Reproductive Health Services at the Health Facility level. You are required to administer the questions in a couple – one of you asking and the other taking notes. Please put the questions in a clear statement so that the interview can easily understand and provide clear responses.*

1. Determine the availability and use of AYRH strategy and standards on AYRH in visited facilities
	1. What kind of AYSRH services are available to young people in this community? Please specify type of services (for each determine sources of such services, who provides, whether young people are happy with the service and what needs to improve)
	2. How accessible are the services in term**s of distance, cost and friendliness** of providers. Please explain for each
	3. Describe what services are available in the facility and how friendly they are to the youth and adolescents
	4. Discuss to what extent the services are available (accessible) to the youth and adolescents in your area and to what extent the adolescents and youth are satisfied
	5. Do you get all the services you need at the facility? If not, what are the gaps/problems in this regard.

 3. Determine availability of supplies and commodities for AYRH service provision at

service delivery Points.

3.1. Describe the adequacy of supplies and commodities in terms of the demand for services the Facility

3.2. Describe if there are problems in this regard (limitations or gaps)

3.3. Is the availability of the supplies and commodities regular or irregular – explain further

3.4. Describe to what extent the service satisfies the SRH needs of adolescents and Youth

1. Establish the support and commitments that the RHBs have made towards AYRH service expansion
	1. Describe the efforts made so far (if any) to strengthen and expand the services within the last one year or so.
	2. Have there been efforts made to improve the services since you joined the facility –describe.

5. Describe the Demand creation works implemented so far

5.1. How did you become aware of the services provided in the centre?

5.2. To what extent are the youth informed/aware of the existence of SRH services in the facility

5.3. What awareness raising activities were undertaken within the last one year so as increase the demand for the service?.

5.4. Please state if you have any other opinions.

**Annex 5. List of Participants**

**Table I**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| S. No | Name  | Region/Woreda/town  | Service year | Position  |
|  | KefenaItita | Ambo Town | 12 | Office head |
|  | Dabasakefema | Ambo Town | 27 | Family health process owner |
|  | Tamirat | Ambo | 24 | Head of the center |
|  | TewdrosDebeba | Adama | 12 | Office head |
|  | NegaTilahun | Bishoftu | 12 | Human resource management |
|  | AshebirAsefa | Bishoftu | 14 | Family health services sub process owner  |
|  | Hana  | Bishoftu | 3 | Youth center head |
|  | DefabachewSetegn | AA | 15 | Team leader Adolescent and youth program |
|  | Betalhem | AA | 15 | AYSRH service expert |
|  | MeronHagos | AA | 7 | Area Manager |
|  | AlemayehuHunduma | AA | 10 | Family health development sub process coordinator |
|  | Samira Mohmed | Adama | 9 | Health center head |
|  | Barudin Sharif | Adama | 17 | Planning and budget |
|  | TesfayeAlemu | AA | 9 | Program Director |

**Table 1: Key Informants Interview with Health Center, Woreda and regional offices/Bureau respondents**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Region | Participating wereda/HF | No of KIIs | No of completed self reported survey | No of FGD Sessions (participants) |
| Oromia  | Kimbibit/ShenoShashemene, Bushoftu, Adama, Ambo ORHB | 6 | 15  | 4 (26) |
| Amahra | Showa RobitDebreBirhan | 2 | 7 | 2 (18) |
| Tigray  | Mekelle, Wukro | 2 | 6 | 2 (22) |
| SNNPR | Yirgalem, Hawasa, Alaba | 3 | 13 | 2 (18) |
| Total | 9 | 41 | 10 (84) |

**Table 2: Stakeholders’ Response from various organizations**

|  |  |  |
| --- | --- | --- |
| **Region** | **Woredas/Sites** | **No of KIIs** |
| Federal | Ministry of Health  | 1 |
| Ministry of Youth and Sports  | 1 |
| Family Guidance Association  | 1 |
| Hiwot Ethiopia  | 1 |
| Save Your Generation Ethiopia  | 1 |
| Marie Stopes  | 1 |
| Path Finder  | 1 |
| CORHA | 2 |
| UNFPA  | 1 |
| Total | 10 |

