



GLOBAL STANDARDS FOR QUALITY HEALTH-CARE SERVICES FOR ADOLESCENTS

*A GUIDE TO IMPLEMENT A STANDARDS-DRIVEN APPROACH TO IMPROVE
THE QUALITY OF HEALTH-CARE SERVICES FOR ADOLESCENTS*

Volume 1: Standards and criteria





GLOBAL STANDARDS FOR QUALITY HEALTH-CARE SERVICES FOR ADOLESCENTS

A guide to implement a standards-driven approach to improve the quality of health-care services for adolescents

Volume 1: Standards and criteria



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- Volume 1: Standards and criteria
- Volume 2: Implementation guide
- Volume 3: Tools to conduct quality and coverage measurement surveys to collect data about compliance with the global standards
- Volume 4: Scoring sheets for data analysis





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ABBREVIATIONS

HMIS health management information systems

NGO nongovernmental organizations

SOP standard operating procedure

WHO World Health Organization



GLOSSARY

Adolescent – WHO defines adolescents as people between 10 and 19 years old.

Assent – Refers to children’s and adolescents’ participation in decision-making on health care and research intervention(s) by giving an agreement. Assent is not regulated by law as is consent, and it is sometimes referred to as a moral obligation closely linked to good practice in dealing with patients. It emphasizes 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 (see also **informed choice, informed consent**).

Attitude – A person’s views about a thing, process or person, which influence behaviour.

Community health worker – Any health worker who performs functions related to health-care delivery in the community. Community health workers have received training on the interventions and activities they are involved in, but have not received formal professional, paraprofessional or tertiary education. They are normally members of the communities where they work, selected by the communities, answerable to the communities for their activities and should be supported by the health system.

Competency – Sufficient *knowledge* and psychomotor, communication and decision-making *skills* and the *attitudes* to enable the performance of actions and specific tasks to a defined level of proficiency.

Confidentiality – The right of an individual to privacy of personal information, including health-care records. This means that access to personal data and information is restricted to individuals who have a reason and permission for such access. The requirement to maintain confidentiality governs not only how data and information are collected (e.g. a private space in which to conduct a consultation), but also how the data are stored (e.g. without names and other identifiers) and how, if at all, the data are shared.

Criterion (of a standard, see also standard) – A measurable element of a standard that defines a characteristic of the service that needs to be in place (**input criterion**) or implemented (**process criterion**) in order to achieve the defined standard (**output criterion**).

Evolving capacity – The capacity of an adolescent to understand matters affecting his or her life and health change with age and maturity. The more an adolescent “knows, has experienced and understands, the more the parent, legal guardian or other persons legally responsible for him or her can transform direction and guidance into reminders and advice, and later into exchange on an equal footing.”¹ In health care it means that as the adolescent matures, his or her views have increasing weight in choices regarding care. The fact that the adolescent is very young or in a vulnerable situation (e.g. has a disability, belongs to a minority group, is a migrant) does not deprive him or her of the right to express his or her views, nor does it reduce the weight given to the adolescent’s views in determining his or her best interests,² and, hence, choices regarding aspects of care.

¹ The General comment No. 12 of the Convention of the Rights of the Child, page 17. <http://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC-C-GC-12.pdf>.

² The General comment No. 14 of the Convention of the Rights of the Child, page 13, paragraph 13. http://www2.ohchr.org/English/bodies/crc/docs/GC/CRC_C_GC_14_ENG.pdf.

Gatekeeper(s) – Adults that have influence over adolescents’ access to and use of services, e.g. parents and/or other family members, legal guardians, teachers, community leaders.

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.

Informed choice – A choice made by an adolescent regarding elements of his or her care (e.g. treatment options, follow-up options, refusal of service for care) as result of adequate, appropriate and clear information in order to understand the nature, risks, alternatives of a medical procedure or treatment and their implications for health and other aspects of the adolescent’s life. If there is more than one possible course of action for a health condition, or if the outcome of a treatment is uncertain, the advantages of all possible options must be weighed against all possible risks and side-effects. Also, the views of the adolescent must be given due weight based on his or her age and maturity¹ (see also **evolving capacity**).

Informed consent – A documented (usually written) agreement or permission accompanied by full and clear information on the nature, risks and alternatives of a medical procedure or treatment and their implications before the physician or other health-care professional begins the procedure or treatment. After receiving this information, the adolescent (or the third party authorized to give the informed consent) either consents to or refuses the procedure or treatment. The procedures and treatments requiring informed consent are stipulated in country laws and regulations. Many procedures and treatments do not require informed consent; however, they all require that the adolescent is supported to make an informed choice and give an assent if so desired (see also **assent, informed choice and evolving capacity**).

Key populations – Refers to defined groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV (Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2014, <http://www.who.int/hiv/pub/guidelines/keypopulations/en/>). Their engagement is critical to a successful HIV response; they are key to the epidemic and key to the response. Key populations include men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people. Adolescent members of key populations are more vulnerable than adults in the same groups, and people may be part of more than one key population. Other priority populations at high risk include the seronegative partners in serodiscordant relationships and the clients of sex workers. Also, there is a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms. Each country should define the specific populations at higher risk that are critical to their epidemic and response based on the epidemiological and social context (http://www.unaids.org/sites/default/files/media_asset/JC2118_terminology-guidelines_en_0.pdf p18).

Outreach (health-care delivery) – Any health-related activity coordinated by the health system that takes place off-site (outside the health facility premises). Outreach activities can be performed by health-care providers (for example, primary care nurses that perform classroom health education or doctors that perform medical check-ups in schools), or by outreach workers (see definition below). The purpose of outreach activities in adolescent health care is to reach adolescents by bringing services close to where they are: schools, universities, clubs, churches, workplaces, street settings, shelters or wherever young

¹ The General comment No. 14 of the Convention of the Rights of the Child, page 13, paragraph 53. http://www2.ohchr.org/English/bodies/crc/docs/GC/CRC_C_GC_14_ENG.pdf.

people gather. Examples of outreach activities include health education and distribution of commodities such as condoms.

Outreach worker – Any volunteer who performs functions related to outreach health-care delivery on behalf of the health system. Outreach workers are not health-care professionals, but receive special training to perform their functions. An example of an outreach worker is a peer educator (see definition below).

Peer education – The process whereby specially trained adolescents undertake informal or organized educational activities with their peers (those similar to themselves in age, background or interests). These activities, occurring over an extended period of time, are aimed at developing adolescents' knowledge, attitudes, beliefs and skills and at enabling them to be responsible for and to protect their own health. Examples of activities that peer educators carry out include co-teaching or guest lecturing during a health education session in school; leading a group discussion in the waiting room of a health facility; doing educational outreach and referrals with “street adolescents” in an urban area; providing information on contraception and distributing condoms to adolescent members of key populations at higher risk of HIV exposure¹ (see also **key populations**); presenting a theatre piece or role play at a community health fair or other event.

Peer educator – An adolescent who was specially trained to perform peer education.

Reward (extrinsic, intrinsic) – Extrinsic rewards – financial or other – are the tangible rewards given to employees by managers, such as pay for performance, bonuses, and benefits. They are called extrinsic because they are external to the work itself, and other people control their size and whether or not they are granted. In contrast, intrinsic rewards are psychological rewards that employees get from doing meaningful work and performing it well. Some examples of intrinsic rewards in health care are the sense of expertise and competence (e.g. the feeling of being an expert on adolescent health care and providing high-quality services) and the sense of professional progress (e.g. seeing convincing signs that changes in the process of care accomplish something, such as adolescents in the community being more satisfied with the care provided and having better health and development outcomes).

