STANDARDS FOR QUALITY HEALTH SERVICES FOR ADOLESCENTS AND YOUTH IN SRI LANKA

FAMILY HEALTH BUREAU

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Message from the Director General of Health Services

Sri Lanka with its strong foundation of curative and preventive healthcare delivery systems is taking all the efforts to achieve universal access to quality healthcare. However despite all efforts to improve health status of the population, addressing adolescent and youth health issues remains a challenge.

Around 4.8 million out of 20.4 million, or 1 in 4 of the Sri Lankan population consists of adolescents and youth aged 10 to 24. Though, they look mostly healthy, there are substantial premature death, illness, and injury among them. Illnesses in this period hinder their achievement of growth and development to their full potential. Alcohol or tobacco use, lack of physical activity, unprotected sex and/or exposure to violence do jeopardize their current health and will have repercussions on their adult hood. Effects will be reflected even in next generation.

Promoting healthy behaviours and intervening timely for issues during adolescence, and taking steps to protect them from health risks are crucial. As one of the important measures to meet this challenge, standards on adolescent and youth friendly health services(AYFHS) was developed by the Ministry of Health with the involvement of all relevant stakeholders and with the technical and financial support from the country office of the World Health Organization.

This document provides guidance to provision of AYFHS in both curative and preventive sectors ensuring optimum accessibility, acceptability and coverage. Hence, it is imperative that stakeholders and service providers at all levels ensure service provision as per the standards. It is expected that all other relevant stakeholders will utilize this document to ensure optimum service provision for adolescents and youth of the country.

Dr. J.M.W. Jayasundara Bandara
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PREFACE

Adolescent and youth health is a key component of family health program throughout the life cycle. Adolescence is a critical transitional period that includes the biological changes of puberty and the need to negotiate key developmental tasks, such as increasing independence and normative experimentation. A strong foundation laid in adolescent in terms of healthy lifestyles is essential for a healthy and productive life in adulthood. Any adverse event or unhealthy lifestyle established in this crucial period will have a long lasting negative impact affecting an individual throughout the whole life span.

Sri Lanka has achieved impressive health indices including reduction in under five and maternal mortality. Still mortality among adolescents seems to be stagnant though at lower level. Morbidity within this period is increasing due to repercussions modern lifestyles.

Adolescent and youth friendly health service(AYFHS) concept was introduced in Sri Lanka in 2005 and national standards for AYFHS was developed in 2006. WHO/UNAIDS global standards for quality health care services for adolescents was developed in 2015 with the aim of enabling adolescents obtaining optimum health services that they need to promote, protect and improve their health and well-being in an adolescent friendly manner. After reviewing the present context in the country and global literature, existing AYFHS standards are revised after ten years through an extensive consultative process involving relevant stakeholders with technical and financial support from World Health Organization Country Office with provision of consultancy of Dr. Krishna Bose, an international expert in the field. It is expected that this document will provide guidance to all relevant stakeholders and service providers in curative and preventive health sectors in improving adolescent and youth health services of our country with ensuring optimum accessibility, acceptability and

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ABBREVIATIONS

AFHS	Adolescent Friendly Health Services
AYFHS	Adolescent and Youth Friendly Health Services
FHB	Family Health Bureau
HMIS	Health Management Information Systems
MO	Medical Officer
MoH	Ministry of Health
NGO	Non-governmental Organisation
PHI	Public Health Inspector
SHP	School Health Program
SOP	Standard Operating Procedures
WHO	World Health Organisation

Glossary

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

Assent – Refers to children's and adolescents' participation in decision-making on health care and research intervention(s) by giving an agreement. Assent is not regulated by law as is consent, and it is sometimes referred to as a moral obligation closely linked to good practice in dealing with patients. It emphasizes that in all cases, whether or not the consent of the parent/ guardian is required, the voluntary, adequately informed, non-forced and non-rushed assent of the adolescent should be obtained (see also informed choice, informed consent).

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

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

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

Confidentiality– The right of an individual to privacy of personal information, including health-care records. This means that access to personal data and information is restricted to individuals who have a reason and permission for such access. The requirement to maintain confidentiality governs not only how data and information are collected (e.g. a private space in which to conduct a consultation), but also how the data are stored (e.g. without names and other identifiers) and how, if at all, the data are shared.Criterion (of a standard, see also standard; note: CRITERIA are the plural) – A measurable (element of a standard that defines a characteristic of the service that needs to be in place (input criterion) or implemented (process criterion) in order to achieve the defined standard (output criterion).

