



Ministry of Health & Wellness

Adolescent Sexual and Reproductive Health Programme

NATIONAL STANDARDS FOR DELIVERING QUALITY HEALTH-CARE SERVICES FOR ADOLESCENTS

May 2018

TABLE OF CONTENTS

1.0	ABBREVIATIONS	3
2.0	GLOSSARY	7
3.0	INTRODUCTION	10
4.1	8 National Standards.....	11
4.2	Standards' Rationale, Intent and Criteria.....	12
	Standard 1 – Adolescents' health literacy	12
4.3.1	Measurable Criteria of Standard 1.....	13
	Standard 2 – Community Support:.....	14
4.3.2	Measurable criteria for Standard 2	14
4.3.4	Standard 3 – Appropriate Package of Services.....	15
4.3.4	Standard 4 – Providers' Competencies	17
4.3.5	Standard 5 – Facility Characteristics.....	20
4.3.6	Standard 6 – Equity and Non-Discrimination	22
4.3.7	Standard 7 – Data and Quality Improvement	24
	Rationale for Standard 7	25
4.3.8	Standard 8 - Adolescents' Participation	27
5.0	IMPLEMENTATION	30
5.1	Implementation Plan	30
	Rationale for Monitoring and Evaluation.....	45
7.0	IMPLEMENTATION OF MONITORING AND EVALUATION FRAMEWORK	46
8.0	KEY REFERENCE DOCUMENTS.....	49

1.0 ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
BOFWA	Botswana Family Welfare Association
CBO	Community Based Organisation
CMS	Central Medical Stores
MoH	Ministry of Health and Wellness
FBO	Faith Based Organisation
ICPD	International Conference on Population and Development
HIV	Human Immune Virus
IEC	Information and Education Communication
NDP	National Development Plan
NGO	Non-Governmental Organisation
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
WHO	World Health Organisation

Foreword

Adolescents and young people aged 10 – 24 years contribute more than 30% of Botswana's population. Today's young people have diverse experiences given the different political, economic, social and cultural realities they face in their communities as they transition from childhood to adulthood. Most of them go through this journey unaided hence challenges and pitfalls. They face many Sexual and Reproductive Health (SRH) challenges which includes; early sexual debut, early & unplanned pregnancies, STI's, new HIV infections, unsafe abortion, Sexual & Gender Based Violence (SGBV), mental health, drug and substance abuse.

The Ministry of Health and Wellness (MOHW) in collaboration with other stakeholders have over a decade been implementing the Adolescent Sexual & Reproductive Health programme- with one of the strategic areas being establishment of Youth Friendly Health facilities to specifically address the SRH needs of adolescents & young people. On the other hand, the government committed to the East and Southern Africa (ESA) Commitment in 2013 on the implementation of Comprehensive Sexuality Education (CSE) and the delivery of quality Youth Friendly Health Services (YFHS).

The establishment of YFHS facilities and delivery of quality YFHS, targeted adolescents and young people both males and females aged 10 – 24 years of ages with health information and services through static and outreach approach. Provisions of services are offered by competent and trained health care providers in a most suitable and comfortable space area to ensure access and utilization of these services. Delivery of quality services was guided by a minimum package of YFS services and subsequently reviewed in 2016. However, the assessment of delivery of YFS (2016) revealed that provision of services was fragmented, poorly coordinated and uneven.

The International Conference on Population & Development (ICPD) Plan of Action and its follow up plans, urged governments to make reproductive health services available, attractive, accessible, acceptable, effective and affordable to young people. In addition, the **WHO report on 'Health for the World's Adolescents: a Second Chance in the Second Decade' (2014)**, emphasizes the need to transform the health systems in order to respond to the health needs of adolescents. This called for the urgent need to develop national YFHS standards to close the gaps on delivery of quality services. The national standards for the effective implementation of YFHS are aligned to the WHO Global Standards for Quality of Health-care Services for Adolescents (2015), in line with the Sustainable Development Goals (SDGs) and the Global Strategy for Women's, Children's and Adolescents (GSWCAs (2016 - 2030).

The **eight (8)** YFHS standards includes; **1. Adolescent health literacy, 2. Community support, 3. Appropriate package of services, 4. Provider's competencies, 5. Facility characteristics, 6. Equity and non-discrimination, 7. Data & quality improvement and 8. Adolescent's participation.** While these 8 standards are not new to service delivery, the emphasis should be provision of quality YFHS to adolescents and young people in Botswana. These standards are coupled with a Monitoring and Evaluation (M&E) framework which is intended to measure service delivery and ensuring services are of good quality. These will be conducted periodically to influence evidence based programming.

The Ministry of Health and Wellness is committed to ensuring these national service standards are adhered to for the benefit of adolescents and young people in the Botswana. We also hope that all stakeholders and/ or implementing partners involved in provision of YFHS will fully adhere these

standards. Finally, I urge all of us to acquaint ourselves with these standards and use them as reference in the provision of SRHR information and services to our adolescents & young people.

I thank you.

Dr Tshepo Machacha
Deputy Permanent Secretary
Department of Health Services Management
Ministry of Health & Wellness

Acknowledgement

The Ministry of Health and Wellness wishes to appreciate the financial and technical support provided by UNFPA country office led by Ms Kefilwe Koogotsitse, WHO Country Office, Ms Lucy Sejo Maribe NPO SRH, WHO Regional Office represented by Dr Woldehanna Teshome Desta (Medical Officer/ Child and Adolescent Health / WHO/AFRO) and Dr Valentina Baltag (Adolescent Health / WHO/HQ) for the development of the National Standards for Quality Health-Care Services for Adolescents and Monitoring & Evaluation Framework. Your continuous support in ensuring quality services for adolescents and young people is of great value.