Rights – Adolescents' health-related rights include at least the following:

- Care that is considerate, respectful and non-judgemental of the adolescent's unique values and beliefs. Some values and beliefs are commonly held by all adolescents or community members and are frequently cultural and religious in origin. Others are held by the adolescent client alone. Strongly held values and beliefs can shape the care process and how adolescents respond to care. Thus, each health-care provider must seek to provide care and services that respect the differing values and beliefs of adolescents. Also, health-care providers should be non-judgemental regarding adolescents' personal characteristics, life style choices or life circumstances.
- Care that is respectful of the adolescent's need for privacy during consultations, examinations and treatments. Adolescent privacy is important, especially during clinical examinations and procedures. Adolescents may desire privacy from other staff, other patients, and even family members. Staff members must learn their adolescent clients' privacy needs and respect those needs.
- Protection from physical and verbal assault. This responsibility is particularly relevant to very young adolescents and vulnerable adolescents, the mentally ill, and others unable to protect themselves or signal for help.

¹ Men who have sex with men, people who inject drugs, sex workers, transgender people and people in prisons.

- Information that is confidential and protected from loss or misuse. The facility respects information as confidential and has implemented policies and procedures that protect information from loss or misuse. Staff respect adolescent confidentiality by not disclosing the information to a third party unless legally required, by not posting confidential information or holding client-related discussions in public places.
- Non-discrimination, which is the right of every adolescent to the highest attainable standard of health and quality health care, without discrimination of any kind, irrespective of the adolescent's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.
- Adolescent participation in care processes. Unless the decision-making capacity is delegated by law to a third party, or the adolescent lacks decision-making capacity as assessed by the relevant authority,¹ the adolescent decides about all aspects of care, including refusing care. The adolescent also decides which family member and friends, if any, participate with him or her in the care process. Adolescents' involvement in care is respected irrespective of whether or not the adolescent has a legal capacity for decision-making. An adult's judgement of an adolescent's best interests cannot override the obligation to respect all rights of adolescents as stipulated in the Convention of the Rights of the Child.² This includes the right of the adolescent who is capable of forming his or her own views to express those views freely in all matters affecting him or her, and having those views given due weight in accordance with the age and maturity³ (see also **evolving capacities**). The facility supports and promotes adolescent involvement in all aspects of care by developing and implementing related policies and procedures.

Standard – A statement of a defined level of quality in the delivery of services that is required to meet the needs of intended beneficiaries. A standard defines the performance expectations, structures or processes needed for an organization to provide safe, equitable, acceptable, accessible, effective and appropriate services.

Support staff – Individuals who provide indirect patient care (for example, receptionists, secretaries) or who are involved in maintaining certain quality standards (e. g. cleaning or security staff).

¹ In many countries health-care providers have the authority to assess whether or not the adolescent has decision-making capacity; in some circumstances the decision may be taken in court.

² The General comment No. 13 of the Convention of the Rights of the Child. http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf

³ Article 12 of the Convention of the Rights of the Child. <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

INTRODUCTION

The World Health Organization report *Health for the world's adolescents: a second chance in the second decade* suggests that to make progress toward universal health coverage, ministries of health and the health sector more generally will need to transform how health systems respond to the health needs of adolescents. It recommends developing and implementing national quality standards and monitoring systems as one of the actions necessary to make this transformation.

Global initiatives are urging countries to prioritize quality as a way of reinforcing human rights-based approaches to health. Yet, evidence from both high- and low-income countries shows that services for adolescents are highly fragmented, poorly coordinated and uneven in quality. Adolescents often find mainstream primary care services unacceptable because of perceived lack of respect, privacy and confidentiality, fear of stigma and discrimination and imposition of the moral values of health-care providers. Pockets of excellent practice exist, but, overall, services need significant improvement.

Recognizing these problems, many countries have moved towards a standards-driven approach to improve the quality of care for adolescents. With ministry of health leadership, more than 25 countries have adopted national quality standards, and some, including Malawi, the Republic of Moldova, South Africa, Tajikistan, Ukraine and the United Republic of Tanzania, have conducted surveys to measure the quality of the services being provided in order to inform action (WHO, 2014a).

Building on country experience and on previous World Health Organization (WHO) guidance documents – *Quality assessment guidebook: a guide to assessing health services for adolescent clients* (2009) and *Making health services adolescent friendly* (2010) – this publication presents global standards for quality health-care services for adolescents, an implementation guide and monitoring tools. It aims to support health-care planners and facility managers in the organization

and delivery of health-care services in a way that responds to adolescents' needs. The intent of the standards is to guide service delivery and quality improvements in all primary and referral facilities not just in a few showcase centres. By making improvements in the quality of care provided, adolescents' rights to accessible, acceptable and effective care will be fulfilled.

This document 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.

The aim of *Global standards for quality health-care services for adolescents* is to assist policy-makers and health service planners in improving the quality of health-care services so that adolescents find it easier to obtain the health services that they need to promote, protect and improve their health and well-being. The implementation plan and the monitoring tools that accompany the standards in this document provide guidance on identifying what actions need to be taken to implement the standards and to assess whether the standards have been achieved.

The primary intention of the standards is to improve the quality of care for adolescents in government health-care services; however, they are equally applicable to facilities run by NGOs and those in the private sector. The ultimate purpose of implementing the standards is to increase adolescents' use of services and, thus, to contribute to better health outcomes.

BACKGROUND

How this document was developed

Development of these standards was a five-stage collaborative process involving many departments in WHO and other stakeholders. The various steps are outlined below and depicted in Fig.1.

Needs assessment through a literature review and two global surveys

WHO commissioned an analysis of published and unpublished systematic reviews and meta-analyses from January 2000 to June 2013 on existing facilitators and barriers to improving the quality of health care for adolescents related to provision of information, communication with providers, engagement with health-care services, regulations and standards, organizational capacity and satisfaction of adolescent clients (Nair M et al., 2015).

In addition, two online global surveys were conducted by WHO in 2013, one with primary care providers and the other with adolescents. These surveys informed the global report *Health for the world's adolescents: a second chance in the second decade*. Both surveys were conducted online via SurveyMonkey.

The survey with primary care providers included questions on accessibility, quality improvement, providers' skills, facility policies regarding equity, confidentiality, privacy and informed consent, financial protection and users' fees, and other aspects relevant to quality of care for adolescents. The survey was answered by 735 respondents from 81 countries representing all six WHO regions.

The survey with adolescents was open to all adolescents between 12 and 19 years old. There were responses from 1143 adolescents from 104 countries. The key areas addressed in the survey were: i) adolescents' understanding of health, including the factors that influence it; ii) adolescents' views about priorities among health issues; iii) barriers to and use of health services; and iv) adolescents' opinions about how their health could be improved.

Analysis of national standards from 25 countries

WHO developed the global standards based on the needs assessment, which was informed by the literature review and online surveys, in conjunction with the analysis of 26 national standards from 25 countries: Bangladesh, Bhutan, Burkina Faso, Congo, Ethiopia, Ghana, India, Indonesia, Kyrgyzstan, Lesotho, Malawi, Mongolia, Myanmar, Nicaragua, Philippines, Republic of Moldova, South Africa, Sri Lanka, Tajikistan, Thailand, Ukraine, United Kingdom (England, Scotland), United Republic of Tanzania, Viet Nam, and Zambia. The analysis of national standards identified the most common standards¹ and their criteria,² which were then reviewed against the findings of the literature review and global surveys. Actions from

Fig. 1. The process for development of the global standards for quality health-care services for adolescents



the countries' implementation plans informed the implementation guide for the global standards. The monitoring tools were informed by the data collection tools from WHO's *Quality assessment guidebook: a guide to assessing health services for adolescent clients* (2009); questions were adapted and added as needed to measure the standards and criteria.

Review by the technical working group

WHO formed a technical working group that included representatives from the Department of Maternal, Newborn, Child and Adolescent Health, the Department of Reproductive Health and Research, and the Department of Immunization, Vaccines and Biologicals. This group reviewed the draft resulting from the combined analysis of national standards and their implementation plans and findings of the needs assessment.