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

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

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

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

Health literacy– The cognitive and social skills that determine the motivation and ability of an adolescent to gain access to, understand and use information in ways that promote and maintain good health.

Informed choice– A choice made by an adolescent regarding elements of his or her care (e.g. treatment options, follow-up options, refusal of service for care) as a result of adequate, appropriate and clear information in order to understand the nature, risks, alternatives of a medical procedure or treatment and their implications for health and other aspects of the adolescent's life. If there is more than one possible course of action for a health condition, or if the outcome of a treatment is uncertain, the advantages of all possible options must be weighed against all possible risks and side-effects. Also, the views of the adolescent must be given due weight based on his or her age and maturity[2] (see also evolving capacity).

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

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

Outreach (health-care delivery) – Any health-related activity coordinated by the health system that takes place off-site (outside the health facility premises). Outreach activities can be performed by 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,

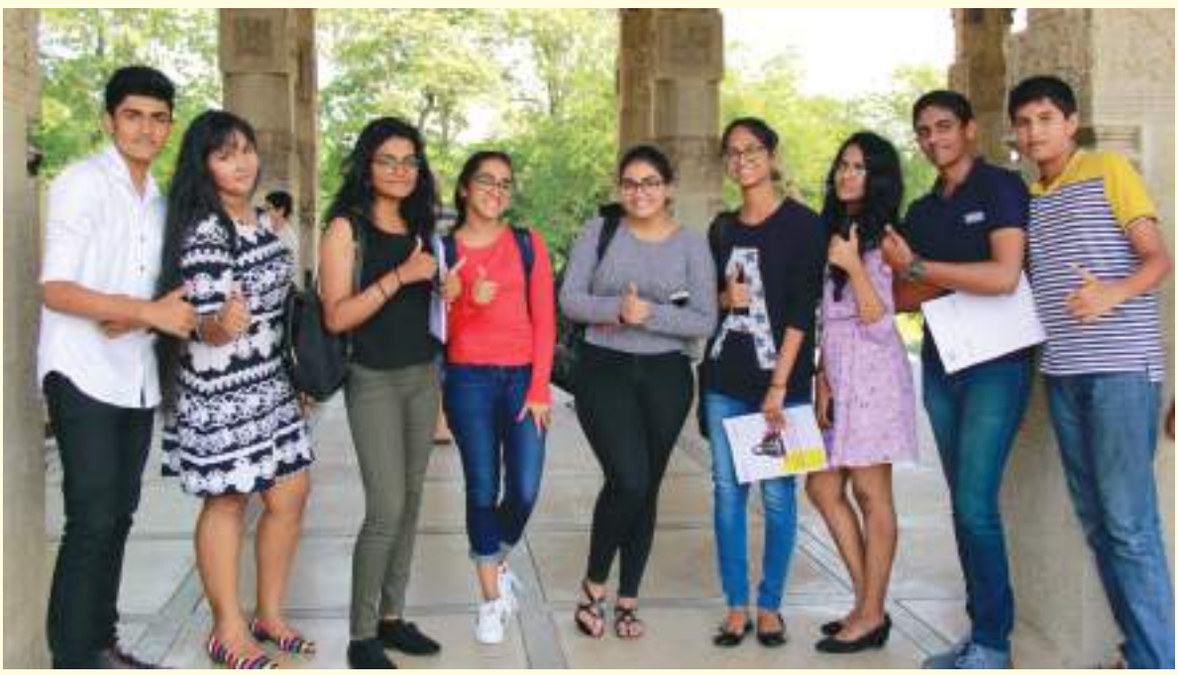
workplaces, street settings, shelters or wherever young people gather. Examples of outreach activities include health education and distribution of commodities such as condoms.

Outreach worker – Any person who performs functions related to outreach health-care delivery on behalf of the health system. Outreach workers are either health-care professionals or others who have received a 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 [3](see also key populations); presenting a theatre piece or role play at a community health fair or other event.

Peer educator – An adolescent or a youth 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).



[3]*Men who have sex with men, people who inject drugs, sex workers, transgender people and people in prisons.*

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 com munity 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-judgmental regarding adolescents' personal characteristics, life style choices or life circumstances.

- Care that is respectful of the adolescent's, need privacy during consultations, examinations and treatments. Privacy is important for adolescents, especially during clinical examinations and procedures. Adolescents may desire privacy from other staff, other patients, and even family members. Staff members must learn their adolescent clients' privacy needs and respect those needs.

- Protection from physical and verbal assault. This responsibility is particularly relevant to very young adolescents and vulnerable adolescents, the mentally ill, and others unable to protect themselves or signal for help.