The Ministry would also like to extend our sincere gratitude to the Technical Working Group led by Ms L. Mokganya for the outstanding leadership and guidance in the development of this document. The ministry highly appreciates the expertise of the different specialists from different organisations actively engaged in pre-service education of health care workers, Health professional Council regulation and clinicians providing Youth Friendly Services, namely: Ms O. Rapinyana and Dr T.W Baratedi (University of Botswana, School of Nursing), Ms L. Moatshe (Department of Health Inspectorate- Ministry of Health & Wellness Head Quarters), Ms R. Sejese (Institute of Health Sciences- Gaborone), Ms H. Kau- Kigo (Nursing & Midwifery Council of Botswana- NMCB), Adolescent Sexual & Reproductive Health Focal Persons/ Trainer of Trainees; Ms P. Mahupu (Kasane Youth Clinic), Ms M. Sechuate (Scottish Livingstone Hospital Youth Clinic), B. Thamuku (Ramotswa Youth Clinic) D. Letsholathebe (Tutume Primary Hospital Youth Clinic) and Mr I. Mbotho (Mahalapye District Hospital Youth Clinic). The ASRH team Ms G. Gaealafswa and Mr T. Rakereng (Sexual & Reproductive Health Division, Ministry of Health & Wellness Head Quarters) for facilitating the whole process of the review.

Your contributions towards the development of this document are invaluable, and have been a demonstration of your commitment to ensuring the delivery of quality services to all adolescents and young people. Once again, your dedication to this exercise has not gone unnoticed. We really appreciate your efforts! Last but not least, we thank all adolescents and young people who contributed to the development of the national YFHS standards. We pledge to use your contributions to serve you better going forward!

Finally, I would like to appreciate Ms Joyce Maphorisa, the consultant who led the process of adapting Global Standards for Quality Health-Care Services for Adolescents to Botswana context. Thank you for your high-level technical expertise which guided the successful completion of this activity. These quality standards will go a long way in ensuring that adolescents and young people in Botswana receive quality health care services.

I thank you, *le kamoso betsho*.

Samuel Kolane
Advisor, Community Health Services
Department of Health Services Management
Ministry of Health & Wellness

2.0 GLOSSARY

Adolescent - Defines adolescents as people aged between 10 and 19 years old.

Assent - denotes willingness to voluntarily participate in decision-making on health care and research interventions by a person who by definition is too young to give informed consent but who is old enough to understand the proposed research or intervention in general, its expected risks and possible benefits, and the activities expected of them as participants. Assent should be established if the parent/guardian has given their consent.

Attitude -Someone's views about a thing, process or person, which influence behaviour.

Community health worker (CHW)-Are members of a community who are chosen by community members or organizations to provide basic health and medical care to their community who are capable of providing preventive, promotional and rehabilitation care to these communities.

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 -Is the protection of personal information. Confidentiality means keeping a client's information between service provider and the client, not telling the third party. Access to personal data and information is restricted to individuals who have a reason and permission for such access. Information should be collected in a private space and data should be stored anonymously.

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 experience 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". As the adolescents 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 and hence choices regarding aspects of care.

Gatekeepers -Adults that have influence over adolescents' access to and use of services e.g. parents or other family members, legal guardians, teachers, community leaders such as Dikgosi, Pastors/Priests, etc.

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. For example; 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 cause 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 their age and maturity

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 the Botswana 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/>).

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 healthcare 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 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 exposure (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 and need for privacy during consultations, examinations and treatments. Their privacy is important, especially during clinical examinations and procedures. Staff members must know that adolescent are clients they need privacy and respect.
- Protection from physical and verbal assault. This responsibility is particularly relevant to young vulnerable adolescents that are mentally ill, and those unable to protect themselves.
- The staff should respects confidential information and also protect the information from loss or misuse, by not disclosing the information to a third party unless legally required.
- Non-discrimination is the right of every adolescent to the highest attainable standard of health and quality health care, without discrimination of any kind, irrespective of 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.

- The adolescent decides about all aspects of care, including refusing care. The adolescent also decides which family member and friends if any join with him or her in the care process. Their involvement in care is respected irrespective of whether or not they have 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 them as stipulated in the Convention of the Rights of the Child.¹ 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 maturity² (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, and secretaries) or who are involved in maintaining certain quality standards (e. g. cleaning or security staff).

3.0 INTRODUCTION

¹ 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

² Article 12 of the Convention of the Rights of the Child. <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

The development of National Standards for Quality Health-Care Services for Adolescents recognizes the need to improve services provided to adolescents and young people in an acceptable, preferred manner. The World Health Organization report: *Health for the world's adolescents: a second chance in the second decade*, reminded all stakeholders of the urgent need to transform how health systems respond to the health needs of adolescents and ultimately to make progress toward universal health coverage. It further recommended developing and implementing national quality standards and monitoring systems as one of the actions necessary to make this transformation.

By October 2017 there were 26 public health facilities providing youth friendly health services throughout the country. Access to quality youth friendly health services remains a challenge for many adolescents and young people ranging from limited health facilities offering youth friendly health services, to availability of trained health care workers on delivering quality services and limited knowledge on available services, including ability to guide the delivery of quality services that meet their needs. Recognizing these challenges, Botswana has moved towards a standards-driven approach to improve the quality of care for adolescents and young people.

The national standards are aligned to the *Global standards for quality health-care services for adolescents*. At the national level, the standards are aligned to the Botswana Integrated Sexual Reproductive Maternal, Neo-Natal, Adolescent Health & Nutrition (RMNAHN+N) Strategy and the Adolescent Health Operational Plan and 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 standards provide guidance on service delivery and quality improvements in all Service Delivery Points (SDPs) offering youth friendly health services. By making improvements in the quality of care provided, adolescents' rights to accessible, acceptable and effective care will be fulfilled.