Peer review

After the technical working group review, WHO regional and country offices³ and external

reviewers representing national and international experts from governments and academia,⁴ NGOs and development partners⁵ reviewed the document. At this stage no radical changes were recommended to the standards' areas. However, there were useful suggestions for better emphasis of the human rights-based approach, avoiding redundancies between criteria and ensuring that the criteria measured all important aspects of standards. There were also proposals for the structure of the document, which added considerably to its clarity.

Field test and consolidation

The pre-final draft was subsequently field-tested in Benin for the national adaptation and in a regional expert consultation of Latin American and Caribbean countries that took place in November 2014. The consultation aimed to develop regional sexual and reproductive health standards using the global standards. The field test showed that the document was adequate for both national and regional contexts, and no substantial changes were suggested.



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¹ A standard was considered common if it was found in at least 50% of reviewed countries' standards.

² A criterion was considered common if it was found in at least 25% of reviewed countries' criteria.

³ WHO Country Office in Ukraine, WHO Regional Office for Africa, WHO Regional Office for Europe, WHO Regional Office for the Western Pacific.

⁴ Australia, Estonia, India, Republic of Moldova, United Republic of Tanzania.

⁵ Evidence to Action, International Planned Parenthood Federation, Jhpiego, loveLife, Pathfinder International, Save the Children, United Nations Children's Fund, United Nations Population Fund.

GLOBAL STANDARDS FOR QUALITY HEALTH-CARE SERVICES FOR ADOLESCENTS

Eight global standards define the required level of quality in the delivery of services as shown in the table below. Each standard reflects an important facet of quality services, and in order to meet the

needs of adolescents all standards need to be met. This section presents each of these standards and its criteria, categorized as input, process and output criteria.

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

¹ Service provision in the facility should be linked, as relevant, with service provision in referral level health facilities, schools and other community settings.

Standards' rationale, intent and criteria

Standard 1 – Adolescents' health literacy

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

Rationale for Standard 1

Evidence suggests that adolescents do not have adequate health literacy (see Glossary) to enable them to gain access to, understand and effectively use information in ways that promote and maintain their good health (WHO, 2014a). 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).

In addition, health literacy means more than just being able to read pamphlets and successfully make appointments. Adolescents often lack accurate knowledge regarding health and disease,

Measurable criteria of Standard 1

Input criteria	Process criteria	Output criteria
<p>1. The health facility has a signboard that mentions operating hours.¹</p> <p>2. The health facility has in the waiting area up-to-date information, education and communication materials specifically developed for adolescents.</p> <p>3. Health-care providers have competencies² to provide health education to adolescents and to communicate about health³ and available services (health, social and other services⁴).</p> <p>4. The health facility has outreach workers⁵ that are trained to conduct health education for adolescents in the community.</p> <p>5. The health facility has a plan for outreach activities and/or involvement of outreach workers in activities to promote health and increase adolescents' use of services.</p>	<p>6. Health-care 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.</p> <p>7. Outreach activities to promote health and increase adolescents' use of services are carried out according to the health facility's plan.</p>	<p>8. Adolescents are knowledgeable about health.</p> <p>9. Adolescents are aware of what health services are being provided, where and when they are provided and how to obtain them.</p>

¹ If there are special days and/or hours for adolescents, these should be clearly mentioned.

² Competencies (see Glossary) are defined in a job description; see *Core competencies in adolescent health and development for primary care providers* at http://www.who.int/maternal_child_adolescent/documents/core_competencies/en/.

³ This includes not only knowledge about an adolescent's own health status, but also knowledge about positive health behaviours, risk and protective factors and health determinants.

⁴ Other services that adolescents might need may include shelters, recreational services, vocational training services or services provided by agencies that finance care, provide transportation.

⁵ This includes community health workers, health volunteers, peer educators.

health-related behaviours, risk and protective factors, and the social determinants of health (WHO 2014a). This knowledge is crucial to increase adolescents' motivation and encourage actions which may lead to a modification of health-related behaviours and risk or resilience factors.

Many sectors, primarily the education sector, have responsibilities to contribute to adolescents' health literacy. Within this collective effort, health-care facilities and health-care providers play an important role. Adolescents value the active listening skills of clinicians and the clarity and amount of information provided to them (Ambresin A-E et al., 2012). Adolescents' positive experience of care depends also on the availability of teen-oriented leaflets and up-to-date health information in the waiting room, including television or games (Ambresin A-E et al., 2012). Standard 1, therefore, stresses the importance of health education (within the facility and through outreach) and 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.

Intent of Standard 1

Health education is carried out in both the health facility and the community (see also Standard 2). Informational materials use a language, format and comprehension level appropriate to adolescents of various ethnic and age groups. To help adolescents better understand the available health services, information is clearly communicated about types

of services, health-care 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 care providers, governmental and NGOs and community agencies that can serve adolescents, and develops a network of services and referrals with them (see also Standard 3).

Standard 2 – Community support

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

Rationale for Standard 2

Parents, guardians, family and 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 programmes are not successful (WHO, 2014a; Denno DM et al., 2015). In many countries unmarried adolescents have little support to access and use sexual and reproductive health services (Chandra-Mouli et al., 2014). This standard, thus, sets expectations for the level of support for adolescents' use of services from parents, guardians and other community members.

Intent of Standard 2

The health facility informs community members about the value of providing health services to adolescents either during visits to the facility or through outreach (see Glossary). However, merely informing community members about the importance of adolescents' use of health-care 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 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 (see also Standards 1 and 8).



Measurable criteria for Standard 2

Input	Process	Output
10. Health-care providers have competencies ¹ and support materials to communicate with parents, guardians and other community members and organizations about the value of providing health services to adolescents.	13. The health facility engages in partnerships with adolescents, gatekeepers and community organizations to develop health education and behaviour-oriented communication strategies and materials and plan service provision.	17. Gatekeepers and community organizations support the provision of health services to, and their utilization by, adolescents.
11. The health facility has an updated list of agencies and organizations with which it partners to increase community support for adolescents' use of services.	14. Health-care providers inform parents/guardians visiting the health facility about the value of providing health services to adolescents.	
12. The health facility has a plan for outreach activities and/or involvement of outreach workers in activities to increase gatekeepers' support for adolescents' use of services.	15. Health-care providers and/or outreach workers inform parents/guardians and teachers during school meetings about the value of providing health services to adolescents.	
	16. Health-care providers and/or outreach workers inform youth and other community organizations about the value of providing health services to adolescents.	

Standard 3 – Appropriate package of services

The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.²

Rationale for Standard 3

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). 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 (WHO, 2014a). 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 they cause include nutrition, substance use, intentional and unintentional injuries and chronic illness. Sexual and reproductive health, including HIV in adolescents, remains a critical health concern in many regions; however, it is important that other contributors to the burden of disease are 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 or referral (WHO, 2015b).

¹ Competencies (see Glossary) are defined in a job description; see *Core competencies in adolescent health and development for primary care providers* at http://www.who.int/maternal_child_adolescent/documents/core_competencies/en/.

² Service provision in the facility should be linked, as relevant, with service provision in referral level health facilities, schools and other community settings.

Evidence shows that health services are often clinically oriented and opportunities for preventive interventions are frequently overlooked. Further, health-care providers often do not have clear guidance as to which services are important to provide to their adolescent clients.