- Information that is confidential and protected from loss or misuse. The facility respects information as confidential and has implemented policies and procedures that protect information from loss or misuse. Staff respect adolescent confidentiality by not disclosing the information to a third party unless legally required by not posting confidential information or holding client-related discussions in public places.

- Non-discrimination, which is the right of every adolescent to the highest attainable standard of health and quality health care, without discrimination of any kind, irrespective of the adolescent's or his or her parent's or legal guardian's race, colour, sex, language,religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

- Adolescent participation in care processes. Unless the decision-making capacity is delegated by law to a third party, or the adolescent lacks decision-making capacity as assessed by the relevant authority[4], the adolescent decides about all aspects of care, including refusing care. The adolescent also decides which family member and friends, if any, participate with him or her in the care process. Adolescents' involvement in care is respected irrespective of whether or not the adolescent has a legal capacity for decision-making. An adult's judgment of an adolescent's best interests cannot override the obligation to respect all rights of adolescents as stipulated in the Convention of the Rights of the Child[5]. 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 maturity[6] (see also evolving capacities). The facility supports and promotes adolescent involvement in all aspects of care by developing and implementing related policies and procedures.

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

[5] *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*

[6] *Article 12 of the Convention of the Rights of the Child.http://www.ohchr.org/en/professionalinterest/pages/crc.aspx*

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

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

- **Youth** – Those persons between the ages of 15 and 24 years.

- **Young People** – Those persons between the ages of 10-24 years.

Introduction

A new global coalition of more than 500 leading health and development organizations worldwide is urging governments to accelerate reforms that ensure everyone, everywhere, can access quality health services without being forced into poverty. The coalition emphasises the importance of universal access to health services for saving lives, which is a target within the "Global Strategy for Women's, Children's and Adolescents' Health (2016-2030): Survive, Thrive, Transform. World Health Organization's report on Health for the world's adolescents: a second chance in the second decade notes (WHO, 2014a) that making progress towards universal health coverage will require Ministries of Health and the health sector to transform how health systems respond to the health needs of adolescents. It recommends developing and implementing national quality standards and monitoring systems as one of the actions necessary to make this transformation.

Yet, evidence from both high- and low-income countries show that services for adolescents and youth are highly fragmented, poorly coordinated and uneven in quality. Adolescents and youth often find mainstream primary care services unacceptable because of perceived lack of respect, privacy and confidentiality, fear of stigma and discrimination, and imposition of the moral values of healthcare providers. Pockets of excellent practice do exist, but, overall, services need significant improvement. Therefore many countries have adapted a standards driven approach to improving the quality of care for adolescents and youth. With the leadership of Ministry of Health, more than 25 countries have adopted national quality standards for the delivery of health services for adolescents and youth. Moreover, several countries including Bangladesh, Bhutan, Haryana and Jharkhand States in India, Malawi, the Republic of Moldova, South Africa, Tajikistan, Ukraine and the United Republic of Tanzania have conducted surveys to measure the quality of the services being provided in order to inform action (WHO, 2014a).

This guide presents the process and steps undertaken by the Family Health Bureau, Ministry of Health Sri Lanka, to ensure that a standards driven approach guides the implementation of the National Strategic Plan on Adolescent Health (2013-2017), (MoHSRL 2013).

The aim of National standards for quality health-care services for adolescents and youth is to assist policy-makers and health service planners in improving the quality of healthcare services so that adolescents and youth find it easier to obtain the health services that they need to promote, protect and improve their health and well-being.

The implementation plan and the monitoring tools that accompany the standards in this document provide guidance on identifying what actions need to be taken to implement the standards and to assess whether the standards have been achieved.

While the primary intention of the standards is to improve the quality of care for adolescents and youth in government healthcare services, they are equally applicable to facilities run by NGOs and those in the private sector. The ultimate purpose of implementing the standards is to increase use of adolescents and youths health services towards the goal of Universal Health Coverage, thus contributing to better health outcomes.

Background

Five million, one fourth of the Sri Lankan population is young persons of 10-24 years of age. Adolescents, 10-19 year group, accounts for 16% of the total population. Youth identified as 15-24 year group consists of another 16%.

Young persons are considered as an apparently healthy group. Yet, it is a time period where they undergo rapid emotional, physical and intellectual transition from childhood to adolescence and to independent adulthood. Though they get physical maturation by 10-16 years, brain maturation continues up to mid-twenties. They like to experiment new things, yet they are unable to perceive the consequences. This situation leads them for risk taking behaviours and may end up with premature deaths due to accidents, suicide, violence, pregnancy related complications and other illnesses that are either preventable or treatable. Healthy as well as unhealthy lifestyles established in this period will last into adulthood. Effects of them will extend even beyond adulthood into next generation. Unhealthy lifestyles such as tobacco and alcohol use, poor dietary habits and sedentary lifestyles, lead to illness or premature death later in life.