4.1 8 National Standards

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 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 ³ .
Providers' competencies	Standard 4: Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfil adolescents' rights to information, privacy,

³ Service provision in the facility should be linked, as relevant, with service provision in referral level health facilities, schools and other community settings.

	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.

4.2 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.

Standard 1 highlights the importance of health education (within the facility and through outreach) and individual behaviour-oriented communication that contributes to the development of adolescents' skills and knowledge, and their efficacy to act on their knowledge, in order to maintain good health.

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). According to the World Bank report, May 2011⁴ literacy rate among females aged 15 years and above is a high 84% but there is no known study that has been undertaken to determine healthy ASRH literacy rates among adolescents. However in 2010, a review of the implementation of the ASRH strategy revealed low knowledge on contraceptives, only 45 of young

⁴<http://siteresources.worldbank.org/INTPRH/Resources/376374-1282255445143/Botswana52411web.pdf>

people knew three methods of contraceptives. Comprehensive knowledge on HIV is below 50 percent. 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). Health literacy include accurate knowledge regarding health and disease 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. Adolescents' positive experience of care is also dependent 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).

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 Standard3).

4.3.1 Measurable Criteria of Standard 1

Input criteria	Process criteria	Output criteria
----------------	------------------	-----------------

1. The health facility has a signboard that mentions operating hours and services offered ⁵ .	7. Health Care providers provide age and developmentally appropriate health education and counselling in a language appropriate to adolescent clients and inform them about the availability of health, social services and other services.	9. Adolescents are knowledgeable about health.
2. The health facility has in the waiting area up-to-date information, education and communication materials specifically developed for adolescents.		10. Adolescents are aware of what health services are being provided, where and when they are provided and how to obtain them.
3. The health care facility has innovative IT platforms to disseminate information		
4. Health care providers have competencies to provide health education to adolescents and to communicate about health and available services (health, social and other services)		
5. The health facility has outreach workers that are trained to conduct health education for adolescents in the community.	8. Outreach activities to promote health and increase adolescents' use of services are carried out according to the health facility's plan	
6. 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.		

Standard 2 – Community Support

The health facility implements systems to ensure 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).

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 engages 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 5).

4.3.2 Measurable criteria for Standard 2

⁵ If there are special days and/or hours for adolescents, these should be clearly mentioned.

Input	Process	Output
1. Health-care providers have competencies⁶ and support materials to communicate with parents, guardians and other community members and organizations about the value of providing health services to adolescents. 2. The health facility has an updated list of agencies and organizations with which it partners to increase community support for adolescents' use of services. 3. 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. 4. The facility has coordinated orientation of key decision-making committees/organisations within the village on adolescent health	1. The healthy 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. 2. Health-care providers inform parents/guardians visiting the health facility about the value of providing health services to adolescents 3. Health-care providers and/or outreach workers inform parents/ guardians and teachers during school meetings about the value of providing health services to adolescents. 4. Health-care providers and/or outreach workers inform youth and other community organizations about the value of providing health services to adolescents.	1. Gatekeepers and community organizations support the provision of health services to, and their utilization by, adolescents.

4.3.4 Standard 3 – Appropriate Package of Services

⁶ 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/.

The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfil the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.⁷

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.

Intent of Standard 3

Standard 3 stresses three important elements;

1. Health care for adolescents encompasses a range of services ranging from information, counselling, diagnosis, treatment and care.
2. The package of services offered in the facility reflects the health-care needs of adolescents in the communities. While priorities might vary 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).
3. The health facility should determine which services are offered on-site and what services 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 communities served by the facility should exist, as well as between various levels of the health care system and between various specialties. Within its

Minimum ASRH Care Package

1. IEC and Advocacy to the general public
2. IEC and Counselling on ASRH issues and for behaviour change
3. Provision of FP services
4. Provision of ANC and PMTCT, delivery and PNC including male involvement in SRH services
5. Provision of Comprehensive Post Abortion Care and Counselling
6. Management of STIs/HIV/AIDS
7. Provision of HIV VCT (Pre and Post Test Counselling)
8. Family Life Education
9. Mental Health Services
10. Alcohol and Substance Abuse Counselling
11. Nutritional Health
12. Screening for cancers; include Reproductive Health Cancers
13. Sexual & Gender Based Violence Services (S & GBV) including Post S & GBV Clinical Care)

⁷ Service provision in the facility should be linked, as relevant, with service provision in referral level health facilities, schools and other community settings

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 communities (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).

Measurable Criteria for Standard 3

Input	Process	Output
1. Policies are in place that define the required package⁸ of health information, counselling, diagnostic, treatment and care services, adolescents' rights and provider obligations and enable its provision. 2. Policies and procedures⁹ are in place that identify health services that are provided in the health facility and community settings such as schools.²⁰ 3. Policies and procedures are in place that describes the referral system to services within and outside the health sector, including provisions for transition care for adolescents with chronic conditions. 4. Policies guidelines should be disseminated to providers every five years and be shared with the consumers for awareness and ownership.	1. 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.¹⁰ 2. 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.	1. 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.

4.3.4 Standard 4 – Providers' Competencies

⁸ 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>.

⁹ Standard operating procedures are desired where possible; these should be periodically updated

¹⁰ Evidence-based management in line with guidelines and protocols is covered in Standard 4.

Health-care providers demonstrate the technical competence¹¹ required to provide effective health services to adolescents. Both healthcare 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, therefore the competencies of ASRH service providers is key in ensuring effectiveness in service provision.