Intent of Standard 3

Standard 3 stresses three important elements. First, health care for adolescents encompasses a range of services such as information, counselling, diagnosis, treatment and care. Second, the package of services offered in the facility reflects the health-care needs of adolescents in the community(ies). While priorities might vary from country to country, and from community to community, adolescents need services in a range of areas – mental health, sexual and reproductive health, HIV, nutrition and physical activity, injuries and violence, substance use, and immunization (see also Standards 7 and 8). WHO-recommended services and interventions for adolescents can be

found in the WHO report *Health for the world's adolescents: a second chance in the second decade*.¹ Third, it is very important that the facility determines exactly what services are to be offered on-site and what services are to be made available through referral and outreach (see Glossary). 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 facility and the community(ies) served by the facility should exist, as well as between various levels of the health-care system and between various specialties. For instance, planning the transition from child-centred to adult-centred health care was found to be an important indicator of the quality of adolescent health care (Ambresin A-E et al., 2012), and requires good coordination and joint planning for the transition between paediatrician and general practitioner. In countries where school health services exist, close collaboration between the health-care facility and school health personnel

Measurable criteria for Standard 3

Input	Process	Output
18. Policies are in place that define the required package ² of health information, counselling, diagnostic, treatment and care services and enable its provision.	21. Health-care providers provide the required package of health information, counselling, diagnostic, treatment and care services in the facility and/or in community settings, in line with policies and procedures. ⁵	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. Policies and procedures ³ are in place that identify which health services are provided in the health facility and which in community settings such as schools. ⁴	22. Service providers refer adolescents to the appropriate service and level of care according to local policies and procedures, and follow the policies for transition care.	
20. Policies and procedures are in place that describe the referral system to services within and outside the health sector, including provisions for transition care for adolescents with chronic conditions.		

¹ Available at <http://apps.who.int/adolescent/second-decade/section6/page1/universal-health-coverage.html>.

² While countries may prioritize services according to the local situation, the range of services that adolescents require usually includes mental health, sexual and reproductive health, HIV, nutrition and physical activity, injuries and violence, substance use, and immunization. To inform countries' efforts in articulating national packages of adolescent health services, see WHO recommended services and interventions for adolescents at <http://apps.who.int/adolescent/second-decade/section6/page1/universal-health-coverage.html>.

³ Standard operating procedures are desired where possible; these should be periodically updated.

⁴ Services in the community may be provided by a wide range of both volunteer and paid health providers that work within and among the community, and are often referred to as community health workers.

⁵ Evidence-based management in line with guidelines and protocols is covered in Standard 4.

should exist to ensure coordination, continuity of care and joint actions in the community. In addition, coordination with and referral to social, educational, recreational, transportation, legal and other services outside the health sector should be implemented.

Within its area, the facility identifies the health- and non-health-related agencies that may serve as public or private referral sources for adolescents and related agencies that finance care, provide transportation or provide specialized services. The facility, thus, develops a network of other care providers, governmental and NGOs and community agencies to meet the health needs of adolescents in the community(ies) (see also Standard 2). In addition, some services may be offered through outreach, either by health-care providers themselves (e.g. prevention education and/or regular check-ups in schools), or by collaborating with trained outreach workers (see Glossary).

Standard 4 – Providers’ competencies

Health-care providers demonstrate the technical competence¹ required to provide effective health services to adolescents. Both health-care providers and support staff respect, protect and fulfil adolescents’ rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.

Rationale for Standard 4

Health-care providers’ attitudes, knowledge and skills are at the core of quality service provision (Ambresin A-E et al., 2012; WHO, 2010; WHO, 2015a). Guideline-driven care is central to young people’s positive experience of care (Ambresin A-E et al., 2012). Yet, many health-care professionals report insufficient knowledge of and technical competence in adolescent-specific aspects of health promotion, disease prevention and management. Many providers do not feel confident to communicate effectively about such issues as domestic and school violence, family or intimate partner relationships, and nutrition or substance use (WHO, 2014a).

In addition, health-care 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). Insufficient respect in clinical practice for adolescents’ rights to information, privacy, confidentiality, non-discrimination and non-judgemental attitudes is a major barrier to adolescents’ use of services (WHO, 2014a). Therefore, hand in hand with developing technical competencies in adolescent health care, 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 4 sets the expectations for the technical and attitudinal competencies required of providers for effective care, including competencies related to a human rights-based approach to adolescent health care. Importantly, the latter also applies to support staff (see Glossary). These competencies are detailed in the *Core competencies in adolescent health and development for primary care providers* (WHO, 2015a). They emphasize that health-care 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



¹ See *Core competencies in adolescent health and development for primary care providers* at http://www.who.int/maternal_child_adolescent/documents/core_competencies/en/. A WHO guideline recommends, for example, the provision of sexual and reproductive health services, including contraceptive information and services, for adolescents without mandatory parental and guardian authorization/notification, in order to meet the educational and service needs of adolescents (WHO, 2014b).

prejudices that may interfere with the ability to provide confidential, non-discriminatory, non-judgemental and respectful care to adolescents.

To ensure technical competence, the facility ensures that the number, qualifications and skill mix of staff is adequate to deliver the required package of adolescent care services (see also Standard 3), and to meet the facility's mission and objectives *vis-a-vis* adolescent health care. To maintain acceptable staff performance, ensure

up-to-date management of conditions, teach new skills or new aspects of equipment and procedures, the facility provides opportunities for in-service training and other education. Even when formal continuous professional education systems in adolescent health care do not exist, 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-care providers and support staff of the required profile ¹ are in place.	31. Health-care providers follow evidence-based guidelines and protocols in delivering care to adolescents.	33. Adolescents receive effective ⁴ health services.
25. Health-care providers have the technical competencies ² necessary to provide the required package of services.	32. Health-care providers and support staff relate to adolescents in a friendly manner, and respect their rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude, and respectful care.	34. Adolescents receive services in a friendly, supportive, respectful, non-discriminatory and non-judgemental manner, and know their rights in health care.
26. Health-care providers have been trained/sensitized on the importance of respecting the rights of adolescents to information, privacy, confidentiality, and of the health care that is provided in a respectful, non-judgemental and non-discriminatory manner.		35. Adolescents receive accurate, age-appropriate and clear information to facilitate informed choice.
27. Providers' obligations and adolescents' rights ³ are clearly displayed in the health facility.		
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-care providers' performance.		
30. A system of continuous professional education that includes an adolescent health-care component is in place to ensure lifelong learning.		

¹ The required competencies of staff should be clear in job descriptions.

² Competencies should encompass all areas of the package (e.g. mental health, sexual and reproductive health, violence prevention), as well as the entire range of services as delineated in Standard 3 (information, counselling, diagnosis, treatment and care).

³ This includes rights (see Glossary) to information, privacy, confidentiality, non-discrimination, non-judgemental attitude, and respectful care.

⁴ Effectiveness is measured against evidence-based standards of care (e.g. criterion-based audit) using a combination of methods, such as an audit of medical records and observation. Tools to measure the effectiveness of care of selected conditions are currently being developed and are not part of this guide.

Up-to-date decision support tools, such as clinical practice guidelines and protocols, are used to ensure effective care and minimize variations in care. Clinical practice guidelines and protocols may be adapted from external sources or created by staff within the facility. Regardless of the source, the scientific basis of a guideline should be evaluated and all clinical practice guidelines and protocols should be reviewed and approved by the facility's leaders and clinical practitioners before implementation. This will ensure that the guidelines and protocols are standardized to accommodate local and regional practice and the health-care and disease realities of adolescents in the community(ies).

The facility advances health-related rights (see Glossary) for all its adolescent clients to ensure they have the services they need. The manager(s) provides direction to ensure that staff assume responsibility for protecting these rights. Obtaining health care may be frightening and confusing for adolescents, making it difficult for them to understand and act on their rights. Thus, the facility clearly displays a written statement of adolescents' rights, and adolescents are made aware of this statement when they seek services from the facility (see also Standards 6 and 8). The statement is appropriate for adolescents' age, understanding, and language. When written communication is not effective or appropriate, the adolescent is informed of his/her rights in a manner he/she can understand. Health-care providers and support staff respect, protect and fulfil adolescent rights throughout the care process.

Standard 5 – Facility characteristics

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

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 (Ambresin A-E et al., 2012; WHO, 2010). The facility's physical environment (cleanliness, design features that enable privacy and confidentiality) is a characteristic highly valued by adolescents (Ambresin A-E et al., 2012). In

addition, adolescents may not use the facility if they perceive it to be equipped inadequately, or lack the necessary drugs and supplies.