Adolescent fertility rate has increased from 28 to 30 per 1,000 women age 15 to 19 in from 2006 to 2016. Teenage pregnancy rate is was 4.8% in 2016. According to the national youth health survey conducted in 2012/13 among 8820 youth, percentages of ever smoked and ever used alcohol, are still at persistently high levels of 16% and 20%, respectively. Sixteen percent has tried other additive substances. Nearly 6.5% reported to have seriously considered attempting suicide

and 4% had made plans on how they would attempt suicides. Around 30% reported to have engaged in some sexual activity within past one year. Almost half of the youths are not aware of even basic physiology and common sexual reproductive issues. Only 45% had heard of emergency contraceptive pills. Within proceeding week, 44% reported to have consumed carbonated drinks and 20% had taken precooked food such as sausages and meatballs. Nearly 50% of males and 75% of females were having sedentary lifestyles. Nearly 60% were equipped with mobile phones and 10% tried to use this facility to develop relationships with unknown people.

All these reflect the need for young people to have adolescent youth-friendly models of health service at primary care level. Adolescent and Youth Friendly Health Service (AYFHS) concept was introduced in Sri Lanka in 2005. Though around 50 AYFHS centres were established by late 2008, there were only nine functioning AYFHS centres by 2015. Meanwhile "Youth" component was incorporated into the family health programme of the Family Health Bureau in the latter half of 2015. With that revamping of the AYFHS was initiated under the concept of "Yowun Piyasa".

Three models for "Yowun Piyasa" (AYFHS) are considered: Hospital based, Field based (at MOH office) and Centre based (separate centre with other facilities). The issues which led to the failure or closure of AYFHS were reviewed and the main reasons were lack of demand due to unawareness and poor quality of services. The national standards for AYFHS will help to overcome these barriers and facilitate the implementation of the AYFHS.

National strategic plan for adolescent health

Delivering quality health services with universal coverage while maintaining confidentiality is one of the guiding principles in the "National Strategic Plan for Adolescent Health (2013-2017)" for Sri Lanka (MoHSRL 2013).Sri Lanka is one of the first countries in the South East Asian Region to develop National Standards for Adolescent and Youth Friendly Health Services in 2006 which comprised of five standards. Those five standards were reviewed and revised after ten years to develop this updated set of eight National Standards for Adolescent and Youth Friendly Health Services (AYFHS), presented in this document. The complete guiding principles for providing AYFHS are provided in the text box below.