**Table II**

* 1. **List of FGD participants**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **S. No** | **Name**  | **Sex**  | **Age**  | **Town**  | **Facility Name**  |
|  | WoynshetTerefa | F | 22 | Ambo | Health center |
|  | Birukwolkeba | F | 24 | Ambo | Health center |
|  | AskaleHumnecha | F | 23 | Ambo | Health center |
|  | HiwotSeid | F | 19 | Adama | Adama FGA youth center |
|  | DdyimGezehang | M | 22 | Adama | Adama FGA youth center |
|  | SeifedinTamiru | M | 22 | Adama | Adama FGA youth center |
|  | Temesgensyntayeh | M | 22 | Adama | Adama FGA youth center |
|  | Yosef Kibru | M | 20 | Adama | Adama FGA youth center |
|  | Likawil Gondar | M | 18 | Adama | Adama FGA youth center |
|  | Yosef Tsige | M | 22 | Adama | Adama FGA youth center |
|  | ZewuduArjiu | M | 25 | Bishoftu | Bishoftu Youth center |
|  | Ferzana Ali | M | 23 | Bishoftu | Bishoftu Youth center |
|  | TaddeEshetu | M | 22 | Bishoftu | Bishoftu Youth center |
|  | BirhanuAbebe | M | 22 | Bishoftu | Bishoftu Youth center |
|  | BiftuMekonnen | F | 23 | Bishoftu | Bishoftu Youth center |
|  | CaaltuUngure | F | 25 | Bishoftu | Bishoftu Youth center |

**Table III: List of Participants**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | Name of participants | Region/Place of work | Position | Service year |
| 1 | AtoHabtamuAsrat | Oromia Region Sheno Town | V/Head of KembebitWoreda Health office  | 7 years  |
| 2 | AtoTemesgenTakele | Oromia Region Sheno Town | Sheno town Health Center Supervisor | 4 years  |
| 3 | Ato TilahunMulugeta | Amhara Region Debirebirhan Town  | Head of City Administration Health Office | 9 years |
| 4 | Ato NebyuDaniale | Amhara Region Debirebirhan Town  | Head of DebirebirhanTown Health Center | 10 years |
| 5 | AtoWeledu G/Hiwot | Amhara Region Shewarobite Town  | A/Head of City Administration Health office | 12 years |
| 6 | AtoAtmensewGoraw | Amhara Region Shewarobite Town  | A/Head of Shewarobit town Health Center | 5 years |
| 7 | AtoTsegayGatibo | SNNP Region Yirgalem Town  | Head of City Administration Health Office | 30 years |
| 8 | Ato Tariku Bekele | SNNP Region Yirgalem Town | A/Head of Yirgalem town Health Center | 7 years |
| 9 | W/roWeyneshetEmeru | SNNP Region Hawassa Town | MCH officer | 15 years  |
| 10 | S/r TsegeMamo | SNNP Region Hawassa Town | A/Head of Hawassa millennium Health Center | 8 years  |
| 11 | AtoSleshiAdmassu | SNNP Region Alaba Town | MCH officer | 24 years  |
| 12 | Ato Gemechu Edessa | SNNP Region Alaba Town | Head of Alaba Town Health Center | 3 years  |
| 13 | Ato Mekonnen W/Mikael  | Tigray Region, Mekelle | Head of Health Center/Director | 9 years |
| 14 | W/ro HewanTesfaye | Tigray Region, Mekelle | Health Promotion and Disease Prevention coordinator  | 10 years |
| 15 | Ato AddishHintsa | Tigray, Wukro | Wukro Acting Head of Health Center | 26 years |
| 16 | AtoTesfaye G/Silasse | Tigray, Wukro | Vice Head of Woreda Health Office  | 26years |
| 17 | Sr Worknesh | Path Finder  | Programme Officer |  |
| 18 | Sr Aster  | Ministry of Health  | Team Leader |  |
| 18 | Sr FekerteBelete | CORHA | Ex. Director |  |
| 19 | Ato Dejene | CORHA | Programme Officer  |  |
| 20 | Ato Dawit | UNFPA | Programme Officer  |  |