Intent of Standard 5

Standard 5 stresses, therefore, 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: one deals with the organization of operating hours and an appointment system to meet the needs of adolescents; the second stresses the importance of design features and local policies to maintain privacy and confidentiality; and the third emphasizes the importance of systems to ensure adequate equipment, drugs and supplies.

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

- the operating hours are convenient for adolescents in the community(ies)
- care 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 facility plans and implements 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 (see Standard 4), but it is also a matter of how the facility 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 treatments.
- 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 facility provides 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 come in contact with 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 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, school teachers or employers, without the adolescent's consent.

The facility implements actions for inspecting, testing, and maintaining medical equipment and documenting the results. The facility 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. A policy is in place, including assigned responsibilities across health-care providers and support staff, to ensure a welcoming and clean environment, ¹ minimize waiting times and ensure convenient operating hours and flexible appointment procedures.	41. Health-care providers offer consultations during hours that are convenient to adolescents in local communities, with or without an appointment.	45. The health facility has convenient operating hours, appointment procedures and waiting times kept to a minimum.
37. The facility has basic amenities (electricity, water, sanitation and waste disposal).	42. Health-care providers and support staff follow policies and procedures to protect the privacy and confidentiality of adolescents.	46. The health facility has a welcoming and clean environment.
38. Policies and procedures to protect the privacy and confidentiality of adolescents are in place. Both health-care providers and support staff know them as well as their own roles and responsibilities.	43. Medicines and supplies are in adequate quantities without shortages (stock-outs), and are equitably used.	47. Adolescents receive private and confidential health care at all times during the consultation process.
39. A system of procurement and stock management of the medicines and supplies necessary to deliver the required package of services is in place.	44. The equipment necessary to provide the required package of services to adolescents is available, functioning and equitably used.	48. The facility has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
40. A system of procurement, inventory, maintenance and safe use of the equipment necessary to deliver the required package of services is in place.		

¹ This includes a comfortable seating area, available drinking water, educational materials in local language(s) that are attractive to adolescents, clean surroundings, waiting area and toilets.

Standard 6 – Equity and non-discrimination

The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education, ethnic origin, sexual orientation or other characteristics.

Rationale for Standard 6

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 (WHO, 2014a; Waddington C and Sambo C, 2015). For example, unmarried adolescents may be stigmatized if they seek STI and HIV testing, safe abortion (where it is legal) or contraceptive services

(Chandra-Mouli et al., 2014). In addition, out-of-pocket payments that have a deterrent 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 (Waddington C and Sambo C, 2015).

Intent of Standard 6

This standard stresses the importance of providing equitable care 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,

Measurable criteria of Standard 6

Input	Process	Output
49. Policies and procedures are in place stating the obligation of facility staff to provide services to all adolescents irrespective of their ability to pay, age, sex, marital status, schooling, race/ethnicity, sexual orientation or other characteristics.	54. Health-care providers and support staff demonstrate the same friendly, non-judgemental and respectful attitude to all adolescents, regardless of age, sex, marital status, sexual orientation, cultural background, ethnic origin, disability or any other reason.	57. All adolescents – irrespective of their ability to pay, age, sex, marital status, education, ethnic origin, sexual orientation or other characteristics – report similar experiences of care. ^{1,2}
50. Policies and procedures are in place for services that are free at the point of use, or affordable.	55. Health-care providers provide services to all adolescents without discrimination, in line with policies and procedures.	58. Vulnerable group(s) of adolescents are involved in the planning, monitoring and evaluation of health services, as well as in certain aspects of health-service provision. ³
51. Health-care providers and support staff are aware of the above policies and procedures, and know how to implement them.	56. The health facility involves vulnerable group(s) of adolescents in the planning, monitoring and evaluation of health services, as well as in certain aspects of health-service provision.	
52. The policy commitment of the health facility to provide health services to all adolescents without discrimination, and to take remedial actions when necessary, is displayed prominently in the health facility.		
53. Health-care providers know who are the vulnerable group(s) of adolescents in their community(ies).		

¹ This includes the experience of care alongside *all dimensions* of quality of care as outlined in these standards (e.g. access to information, staff attitude, communication, guideline-driven care).

² This criterion can be measured by comparing the experience of care in groups of adolescents with various socio-economic characteristics.

³ For example, as peer educators, counsellors, trainers.

use of medicines and technologies, involvement in the care process and its planning and monitoring that various groups of adolescents experience.

The facility works collaboratively with other agencies and health-care providers to identify vulnerable group(s) of adolescents in their community(ies), understand the needs of these groups, and involve them in the planning, monitoring and evaluation of health services (see also Standards 2 and 8). The facility provides equitable care and treatment for adolescents with the same health problems and care needs. Providers use guidelines and protocols that ensure a high level of patient care (see Standard 4), which is applied to all groups of adolescents in an equitable manner. 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 facility has policies and procedures for services that are free at the point of use, or affordable, to adolescents.

Standard 7 – Data and quality improvement

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

Rationale for Standard 7

Effective policy-making for adolescent health care and programme design requires strategic information on the health-related behaviours of adolescents and about available health services for them. For the latter, data that come from routine facility data collection and facility assessments of services and service quality are extremely important (WHO, 2014a). Through facility-level registers health management information systems (HMIS) collect data that includes client information about age, sex, presenting problem, diagnosis and services provided. However, in most low and middle income countries, by the time these

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 health facility collects data on service utilization disaggregated by age and sex, and conducts regular self-assessments of quality of care. ¹	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-care providers are trained to collect and analyse data to inform quality improvement initiatives.	65. Health-care providers and support staff use data on service utilization and quality of care for action planning and implementation of quality improvement initiatives.	69. Facility's reports to districts on quality of care 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-care providers and support staff receive supportive supervision in areas identified during self-assessments.	70. Health facility staff feel supported by supervisors and motivated to comply with the standards.
62. Mechanisms are in place to link supportive supervision to priorities for improvement as identified during the monitoring of the implementation of standards.	67. Good performance is recognized and rewarded.	
63. Mechanisms are in place for reward and recognition of highly performing health-care providers and support staff.		

¹ This includes the assessment of adolescents' experience of care. See Standard 8.

data are aggregated at the national level, it is not possible to identify the data on adolescents. HMIS tend to focus on children less than 5 years of age and women of reproductive age, 15–49 years of age. Even in high income countries where HMIS are better developed, the data are frequently not sufficiently disaggregated by age to be able to focus on the adolescent age group, 10–19 years of age, and the subgroups of 10–14 and 15–19 years of age (WHO, 2014a). In addition, data on quality of care, even if they exist, often lack a focus on adolescent-specific elements of quality. Countries that have made progress in measuring the quality of health services for adolescents, based on nationally developed standards, have shown greater utilization of improved quality services.

Intent of Standard 7

This standard, therefore, stresses the importance of the facility's actions to collect, analyse and use data on cause-specific service utilization and quality of care, disaggregated by age and sex to support quality improvement (see also Standard 8). To monitor equity, it might be necessary to disaggregate data by other important characteristics such as school enrolment or marital status (see Standard 6). 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 facility understands that aggregate data are an important part of the facility's performance improvement activities; it provides a profile of the facility 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 local, subnational and national review meetings.

The aggregation and analysis of data and information and planning of subsequent improvements frequently requires knowledge and skills that most staff do 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-care 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 facility managers or health systems. However, actions such as supportive supervision or reward and recognition of highly performing staff will help drive a culture that engages in health improvement initiatives.



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Standard 8 – Adolescents’ participation

Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care as well as in certain appropriate aspects of service provision.

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 care (Ambresin A-E et al., 2012). It is essential that their involvement is encouraged and supported by facility staff. There are a number of ways that adolescents can be involved, 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 given the opportunity and empowered and trained, 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-care solution or management option to their personal circumstances. Ignoring

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.

Intent of Standard 8

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

To ensure adolescents’ participation in the planning, monitoring and evaluation of health services, the facility regularly solicits adolescents’ perceptions of its services (see also Standards 6 and 7). Including adolescents in the governance structure of the facility is one way to understand their perceptions of its services. In this role,



participants will be limited in number, thus, it will be equally important to solicit this information from other agencies and organizations in the community (see also Standard 2). 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 facility has a process to receive, analyse, and use this information to influence its programmes and services.

