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# Creating Youth-Friendly Sexual Health Services in Sub-Saharan Africa

Issues at a Glance

In most countries in sub-Saharan Africa, youth encounter significant obstacles to receiving sexual and reproductive health services and to obtaining effective, modern contraception and condoms to protect against sexually transmitted infections (STIs), including HIV. Youth-friendly services remove obstacles to sexual health care. Examples of such projects operate in Ghana, Uganda, and Kenya.

## African Youth Face Obstacles to Accessing Contraception and HIV Testing.

Research identifies major barriers to young people's ability to access contraception and HIV testing. These barriers relate primarily to specific aspects of reproductive and sexual health services—the characteristics of the facilities, the design of services, and providers' attitudes and actions.

### The Facilities

Many facilities are too close to youth's homes or too far away. Surveys reveal that young people do not want to run into family members and neighbors when entering, utilizing, or leaving sexual health facilities. However, many youth have difficulty traveling very far away, unless public transportation is available. Other facilities-related barriers include: a lack of privacy; no area set aside where young people can wait to be seen; and décor that is overly clinical, too adult, and/or welcoming *only* to women and not also to men.

### The Design of Services

Research identifies several features in the design of services that may actively discourage youth's using the services. Design obstacles include, but are not limited to, cost, crowded waiting rooms, counseling spaces that do not afford privacy, appointment times that do not accommodate young people's work and school schedules, little or no accommodation for walk-in patients, and limited contraceptive supplies and options. Hearing about these obstacles may prevent young people from making a first visit. Encountering these obstacles may discourage them from returning. Moreover, young people will not seek services if they do not understand the importance of sexual health care or know where to go for care. Finally, if they must visit a different health care facility for each needed service, youth may discontinue care.

### Providers' Attitudes

Research indicates that the single most important barrier to care relates to providers' attitudes. In many societies and cultures, adults have difficulty accepting teens' sexual development as a natural and positive part of growth and maturation. Young people are not encouraged to seek care if they encounter providers whose attitudes convey that youth should not be seeking sexual health services. Young people may be deeply embarrassed and refuse to return for services if staff asks personal questions loudly enough to be overheard by others. Youth may reject sexual health services if any staff person in the facility fails to take seriously the young person's need for services, treats her/him without respect, and/or tries to dissuade him/her from having sexual intercourse. In such a case, young people may give up—not on having sexual intercourse—but on utilizing sexual health services and on using contraception and condoms to prevent unintended pregnancy and STIs, including HIV.

## Providers Can Make Sexual and Reproductive Health Services Youth-Friendly.

Providers can take a number of steps to encourage youth to seek sexual and reproductive health services and to enable them to use contraception to avoid unintended pregnancy and STIs, including HIV.

### In Designing Facilities

- Locate clinics where public transportation is available and close to places where young people gather, such as schools, markets, and community centers.
- To assure youth's privacy, set aside a separate space for their services, or, if that is not possible, set aside some hours just for youth, in the late afternoon and evening and on weekends.
- Within the space and times set aside for youth, create an atmosphere that is welcoming, youthful, informal, and culturally appropriate for *all* the youth using the services.

### In Designing Services

- Involve young people in designing and running services. Youth may be more able than adults to accurately identify the needs of their peers and can propose appropriate ways to meet those needs. Train youth as peer educators.
- Offer youth free or low cost services.
- Schedule appointments to minimize waiting time and crowding in the waiting rooms.
- Permit youth to walk-in for services without an appointment and reserve appointment spaces for youth in the evening and on weekends.
- Ensure that counseling spaces are private and that others cannot overhear.
- Maintain adequate supplies and a wide variety of contraceptive methods.
- Whenever possible, provide contraception to young women without requiring a pelvic examination and blood tests.
- Welcome young men. Recruit and train male staff to meet the sexual health needs of young men.
- Welcome clients' partners, when they wish their partners to accompany them.
- Offer as many services as possible in a single location. If necessary, refer young people to youth-friendly facilities where they can obtain all the services they need.
- Provide culturally appropriate information in the language and at the comprehension level of the client. Make sure that information meets youth's needs and concerns.
- Reach out with activities that make young people aware of the importance of sexual health care. Inform youth about available services and assure them of confidentiality.

### In Addressing Attitudes

- Treat young people as respectfully as adults. Avoid judging youth's behavior. Work to develop solid, mutually trusting relationships with them.
- Provide all staff with ongoing training in adolescent development, understanding young people's needs and concerns, and treating youth confidentially and respectfully. Staff may need assistance in recognizing and changing attitudes that pose barriers to youth.
- Encourage counselors to spend as much time as necessary with each adolescent client in order to address all of her/his concerns.

## Laws and Policies Also Hinder Youth's Access to Services.

Youth also face barriers in the form of laws and policies that prohibit or limit confidentiality in serving youth. Such laws and policies fail to recognize both youth's needs and their ability to make responsible sexual health decisions. Concerned organizations should work together for legal and policy reform to eliminate these barriers and to raise public awareness about the sexual and reproductive health issues that young people face.