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 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.

Up-to-date decision support tools, such as clinical practice guidelines and protocols, are required 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 communities.

The facility advances health-related rights (see Glossary) for all its adolescent clients to ensure they have the services they need. The managers provide 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-

¹¹ 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).

care providers and support staff respect, protect and fulfil adolescent rights throughout the care process.

Measurable criteria of Standard 4

Input	Process	Output
1. Health-care providers and support staff of the required profile¹² are in place. 2. Health-care providers have the technical competencies¹³ necessary to provide the required package of services 3. Health-care providers and support staff 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. 4. Providers' obligations and adolescents' rights are clearly displayed in the health facility. 5. 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.	1. A system of supportive supervision and mentorship is in place to improve health-care providers' performance. 2. A system of continuous professional education that includes an adolescent health-care component is in place to ensure lifelong learning. 3. Health-care providers follow evidence-based guidelines and protocols in delivering care to adolescents. 4. 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.	1. Adolescents receive effective¹⁴ health services. 2. Adolescents receive services in a friendly, supportive, respectful, non-discriminatory and non-judgemental manner, and know their rights in health care. 3. Adolescents receive accurate, age appropriate and information to facilitate informed choice.

¹² The required competencies of staff should be clear in job descriptions.

¹³ 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).

¹⁴ 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.

4.3.5 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; convenient operating hours for adolescents in the communities; Care may be provided on an appointment basis or a walk-in basis 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:

- a) Offices/examining rooms are designed to ensure privacy for patients during clinical examinations and treatments.
- b) Adequate hand hygiene facilities are located in or adjacent to the office/exam room.
- c) Adequate seating is provided in the waiting room for normal patient flow, in a manner that ensures privacy of communication with reception staff.
- d) The premises, fittings, and furniture are kept clean and in good repair, meeting standards for lighting, heating, ventilation, and infection control.
- e) 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.

- f) Sufficient security is provided to assure the safety of the environment, the premises and offices/exam rooms.
- g) 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.
- h) 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
-------	---------	--------

1. A policy is in place, including assigned responsibilities across health-care providers and support staff, to ensure a welcoming and clean environment, ²⁷ minimize waiting times and ensure convenient operating hours and flexible appointment procedures.	7. Health-care providers offer consultations during hours that are convenient to adolescents in local communities, with or without an appointment	11. The health facility has convenient operating hours, appointment procedures and waiting times kept to a minimum.
2. The facility manage waste according to the National guidelines, e.g. Waste Management Act	8. Health-care providers and support staff follow policies and procedures to protect the safety, the privacy and confidentiality of adolescents.	12. The health facility has a safe, welcoming and clean environment.
3. The facility has basic amenities (electricity, water).	9. Medicines and supplies are in adequate quantities without shortages (stock-outs) and are equitably used.	13. Adolescents receive private and confidential health care at all times during the consultation process.
4. Policies and procedures to protect the safety, 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.	10. The equipment necessary to provide the required package of services to adolescents is available, functioning and equitably used.	14. The facility has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
5. A system of procurement and stock management of the medicines and supplies necessary to deliver the required package of services is in place.		
6. A system of procurement, inventory, maintenance and safe use of the equipment necessary to deliver the required package of services is in place.		

4.3.6 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. For example, unmarried adolescents may be stigmatized if they seek STI and HIV testing, safe abortion (where it is legal) or contraceptive services. 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, use of medicines and technologies, involvement in the care process and its planning and monitoring that various groups of adolescents experience. The facilities are expected to collaboratively work with other agencies and health-care providers to identify and reach vulnerable group(s) of adolescents in their communities, 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 should provide equitable care and treatment for adolescents with the same health problems and care needs. Providers also 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

Measurable criteria of Standard 6

Input	Process	Output
1. 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. 2. Policies and procedures are in place for services that are free at the point of use, or affordable. 3. Health-care providers and support staff are aware of the above policies and procedures and know how to implement them. 4. 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.	5. Health-care providers are to enable, identify vulnerable group(s) of adolescents in their communities. 6. Health-care providers 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. 7. Health-care providers provide services to all adolescents without discrimination, in line with policies and procedures. 8. 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.	9. 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.^{15,16} 10. 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.¹⁷

4.3.7 Standard 7 – Data and Quality Improvement

¹⁵ 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).

¹⁶ This criterion can be measured by comparing the experience of care in groups of adolescents with various socio-economic characteristics.

¹⁷ For example, as peer educators, counsellors, trainers

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 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 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.

Evidently data is collected at all levels in the Botswana health system. However, according to the 2016 Facilities' Review Report, the challenge is that the statistics do not give the perspective of youth on the friendliness of health services. Additional information on factors that are necessary to impact on Youth Friendly Services programs need to be collected to further inform strategies for improvement,

Facilities' Review Report-2016

18/18 facilities had client data, It had been disaggregated by age and sex
18/18 did not provide data on analysed disaggregated data on outreach activities
14/18 had no guidelines and SoPs for monitoring the quality of care provided
13/18 had no data on how information was used to improve the quality of adolescent care
15/18 had no guiding tools for self-assessment and appraisal
12/18 had no record of supervision visits' focus on adolescent care

observes the report. The data collected by the YFS centres can assist the Government and other stakeholders in the planning and

programming of services that are evidence-based and targeted for young people.

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. The benefit of data collection is not to report but to use the data for decision making and improvement. That seems to be a gap that needs to be closed in the implementation of standards.

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 initiative.