Adolescents have the right to participation (see Glossary) in the processes of their own care. Unless the adolescent lacks decision-making capacity, or the decision-making capacity is delegated by law to a third party, the adolescent can make decisions about all aspects of care, including refusing care.¹ The facility supports and promotes adolescent involvement in all aspects of care by developing and implementing policies

and procedures to enable an informed choice (see Glossary). 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 (see also Standard 4). In some situations a documented consent for a procedure or treatment is required (see informed consent in the Glossary). 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 certain aspects of service delivery such as peer education, counselling, training and advocacy. In order to participate in a meaningful way, adolescents should be empowered and trained to do so effectively.

Measurable criteria for Standard 8

Input	Process	Output
71. The governance structure of the facility includes adolescents.	74. The health facility carries out regular activities to identify adolescents' expectations about the service ² and to assess their experience of care, and it involves adolescents in the planning, monitoring and evaluation of health services.	77. Adolescents are involved in planning, monitoring and evaluation of health services.
72. There is a policy in place to engage adolescents in service planning, monitoring and evaluation.	75. Health-care providers provide accurate and clear information on the medical condition and management/treatment options, ³ and explicitly take into account the adolescent's decision on the preferred option and follow-up actions.	78. Adolescents are involved in decisions regarding their own care.
73. Health-care 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.	76. The health facility carries out activities to build adolescents' capacity in certain aspects of health-service provision. ⁴	79. Adolescents are involved in certain aspects of health-service provision.

¹ A WHO guideline recommends, for example, the provision of sexual and reproductive health services, including contraceptive information and services, for adolescents without mandatory parental and guardian authorization/notification, in order to meet the educational and service needs of adolescents (WHO, 2014b).

² This may include adolescents' perceived health-care needs and adolescents' opinions on what services should be provided, as well as aspects of organization (e.g. working hours), provider-related aspects (e.g. strong preference for male or female provider) and other aspects.

³ For each option, evidence-based information on advantages, disadvantages and consequences should be provided; communication with the adolescent is in a language and format he/she can understand.

⁴ For example, peer education.

IMPLEMENTATION

The implementation of standards has two aspects. The first is *what to do* to implement – that is, what are the actions in the facility and beyond that need to be undertaken in order to meet the standards. The second is *how to* implement – that is, the planning and management of the implementation process.

Implementation plan

A standards-driven approach to improve the quality of health-care services for adolescents should be embedded in systemic efforts to strengthen the health sector's response to adolescent health. As outlined in the WHO report *Health for the world's adolescents: a second chance in the second decade*, developing and implementing national quality standards and monitoring systems is just one part of the transformation that health systems need to undergo in order to better respond to adolescent health and development needs. Improving the quality of care at mainstream primary and referral level facilities cannot succeed without strengthening all pillars of the health system:

- *governance*, so that policies are in place that respect, protect and fulfil adolescents' rights in health care and national health management information systems that provide the evidence base for decision-making;
- *financing*, so that allocation of resources and purchasing services is done in a way that meets the need of adolescents;
- *strengthening workforce capacity*, so that health-care providers have the necessary competencies to implement the standards;
- *ensuring that the necessary drugs, supplies and technology are available* so that the functioning of the facility is seamless.

Therefore, apart from actions in the facility and community, national- and district-level,¹ actions will be necessary in each of the health system pillars in order to enable facility staff and managers to implement the standards and their criteria (Table 1). A detailed implementation guide is provided in Volume 2.



¹ The subnational political-administrative units in countries vary, and may include states, regions, provinces, districts or zones. For the purpose of this guide we use the term district to indicate a subnational administrative unit, while in each case the equivalent will depend on specific country.

Table 1. Implementation guide

	National-level actions	District-level actions	Facility-level actions ¹
Governance	<p>Review laws, policies and systems, and modify existing ones if necessary, in key areas: provision of a comprehensive package of services, financial protection of adolescents, confidentiality, age of consent, equity, participation, reorganization of services to make them welcoming for adolescents, health management information systems</p> <p>Communicate national laws and policies, and latest revisions, to district managers and request district level actions</p> <p>Advocate with district managers to ensure their ownership and support for key policies</p> <p>Advocate with other sectors and wider society to ensure their support for key policies</p> <p>Develop or review, as appropriate, norms, standards and standard operating procedures (SOPs), and make them known and available in the districts</p> <p>Develop or review, as appropriate, information and training materials, practice guidelines and other decision support tools in adolescent health care</p> <p>Ensure an adolescent health focus in national reports</p> <p>Conduct data synthesis, monitoring and evaluation activities at the national level and use national data to stimulate local actions</p>	<p>Communicate national laws and policies, and latest revisions, to facility managers, and demand facility-level actions</p> <p>Advocate with facility managers to ensure their ownership and support for key policies</p> <p>Advocate with other sectors and wider society to ensure their ownership and support for key policies</p> <p>Support facility managers to implement key policies, and to translate them into facility SOPs</p> <p>Ensure the availability of information and educational materials at the district level</p> <p>Ensure an adolescent health focus in district reports</p> <p>Conduct data synthesis and monitoring and evaluation activities at the district level and use national and district data to stimulate local actions</p>	<p>Communicate national laws and policies, SOPs, and latest revisions, to facility staff</p> <p>Identify community resources and build partnerships for advocacy and service provision for adolescents</p> <p>Advocate with facility staff, other sectors' services and the wider community to ensure their ownership and support for the implementation of key policies</p> <p>Develop or adapt, as appropriate, local SOPs to implement key policies</p> <p>Supply facility staff with information and training materials, practice guidelines and other decision support tools</p> <p>Ensure an adolescent health focus in facility reports</p> <p>Monitor the implementation of quality standards in the facility, and use data to stimulate actions</p>

¹ These actions are facility-led, but some of them happen in and with the community.

	National-level actions	District-level actions	Facility-level actions
Workforce capacity	<p>Define core competencies in adolescent health and development and develop and implement competency-based training programmes in pre-service and continuous professional education</p> <p>Set up a system for supportive supervision in adolescent health care</p> <p>Ensure an adolescent health focus in job descriptions and policies on skill mix¹</p>	<p>Plan capacity-building activities at the district level</p> <p>Conduct capacity-building activities in adolescent health care and support facility managers in doing so</p> <p>Implement a system of supportive supervision in adolescent health care at the district level</p> <p>Ensure that decision support tools are available in health-care facilities and providers know how to use them</p>	<p>Plan capacity-building activities for facility staff</p> <p>Ensure staff participation in continuous professional education in adolescent health care and in supportive supervision</p> <p>Ensure that decision support tools are available in health-care facilities</p> <p>Conduct capacity-building activities</p> <p>Plan staff profile and manage staff time to enable the implementation of key policies</p>
Financing	<p>Negotiate allocation of funds from the national budget to ensure the provision of a comprehensive package of services to adolescents</p> <p>Finance continuous professional education activities</p> <p>Finance quality improvement initiatives in adolescent health care</p> <p>Finance the production of information and education materials for adolescents and community members</p>	<p>Allocate funds for the provision of a comprehensive package of services in adolescent health care</p> <p>Finance continuous professional education activities</p> <p>Finance quality improvement initiatives in adolescent health care</p> <p>Finance the production of information and educational materials for adolescents and community members</p>	<p>Inform district officials about facility needs to enable allocation of funds for key activities</p>

¹ In the long run, every health-care provider should have core competencies in adolescent health and development, acquired through a combination of pre-service training and continuous professional education. In the interim, there should be at least one health-care provider in the facility trained in adolescent health care to ensure the necessary skill mix of facility's team.