# Programs Offer Youth-Friendly Sexual Health Services.

## Case Study: Innovate—Ghana

In January 2001, the Planned Parenthood Association of Ghana (PPAG) implemented *Innovate* to increase young people's sexual health knowledge, access to reproductive and sexual health services, demand for and use of such services, and participation in the planning, implementation, and evaluation of programs. PPAG opened the *Young and Wise Centre* at its headquarters in Accra. The Centre includes a youth clinic, counseling unit, main hall, library, and computer center. It offers a range of educational, artistic, and entertainment activities. Providing non-sexual health services (limited or expensive in the local community) enables PPAG to also effectively deliver sexual health education and services to youth, including—

- STI testing and treatment
- HIV counseling and testing
- Pregnancy testing
- Post-abortion care
- Family planning services, including emergency contraception (EC).

The Centre's marketing campaign, including the brand, "Young and Wise," as well as a logo and the slogan "Be Wise," promotes the Centre's services through outreach and television, radio, print, and electronic media. Its environment, operating hours, staff attitudes, privacy, and policies on confidentiality are all youth-friendly. Trained youth (paid and volunteer) manage the Centre. Youth participate at every stage of the project, giving young people a strong sense of ownership and attracting new and return clients of varied socioeconomic background.

During its first eight months of operation, the Centre provided 18,995 male and 2,337 female condoms; served 2,646 clinic clients; and counseled 102 youth, with an additional 600 to 800 counseled by telephone. The project recently secured continued funding from the African Youth Alliance and will continue using marketing and outreach to increase awareness and acceptance of the Centre's services. For further information, contact Dr. Heidi Marriott, IPPF, London, at hmarriott@ippf.org.

## Case Study: Adolescent Reproductive Health Project—Uganda

In July 1998, with help from Family Planning International Assistance, the Friends of Children Association (FOCA, a program of Planned Parenthood Federation of America), initiated the *Adolescent Reproductive Health Project* for street youth under age 20 in Kampala, Uganda. The project provides sex education and contraceptive services to help street youth avoid unintended pregnancy, unsafe abortion, and STIs, including HIV.

Thirty peer group leaders, one senior peer group leader, and a registered nurse manage the project. Peer group leaders are street youth who have participated in other FOCA programs and demonstrated leadership skills and responsibility. Leaders receive training and provide sexual and reproductive health counseling for their peers. Leaders also distribute condoms and birth control pills and provide referral for injectable contraception, EC, HIV treatment, and general health services at the FOCA Drop-In Centre. For other health services, the Drop-In Centre refers youth to other free or low-cost providers.

The Project utilizes information, education, and communication (IEC) activities to educate street youth and to inform the community and its leaders about the Drop-In Centre and to sensitize them to young people's sexual health needs. IEC activities include video sessions, sporting events, and concerts.

Evaluation indicated that condoms are the most frequently distributed contraceptive method (77 percent), followed by birth control pills (13 percent), and dual method (both condoms and pills, 10 percent). Data also showed a 97 percent client continuation rate from the Project's second to third year. FOCA is implementing a financial plan to sustain the Project as well as to increase its ability to collect and use data. For further information, contact Dr. Gabriela Schwed, FFPA New York, at gabriela.schwed@ppfa.org.

### Case Study: Voluntary HIV/AIDS Counseling and Testing for Youth—Kenya

In 1999, a partnership between Family Health International, the International Centre for Reproductive Health, and the Kenyan Ministry of Health established nine Voluntary Counseling and Testing (VCT) centers in Mombasa, Kenya. One VCT center is in a Youth Counselling Centre (YCC) where trained youth offer voluntary counseling and testing and young nurses provide STI treatment and distribute contraception. The YCC also offers rapid testing for HIV, providing results within 15 minutes. HIV-positive youth are referred to other health centers for tuberculosis-preventive therapy. The project works with the Girl Guides in a special effort to provide young women with information about voluntary counseling and testing.

Three peripheral Youth Resource and Counselling Centres refer youth for voluntary counseling and testing. Twenty peer educators at these peripheral centers provide HIV prevention information as well as pre-test counseling. These centers attract youth because each offers a library, sports opportunities, general leisure activities, and a drama group. Thus far, the project has produced few IEC materials; however, it plans to produce and disseminate more information.

In evaluation, youth responded favorably to youth-friendly voluntary counseling and testing services. Young people said they preferred to be tested by another young person who understands their issues and concerns. During the first year of the project, some 3,000 people were tested for HIV; approximately 50 percent of them were youth, ages 15 to 24. The project plans to expand the range of sexual health information provided by peer educators at peripheral centers to include modern contraception, EC, post-exposure prophylaxis for HIV, and more. Also, the project plans to provide a nurse counselor at each center and to tackle the issues of dating violence and job training for youth. For further information, contact Dr. Mark Hawken, International Centre for Reproductive Health, at ICRH@ikenya.com.

## Conclusion

Significant barriers frequently deter African youth from obtaining urgently needed sexual health services. Programs in Ghana, Kenya, and Uganda are rapidly and effectively dismantling the barriers that keep young people from receiving HIV and STI testing and counseling as well as reproductive health care, including contraception and condoms. By replicating and/or adapting these programs in culturally appropriate ways, other agencies and communities throughout sub-Saharan Africa can create their own programs to meet the sexual health needs of young people.

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*Written by Cecilia Moya*