Measurable criteria for Standard 7

Input	Process	Output
1. A system is in place to collect data on service utilization that is disaggregated by age, sex and other socio-demographic characteristics as relevant. 2. Health-care providers are trained to collect and analyse data to inform quality improvement initiatives. 3. Tools and mechanisms for self-monitoring of the quality of health services for adolescents are in place. 4. Mechanisms are in place to link supportive supervision and mentoring priorities for improvement as identified during the monitoring of the implementation of standards. 5. Mechanisms are in place for reward and recognition of highly performing health-care providers and support staff.	6. The health facility collects data on service utilization disaggregated by age and sex and conducts regular self-assessments of quality of care.¹⁸ 7. Health-care providers and support staff use data on service utilization and quality of care for action planning and implementation of quality improvement initiatives. 8. Health-care providers and support staff receive supportive supervision in areas identified during self-assessments. 9. Good performance is recognized and rewarded.	10. Facility reports to districts include data on cause-specific utilization of services by adolescents that is disaggregated by age and sex 11. Facility's reports to districts on quality of care have a focus on adolescents. 12. Health facility staff demonstrated support from supervisors and mentors by being motivated to comply with the standards.

4.3.8 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

¹⁸ This includes the assessment of adolescents' experience of care. See 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.¹⁹ 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 element 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

¹⁹ 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).

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
1. The governance structure of the facility includes adolescents. 2. There is a policy in place to engage adolescents in service planning, monitoring and evaluation. 3. 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.	4. The health facility carries out regular activities to identify adolescents' expectations about the service³² and to assess their experience of care, and it involves adolescents in the planning, monitoring and evaluation of health services. 5. Health-care providers provide accurate and clear information on the medical condition and management/treatment options,²⁰ and explicitly take into account the adolescent's decision on the preferred option and follow-up actions. 6. The health facility carries out activities to build adolescents' capacity in certain aspects of health-service provision.²¹	7. Adolescents are involved in planning, monitoring and evaluation of health services. 8. Adolescents are involved in decisions regarding their own care. 9. Adolescents are involved in certain aspects of health service provision.

²⁰ 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.

²¹ For example, peer education.

5.0 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.

5.1 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 needs 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, ²² 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**).

²² 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 ²³
Governance	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.	Communicate National laws policies, and latest revisions, to facility managers and demand facility-level actions	Communicate National laws policies, SOPs and latest revisions to facility staff.
	Communicate national laws and policies, and latest revisions, to district managers and request district level actions.	Advocate with facility managers to ensure their ownership and support for key policies.	Identify community resources and build partnerships for advocacy and service provision for adolescents.
	Advocate with district managers to ensure their ownership and support for key policies.	Advocate with other sectors and wider society to ensure their ownership and support for key policies.	Advocate with facility staff, other sectors' services and the wider community to ensure their ownership and support for the implementation of key policies.
	Advocate with other sectors and wider society to ensure their support for key policies.	Support facility managers to implement key policies, and to translate them into facility SOPs.	Develop or adapt, as appropriate, local SOPs to implement key policies Supply facility staff with information and training materials, practice guidelines and other decision support tools.
	Develop or review, as appropriate, norms, standards and standard operating procedures (SOPs), and make them known and available in the districts.	Ensure the availability of information and educational materials at the district level.	Ensure an adolescent health focus in facility reports Monitor the implementation of quality standards in the facility, and use data to stimulate actions
	Develop or review, as appropriate, information and training materials, practice guidelines and other decision support tools in adolescent health care Ensure an adolescent health focus in national reports.	Ensure an adolescent health focus in district reports.	
		Conduct data synthesis and monitoring and evaluation activities at the district level and use national and district data to stimulate local actions	

²³ These actions are facility-led, but some of them happen in and with the community.

Workforce capacity	Conduct data synthesis, monitoring and evaluation activities at the national level and use national data to stimulate local actions.		
	National-level actions	District-level actions	Facility-level actions
	Define core competencies in adolescent health and development and develop and implement competency-based training programmes in pre-service and continuous professional education Set up a system for supportive supervision in adolescent health care Ensure an adolescent health focus in job descriptions and policies on skill mix	Plan capacity-building activities at the district level Conduct capacity building activities in adolescent health care and support facility managers in doing so Implement a system of supportive supervision in adolescent health care at the district level Ensure that decision support tools are available in health-care facilities and providers know how to use them	Plan capacity-building activities for facility staff. Ensure staff participation in continuous professional education in adolescent health care and in supportive supervision. Ensure that decision support tools are available in health-care facilities. Conduct capacity building activities Plan staff profile and manage staff time to enable the implementation of key policies
Financing	National-level actions	District-level actions	Facility-level actions

	Negotiate allocation of funds from the national budget to ensure the provision of a comprehensive package of services to adolescents	Allocate funds for the provision of a comprehensive package of services in adolescent health care.	Inform district officials about facility needs to enable allocation of funds for key activities
	Finance continuous professional education activities.	Finance continuous professional education activities.	
	Finance quality improvement initiatives in adolescent health care.	Finance quality improvement initiatives in adolescent health care.	
	Finance the production of information and education materials for adolescents and community members.	Finance the production of information and educational materials for adolescents and community members	