Implementation process

The actions outlined in the implementation guide need buy-in at different levels of the health system by various stakeholders before standards are developed and implemented. Developing a shared understanding of adolescent health and establishing the basis for addressing adolescents within the national health policies and strategies are a prerequisite for implementation of the standards. The figure below shows the main steps in the implementation process.

Develop a shared understanding of adolescent health and the need to improve the quality of health-care services

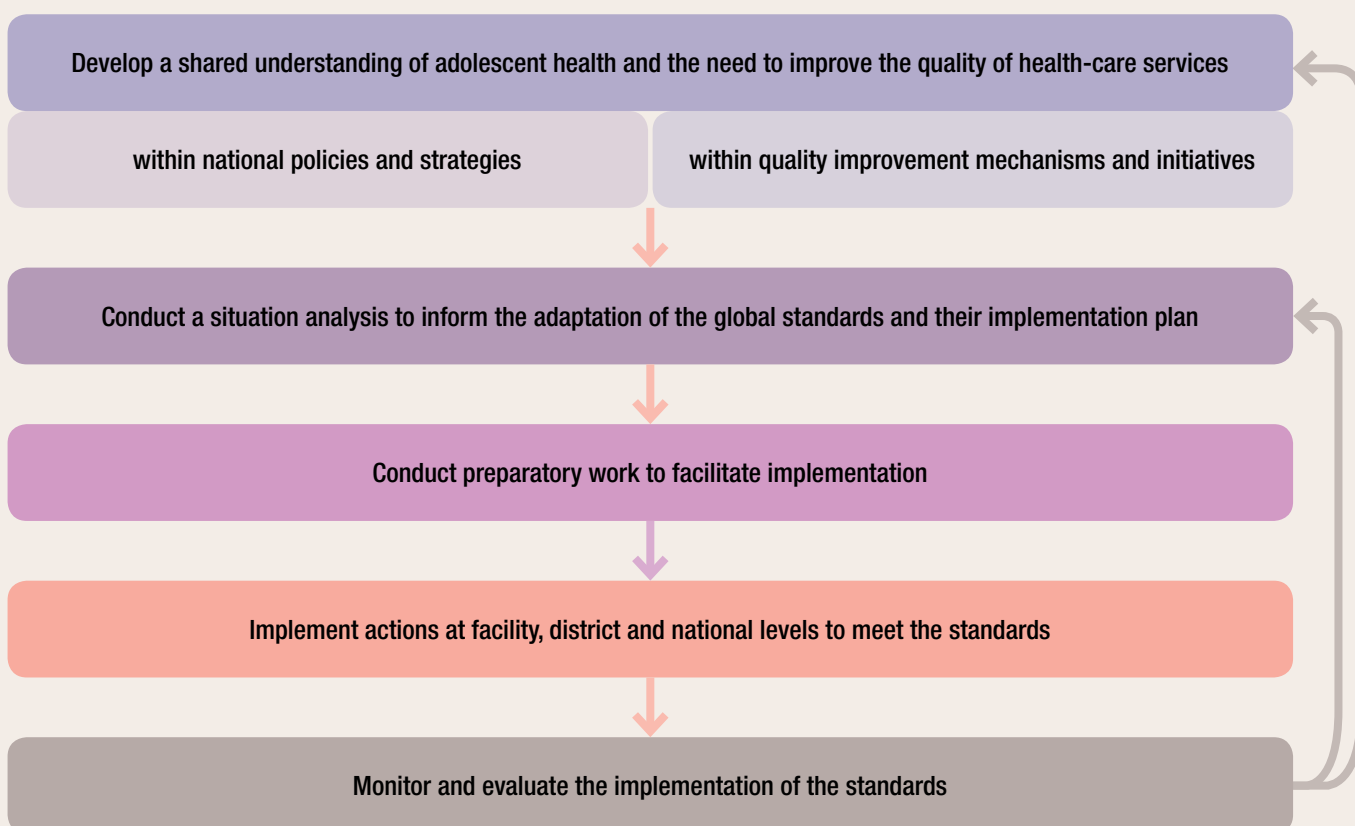
Grounding the quality improvement initiative in national policies and strategies may make it more likely that it will receive both moral and material support of decision-makers in the government and in international organizations. Many countries have realized the importance of explicit attention to adolescent health within national health policies, strategies and plans. Among the national health policy documents from 109 countries retrieved

in 2013 from the WHO Country Planning Cycle Database, 84% of the policies included some attention to adolescents. However, in most cases, the focus was on sexual and reproductive health (including HIV/AIDS), while areas such as mental health, violence and injuries, substance use and substance use disorders, chronic illness, nutrition or physical activity, were less frequently included.

Successful implementation of the global standards requires a participatory process involving key stakeholders to create a shared understanding of the whole range of needs of adolescents beyond a limited focus on sexual and reproductive health. In addition, it requires a shared understanding of the specific contribution that health-care services can make for priority health and development problems. The WHO report *Health for the world's adolescents* is a resource that can inform senior and mid-level staff of ministries of health, NGOs and the range of health sector partners responsible for developing, implementing and supporting policies and programmes that contribute to adolescent health.

It might be helpful to form a national working group for this purpose, or use an existing one, including policy-makers, ministry of health

Fig. 2 Steps in the process of implementation of the global standards



programme managers, technical experts, service providers and community representatives, including adolescents themselves, as well as other interested groups such as international and national NGOs, the United Nations and other internal and external development partners. The meaningful involvement of adolescents in this process is crucial. Adolescents have the capacity to identify approaches or solutions that will best accommodate their personal circumstances or needs. It is essential that policy-makers and health-care providers encourage and support adolescents' involvement in policy formulation and their own health care. In order to participate in a meaningful way, adolescents should be given opportunities, empowered and trained to acquire the necessary skills to lead advocacy efforts and policy- and decision-making processes in the country. The creation of the shared understanding of adolescent health, and the need to improve the quality of health-care services, should not be seen, however, as a one-off event or in isolation from other steps of the process. Even though a national consultation and an informal meeting – or a series of each – might be necessary to start or to build on an existing process, shared understanding will be furthered through the situation analysis, national adaptation of the global standards and the implementation process.

Conduct a situation analysis to inform the national adaptation of the global standards and their implementation plan

The analysis of national standards from 25 countries showed that despite variations in countries' contexts and priority health problems, national standards and criteria largely covered similar areas. It means that overall, global standards are likely to capture the quality problems in service delivery in any given country. However, specific problems and needs will exist, and they need to be identified in order to make a proper adaptation of global standards to the country context. The situation analysis – through discussions with key informants in the ministry of health, NGOs, academic institutions, international agencies and adolescents themselves, and a desk review of published papers and reports – should summarize key issues such as:

- (i) priority health and development problems of adolescents in terms of health outcomes, health-related behaviours, protective and

risk factors and social determinants. This will largely inform the content of the package of services that will need to be offered as part of the implementation of standards.

- (ii) help-seeking and health care-seeking practices of adolescents, and barriers to the provision and utilization of health services by adolescents. This will largely inform the domains of the standards and the need for adaptation of the global standards.
- (iii) by whom – and where – health services are currently provided to adolescents, and which health service providers within the health system of the country are best placed to ensure the largest coverage with the required package of services. This will largely determine what types of facilities are the priority for implementation.
- (iv) what are the experiences within the country in applying quality improvement principles and practices in public health programmes. This will help apply lessons learnt from initiatives in the country that have worked to improve the quality of health service provision and to increase health service utilization by any population group to the adolescent population. In addition, it will inform how to better institutionalize the implementation of the standards for adolescent health care within existing policies and procedures.

Adolescents from key populations face greater HIV risk than the general population and have specific health-related needs. Accordingly, for the response to be appropriate, acceptable and most effective, these risks and needs must be examined locally, and local adolescent members of key populations must be consulted and actively involved in the situational analysis (WHO, 2014c). Key population size and distribution vary from place to place. To determine the required scale of the response, the appropriate balance among different interventions and where interventions should be targeted, it is important to appreciate the size and distribution of adolescent members of key populations, among other factors. Whereas data should guide the response, lack of data is not a reason to stop or not initiate a response to HIV among key populations and their adolescent members. When undertaking information-gathering exercises, it is important to strictly maintain privacy, confidentiality and the security of the information collected. If the safety and the human rights of adolescents from

key populations cannot be protected, collection of certain data, such as mapping where adolescents from key populations congregate, is better avoided (WHO, 2014c).