Table 2: National, District & Facility Criteria & Initiatives

Criterion	Action	N	D	F
1. The health facility has a signboard that mentions operating hours and services offered.	Install visible signboards in all health facilities not just AYFS	*	*	
2. The health facility has in the waiting area up-to-date information, education and communication materials specifically developed for adolescents.	Develop/review standard IEC materials for all facilities & communities (<i>local context</i>) in appropriate packages (multi-media, short videos, social media, new applications & printed copies)	*	*	
3. The health care facility has innovative IT platforms to disseminate information	Review existing platforms and update, share and monitor usage (Social media, new applications)	*	*	*
4. Health-care providers have competencies to provide health education to adolescents and to communicate about health and available services (health, social and other services).	Undertake training of HCP to build their knowledge on health and available services (health, social and other services) Develop pocket- guide on adolescent health for HCP	*	*	
5. The health facility (including stakeholders) has outreach workers that are trained to conduct health education for adolescents in the community.	Undertake stakeholder analysis (roles, accountability, and trained outreach workers) per district. Partner with existing Community Based Health workers and Youth Service Organisations to train and deploy outreach workers to undertake health education in the community		*	*
6. 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.	Develop an outreach plan for different stakeholders to promote health and increase adolescents' use of services.		*	*
7. Health Care providers provide age and developmentally appropriate health education and counselling in a language appropriate to adolescent clients and	Undertake training of HCP on provision of age appropriate health education and counselling (See Std 4)	*	*	

Criterion	Action	N	D	F
inform them about the availability of health, social services and other services.				
8. Outreach activities to promote health and increase adolescents' use of services are carried out according to the health facility's plan	Implement the outreach plan (See 6)		*	*
9. Adolescents are knowledgeable about their health.	Establish feedback system using assessments and exit interviews		*	*
10. Adolescents are aware of what health services are being provided, where and when they are provided and how to obtain them	See 1, 2, 3 and 9		*	*
11. Health-care providers have competencies and support materials to communicate with parents, guardians and other community members and organizations about the value of providing health services to adolescents.	Develop IEC materials and utilize Parent-Child Communication (PCC) guidelines and programmes for parents and community	*	*	*
12. The health facility has an updated list of agencies and organizations with which it partners to increase community support for adolescents' use of services.	See 5		*	*
13. 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.	See 6	*	*	
14. The facility has coordinated orientation of existing key decision-making committees/organisations within the district on adolescent health	Undertake district level orientation/awareness meetings with existing stakeholders on adolescent health utilizing existing committees.		*	*
15. The health facility engages in partnerships with adolescents, gatekeepers and community organizations to develop health education and behaviour-oriented	Partner with Youth serving organisations to develop health education and behaviour-oriented communication strategies and materials and plan service provision.	*	*	*

Criterion	Action	N	D	F
communication strategies and materials and plan service provision.				
16. Health-care providers inform parents/guardians visiting the health facility about the value of providing health services to adolescents	Include provision of YFS and the value of providing health services to adolescents in regular daily/ weekly health talks to parents/ guardians			*
17. Health-care providers and/or outreach workers inform parents/guardians and teachers during school meetings about the value of providing health services to adolescents.	Include YFS in PTA agenda, utilizing PCC manual			*
18. Health-care providers and/or outreach workers inform youth and other community organizations about the value of providing health services to adolescents.	Include YFS during VDC, Kgotla & other community structures meetings on the value of providing health services to adolescents.		*	*
19. Gatekeepers and community organizations support the provision of health services to, and their utilization by adolescents.	See 18		*	*
20. Policies are in place that define the required package of health information, counselling, diagnostic, treatment and care services, adolescents' rights and provider obligations and enable its provision.	Develop and /review policies to ensure inclusion of minimum package of services.	*		
	Monitor implementation of the minimum package of services	*	*	*
21. Policies and procedures are in place that identify health services that are provided in the health facility and community settings such as schools. ²⁰	See 20 Develop Standard Operating Procedures (SOPs) for delivery of quality YFHS at health facility and school level (<i>see School Health Policy</i>)	*		
22. Policies and procedures are in place that describes the referral system to services within and outside the health sector, including provisions for transition	See 20, 21	*		

Criterion	Action	N	D	F
care for adolescents with chronic conditions.				
23. Policies and guidelines are disseminated to health care providers	Disseminate policies and SOPs & YFHS standards in various platforms with relevant stakeholders	*	*	*
24. 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.	Monitoring of compliance on the delivery of YFHS minimum package through systematic self and external assessment tools	*	*	*
25. 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.	Monitor compliance to referral according to the referral system		*	*
26. 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.	Monitor compliance to the standard package and implement corrective actions as required.	*	*	*
27. Health-care providers and support staff of the required profile are in place.	Advocate for the establishment and implementation of staffing norms at health facility	*	*	
28. Health-care providers have the technical competencies necessary to provide the required package of services	Support a comprehensive competency pre and in service training for health care providers on delivery of adolescent health services as part of Continuous Professional Development (<i>Ensure health care providers earn points</i>)	*	*	*
	Undertake monitoring of staff competencies and close existing gaps.	*	*	
29. Health-care providers and support staff have been trained/ sensitized on the importance of respecting the rights of adolescents to information, privacy, confidentiality, and of the health care	See 28	*	*	

Criterion	Action	N	D	F
that is provided in a respectful, non-judgemental and non-discriminatory manner.				
30. Providers' obligations and adolescents' rights and responsibilities are clearly displayed in the health facility.	Develop/ Review and display Rights and Responsibilities and health care provider obligations* in delivering YFHS in the facility	*	*	*
31. Up-to-date decision support tools (guidelines, protocols, algorithms) that include clinical care in line with the standard package of services are in place.	Develop/Review YFHS guidelines and tools to deliver quality YFHS (See 21 on SOPs) Support systematic monitoring of the implementation of YFHS at DHMT and health Facility levels using sanctioned assessment tools.	*	*	*
32. A system of supportive supervision and mentorship is in place to improve health-care providers' performance.	Develop supportive supervision and mentorship tools Monitor performance of the health facility/staff quarterly	*	*	*
33. A system of continuous professional development that includes an adolescent health-care component is in place to ensure lifelong learning.	Link health care providers with available training courses, workshops, webinars that includes adolescent health-care component Conduct trainings and workshops and webinars for health care providers that includes adolescent health-care component	*	*	*
34. Health-care providers follow evidence-based guidelines and protocols in delivering care to adolescents.	(See 21) Conduct clinical audits, case reviews, self-assessments and Continuous Quality Improvement (CQI) Initiatives	*	*	*
35. 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.	See 28 on competency training			*

Criterion	Action	N	D	F
36. Adolescents receive effective health services.	Develop/Review feedback mechanisms through various platforms (suggestion boxes, exit interviews, mystery clients/ Shopping including online on delivery of the minimum standards package Obtain feedback using above platforms on services provided in line with minimum package. Implement actions for 20			*
37. Adolescents receive services in a friendly, supportive, respectful, non-discriminatory and non-judgemental manner, and know their rights in health care.	Undertake systematic feedback from adolescents on the quality of services provided at health facility level (See 36)		*	*
38. Adolescents receive accurate, age appropriate and information to facilitate informed choice.	Implement actions for 5	*		*
39. A policy is in place, including assigned responsibilities across health-care providers and support staff, to ensure a welcoming and clean environment, minimize waiting times and ensure convenient operating hours and flexible appointment procedures.	SOP developed, implemented (See 21) Monitoring implementation of the plans		*	*
40. The facility manage waste according to the National guidelines, e.g. Waste Management Act	Monitor adherence and implementation in line with waste management protocols		*	*
41. The facility has basic amenities (electricity, water).	Ensure availability of basic amenities (electricity and water) for accreditation of all facilities Facilities maintenance plans are implemented		*	*
42. Policies and procedures to protect the safety, privacy and confidentiality of adolescents are in place. Both health-care providers and support staff know	See 21 (SOPs)	*	*	*

Criterion	Action	N	D	F
them as well as their own roles and responsibilities.				
43. A system of procurement and stock management of the medicines and supplies necessary to deliver the required package of services is in place.	Ensure availability of a functional Supply Chain Management system at all levels	*	*	*
44. A system of procurement, inventory, maintenance and safe use of the equipment necessary to deliver the required package of services is in place.	See 43	*	*	*
45. Health-care providers offer consultations during hours that are convenient to adolescents in local communities, with or without an appointment	Ensure health care providers offer services during hours that are convenient to adolescents		*	*
46. Health-care providers and support staff follow policies and procedures to protect the safety, the privacy and confidentiality of adolescents.	See 21 & 42 Monitor the implementation of policies regarding privacy and confidentiality and the compliance with SOPs during periodic assessments and supportive supervision visits to facilities, and support facility managers to take corrective actions as necessary	* *	* *	* *
47. Medicines and supplies are in adequate quantities without shortages (stock-outs) and are equitably used.	Implement actions of 43, 44	*	*	*
48. The equipment necessary to provide the required package of services to adolescents is available, functioning and equitably used.	As part of routine & periodic evaluations of the implementation of national standards for quality health-care services for adolescents, evaluate whether or not the equipment is functioning and equitably used, and take corrective actions as needed. Implement actions for 44	 *	* *	* *

Criterion	Action	N	D	F
49. The health facility has convenient operating hours, appointment procedures and waiting times kept to a minimum.	Implement actions for 39		*	*
50. The health facility has a safe, welcoming and clean environment.	Implement actions for 39		*	*
51. Adolescents receive private and confidential health care at all times during the consultation process.	Implement actions for 29, 35, 42, 46,	*	*	*
52. The facility has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.	Ensure availability of equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.	*	*	*
53. 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.	See 20	*	*	*
54. Policies and procedures are in place indicating that services are free at the point of use, or affordable.	Ensure that policies which outline that services are free or affordable at the point of use are in place See 20	*	*	
55. Health-care providers and support staff are aware of the equity policies and procedures and know how to implement them.	Avail policies and procedures on equity at health facility level Implement action 20,21, 53, 55, 58	*	*	*
56. The health facility shall provide health services to all adolescents without discrimination, and to take remedial actions when necessary is displayed prominently in the health facility.	Facilities display boards with policies and procedures on equitable (including free or affordable) service			*

Criterion	Action	N	D	F
57. Health-care providers are able to identify vulnerable group(s) of adolescents in their communities.	Implement action under 53, 54		*	*
58. 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.	See 36 & 37	*	*	*
59. Health-care providers provide services to all adolescents without discrimination, in line with policies and procedures.	Implement actions for 55, 56, 57 & 58			*
60. 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.	Ensure that vulnerable groups of adolescents are involved in designing, assessing and providing health services, and to have a plan on how to engage adolescents.		*	*
61. 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.	See 36 & 37 (Feedback from young people)			*
62. 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.	Implement 60, 61,			*
63. A system is in place to collect data on service utilization that is disaggregated by age, sex and other socio-demographic characteristics as relevant.	Review data collection tools on delivering quality YFHS to ensure adequate disaggregation	*		