Adapt global standards as per the findings of the situation analysis

The situation analysis might reveal that changes to the global standards and/or their criteria are required in order to better reflect the situation in the country. For example, some of the criteria might be considered not essential, or new standards might be added to reflect a problem area that is currently not adequately captured by the global standards. In this case, the technical working group will need to develop input, process and output criteria for the new standards. They will also need to be sure that the new criteria are not redundant with existing criteria of other standards. It should be decided which of the new criteria should be regularly monitored, and what changes are required in order to do so in the standards' monitoring tools (see Volume 3). Similarly, if adaptations concern criteria within any given standards (e.g. added, deleted or modified criteria), it should be decided what implications it has for the monitoring process and monitoring tools.

The country implementation plan might need to reflect changes that were made in the process of the national adaptation of the global standards. For example, if in the national adaptation process new standards or criteria within standards were added, it might be necessary to identify and implement corresponding actions at the national, district and facility level.

Conduct preparatory work to facilitate the implementation

Before beginning the implementation, certain actions will be necessary such as:

- official adoption/clearance of the standards by relevant authorities;
- identifying the responsible team/unit that will drive the national standards-driven initiative in the country;
- identifying funds to implement actions stipulated in the implementation plan;
- deciding on the sequence and scale of implementation;

- informing key stakeholders at the national, districts and facility levels who could help or hinder the implementation of the initiative.

It may also be necessary to manage the expectations of those involved in the implementation. For example, different stakeholders may have different expectations about where the standards will be implemented – in which facilities, and how many. Expectations also may differ with regard to the need for piloting the implementation, geographic areas for initial implementation and expansion, or the desired pace of scaling up. It is important to clarify what these expectations are and to ensure that they are considered in the design of the implementation process. While piloting the implementation of standards is warranted in order to learn lessons before nation-wide scale-up, it should be understood that *the ultimate aim is that every health-care facility meets the required standards*. The WHO guide *Beginning with the end in mind: planning pilot projects and other programmatic research for successful scaling up* (2011) contains 12 recommendations to ensure that pilot or other programmatic research is designed in ways that lead to lasting and larger-scale impact.

Implement actions at national, district, facility and community levels to meet the standards

Actions at the national, district, facility and community levels are outlined in Table 1, and a detailed guide is provided in Volume 2. It is important to appreciate that facility-level actions may be initiated before the national- and district-level actions are completed. Improving policies and other actions at the national level takes time, and there is no reason to delay facility-level actions that do not require national or district level support and can be accomplished locally.

Monitor and evaluate

This guide contains a set of 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), as well as from direct observation of the care process (Volume 3). Facility compliance with quality standards will be reflected in the

aggregate scores per each standard (out of 100%). Volume 4 includes an explanation of how the aggregated score is calculated.

There are several steps to consider in the planning, implementation and analysis of the results of the quality and coverage measurement surveys: determining the scope of the assessment, forming and training the assessment team, planning the time and resources, pre-testing the data collection instruments, collecting, scoring, summarizing and disseminating data, and planning for improvements. These steps are described in detail in the WHO publication *Quality assessment guidebook: a guide to assessing health services for adolescent clients* (2009).

Tracking the progress in the standards' implementation should happen at three levels: facility, district and national.

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).

While full-scale assessments that measure all the criteria for each of the standards are desirable, 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. For this, some countries have found it practical to select a short list of criteria (e.g. 2–3 criteria per standard) and identify corresponding indicators for routine monitoring (e.g. every 3–6 months), 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. In Myanmar, for example, the national guidance on service standards for adolescent health care recommends quality improvement meetings every 3–4 months. 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.

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- 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. For example, if a national survey found that an important proportion of facilities do not meet Standard 7, which requires that the health facility collects, analyses and uses data on adolescents' service utilization and quality of care, disaggregated by age and sex, one of the underlying reasons might be that data collection and reporting forms, which are endorsed at national level, were not revised accordingly. 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 (see Fig. 2 above).

Table 2 summarizes the scope, methods and expected frequency of the standards' monitoring and evaluation activities at the facility, district and national levels.

Table 2. Examples of activities to monitor and evaluate the implementation of standards

	Level/expected frequency	Description of the method and scope of the monitoring and evaluation activity
Routine monitoring	Facility/every 3 months	Self-assessments using self-assessment tools ¹ 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 analysed 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/every 3–6 months	Supportive supervision sessions by the facility manager 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.
	District/every 6 months	Monitoring visits by district 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 level/ every 2–3 years ²	The scope of the evaluation is to assess district performance against all standards and criteria, and to assess the status of the implementation of district-level actions. ³ 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 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.
	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. ⁴ A baseline survey before standards implementation might provide useful information for comparison. The assessment might be done in selected districts according to defined criteria or in all districts, but within each of the selected districts 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.

¹ The tools that are provided in Volume 3 can be adapted for use in different contexts – be it self-assessments on a limited number of criteria, or external assessments (monitoring visits) by district managers, on a wider, or full, range of standards and criteria. The tools can be equally adapted to develop checklists for supportive supervision.

² In geographically small countries district-level evaluations might not be necessary, as national-level evaluations might be sufficient.

³ The implementation guide in Volume 2 can be used to develop checklists to assess the status of implementation of district-level actions.

⁴ The implementation guide in Volume 2 can be used to develop checklists to assess the status of implementation of national- and district-level actions.

KEY REFERENCE DOCUMENTS

Ambresin A-E, Bennett K, Patton GC, Sanci LA, Sawyer SM (2013). Assessment of youth-friendly health care: a systematic review of indicators drawn from young people's perspectives. *J Adolesc Health*.52(6):670–681.

Chandra-Mouli V, McCarraher DR, Phillips SJ, Williamson NE, Hainsworth G (2014). Contraception for adolescents in low and middle income countries: needs, barriers, and access. *Reprod Health*.11(1):1.

Denno DM, Hoopes AJ, Chandra-Mouli V (2015). Effective strategies to provide adolescent sexual and reproductive health services and to increase demand and community support. *J Adolesc Health*.56(1S):S22–S41. doi: 10.1016/j.jadohealth.2014.09.012.

Nair M, Baltag V, Bose K, Boschi-Pinto C, Lambrechts T, Mathai M (2015). Improving the quality of health care services for adolescents globally: a standards-driven approach. *J Adol Health*. 57:288–98.

Waddington C, Sambo C (2015). Financing health care for adolescents: a necessary part of universal health coverage. *Bull World Health Organ*.93:57–59.

WHO (2010). Quality assessment guidebook: a guide to assessing health services for adolescent clients. Geneva: World Health Organization.

WHO (2011a). Beginning with the end in mind: planning pilot projects and other programmatic research for successful scaling up. Geneva: World Health Organization.

WHO (2011b). Making health services adolescent friendly. Geneva: World Health Organization.

WHO (2014a) [online]. Health for the world's adolescents. A second chance in the second decade. Geneva: World Health Organization (<http://apps.who.int/adolescent/second-decade/>, accessed 4 August 2015).

WHO (2014b). Ensuring human rights in the provision of contraceptive information and services. Guidance and recommendations. Geneva: World Health Organization.

WHO (2014c). Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization (<http://www.who.int/hiv/pub/guidelines/keypopulations/en/>, accessed 4 August 2015).

WHO (2015a). Core competencies in adolescent health and development for primary care providers. Geneva: World Health Organization.

WHO (2015b) [online]. Health systems strengthening glossary. Geneva: World Health Organization (http://www.who.int/healthsystems/hss_glossary/en/, accessed 12 March 2015).



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