Criterion	Action	N	D	F
64. Health-care providers are trained to collect and analyse data to inform quality improvement initiatives.	Ensure that training and orientation on data collection and analysis to inform quality improvement actions are available at all levels.	*	*	*
65. Tools and mechanisms for self-monitoring of the quality of health services for adolescents are in place.	Develop and use tools and mechanism for self-monitoring to monitor the implementation of national standards for quality health-care for adolescents	*	*	*
66. Mechanisms are in place to link supportive supervision and mentoring priorities for improvement as identified during the monitoring of the implementation of standards.	Develop/review and use supervisory and mentoring assessment tools including self-assessment	*	*	*
67. Mechanisms are in place for reward and recognition of highly performing health-care providers and support staff.	Set up a system to reward and recognize highly performing districts, facilities, health-care providers and support staff	*	*	
68. The health facility collects data on service utilization disaggregated by age and sex and conducts regular self-assessments of quality of care.	Ensure collection of data on service utilization disaggregated by age and sex and conducts regular self-assessments of quality of care Implement action for criteria 63-65	*	*	*
69. Health-care providers and support staff use data on service utilization and quality of care for action planning and implementation of quality improvement initiatives.	Implement corrective actions to improve service utilization and compliance with national standards Implement actions for criteria 66, 68		*	*
70. Health-care providers and support staff receive supportive supervision in areas identified during self-assessments.	Implement action 33, 66 Managers ensure that supportive supervision activities, such as peer and supervisor assessments, are carried out regularly and are informed by the findings of facility self-assessments of the quality of health-care services in the facility		*	*
71. Good performance is recognized and rewarded.	Implement actions for 67	*	*	

Criterion	Action	N	D	F
72. Health facility reports include data on specific utilization of services by adolescents that is disaggregated by age and sex	Implement actions for criterion 65 & 68		*	*
73. Health facility reports on quality of care have a focus on adolescents.	Implement action on 68		*	*
74. Health facility staff demonstrates support from supervisors and mentors by being motivated to comply with the standards.	Implement action 70 & 71		*	*
75. The governance structure of the facility includes adolescents.	Develop youth participation and engagement guidelines for governance structures of health-care facilities. Establish/Revive governance structures of health-care facilities that include adolescents.		*	*
76. There is a policy in place to engage adolescents in service planning, monitoring and evaluation.	Review policies and adapt them as necessary to ensure that adolescents are involved in planning, monitoring, evaluation and provision of services Implement actions for 62, 78, 81	*		*
77. 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.	Orientation of staff on the available policy on informed consent and monitor adherence		*	*
78. The health facility carries out regular activities to identify adolescents' expectations about the service and to assess their experience of care, and it involves adolescents in the planning, monitoring and evaluation of health services.	Implement actions for 36, 37, 65, 76		*	*
79. Health-care providers provide accurate and clear information on the medical condition and management/	Actions for criteria 3, 77	*	*	*
		*	*	*

Criterion	Action	N	D	F
treatment options, and explicitly take into account the adolescent's decision on the preferred option and follow-up actions.	Develop or adapt materials using age appropriate visual and audio aids on key medical conditions, their management and treatment options for adolescents			
80. The health facility carries out activities to build adolescents' capacity in certain aspects of health-service provision. ²⁴	Ensure implementation of activities that build the capacity of adolescents in aspects of service provision		*	*
81. Adolescents are involved in planning, monitoring and evaluation of health services.	Implement actions for criterion 75, 78		*	*
82. Adolescents are involved in decisions regarding their own care.	Implement actions for criterion 36 & 79, 81			*
83. Adolescents are involved in certain aspects of health service provision.	Implement actions for criterion 62 & 80		*	*

Rationale for Monitoring and Evaluation

The intent of an M&E system is to ascertain the extent to which the goals and objectives of a programme meets the targets. International Initiative for Impact Evaluation (3ie) notes that there is paucity of evidence-based assessment of adolescent services save for certain contexts or topics, particularly HIV prevention.

Policymakers and other decision-makers currently do not have much evidence on the impact of programming on areas like adolescent pregnancy by and large the evidence base does not yet explore effectiveness for adolescent subpopulations. There are opportunities for researchers to take the next step from reviewing the evidence on a broad topic, such as HIV prevention, to seeking answers around specific approaches, outcomes and adolescent subpopulations.

We need better-quality evaluations and systematic reviews that provide evidence on what works, for whom and at what cost for a wider range of interventions and outcomes and considering the wide array of contexts, populations and needs ASRH covers.²⁵

In the context of the ASRH standards the monitoring framework is intended to inform performance against the criteria for each standard with a view to:

- Select and/or develop best performance indicators (KPI) at input, process output and outcome levels

²⁴ For example, peer education.

²⁵ Kristen Rankin et al: Adolescent sexual and reproductive health: International Initiative for Impact Evaluation (3ie), December 2016

- Identify data sources and ensure collection of data for each indicator is feasible
- Identify those responsible for data collection, analysis, use and dissemination

7.0 IMPLEMENTATION OF MONITORING AND EVALUATION FRAMEWORK

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. 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 level.

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 ²⁶ 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. The facility manager conducts Supportive supervision sessions using the client-provider interaction tool. Based on the results of self-assessment, the facility manager identifies problematic areas and focus on those during supportive supervision visits.
	Region/ District- Bi-annual (every 6 months)	Supportive supervision and Monitoring Visits (SSMVs) by the Regional/ District Health Managers. During the visits the District Managers identify problematic areas (including least performing facilities) and focus on them during the subsequent SSMVs).
	National- annually	Supportive, Monitoring & Mentorship Visits (SMMVs) by National Programme Coordination Office to the Region/District (including priority health facilities) using short list of indicators on a limited number of priority criteria.
Periodic evaluations	District level/ every 2–3 years²⁷	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. ²⁸ 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

²⁶ 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.

²⁷ In geographically small countries district-level evaluations might not be necessary, as national-level evaluations might be sufficient.

²⁸ The implementation guide in Volume 2 can be used to develop checklists to assess the status of implementation of national- and district-level actions

		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. ²⁹ 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.

²⁹ The implementation guide in Volume 2 can be used to develop checklists to assess the status of implementation of national- and district-level actions

8.0 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/health systems/hss_glossary/en/](http://www.who.int/health systems/hss_glossary/en/), accessed 12 March 2015)

MOHW LOGO