GUIDING PRINCIPLES IN PROVIDING AYFHS

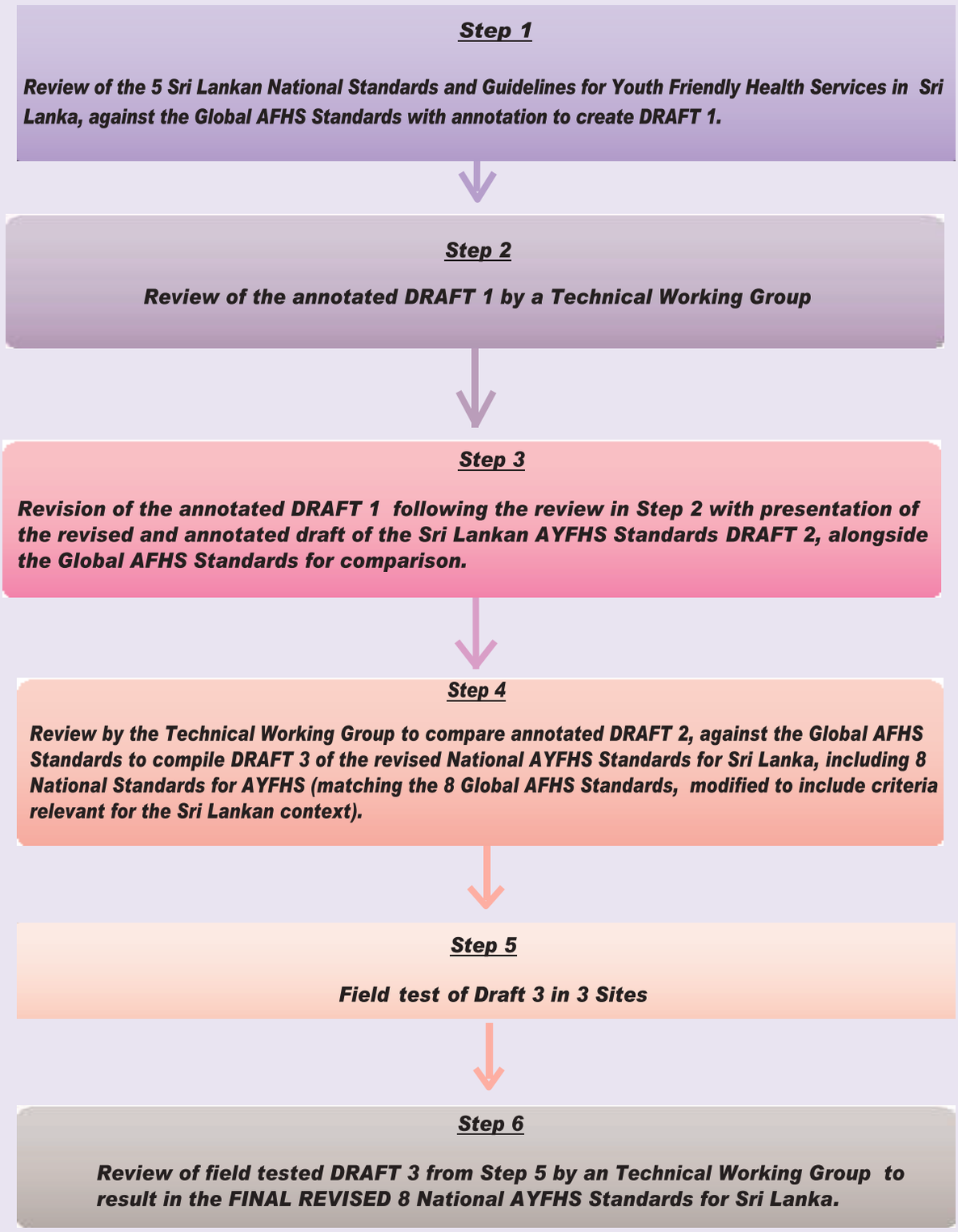
This is based on ensuring the following:

- Rights based approach
- Gender sensitivity
- Equity and non-discrimination
- Participation & empowerment of adolescents and youth
- Non-judgmental approach, respect for & dignity of all beneficiaries
- Privacy and confidentiality
- Respect for law & order and country policies
- Optimal service delivery to adoles cents and youth through building/ strengthening essential linkages.

How these standards were developed

Development of these standards was a six-stage collaborative process by a Technical Working Group consisting of Family Health Bureau, Health Education Bureau, Ministry of Health, Ministry of Education, WHO, UNCEF, UNFPA, Professional Colleges and representatives of adolescents and youth. The steps taken are outlined in Fig.1.

Fig. 1. The process for development of the global standards for quality healthcare services for adolescents and youth



National AYFHS Standards

Each standard reflects an important facet of quality services, and in order to meet the needs of adolescents and youth. This is followed by the tabular presentation of each standard with its underlying criteria, categorized as input, process and output criteria.

I	**Health empowerment of adolescents and youth**	**Standard 1:** The health facility implements systems to ensure that adolescents and youth are knowledgeable about their own health and healthy behaviours, and they know where and when to obtain related services.
II	**AYFHS facility characteristics**	**Standard 2:** All service delivery points are accessible and acceptable to adolescents and youth to receive adolescent and youth friendly health services as perceived by them ensuring privacy and confidentiality. The centres are well managed and have the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents and youth.
III	**Competencies and characteristics of service providers and supportive Staff**	**Standard 3**: Health care providers and supportive staff demonstrate the technical competencies required to provide effective health services to adolescents and youth. Both healthcare providers and support staff respect, protect and fulfil adolescent and youth rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.
IV	**Appropriate package of services**	**Standard 4:** AYFHS facilities effectively provide the health service package which includes information, counselling, preventive, diagnostic and treatment services, with referral, follow up and linkages with other services.
V	**Information system and quality Improvement**	**Standard 5:** The health facility continuously collects analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff participates in continuous quality improvement.

VI	**Community support**	**Standard 6:** The health facility implements systems to ensure those parents, guardians and other community members and community organizations recognise the value of providing health services to adolescents and youth and support such provision and the utilization of services by adolescents and youth.
VII	**Participation of adolescent and youth**	**Standard 7:** Adolescents and youths are involved in the planning, monitoring and evaluation of health services and in decision making regarding their own care, as well as in certain appropriate aspects of service provision.
VIII	**Equity and non-discrimination**	**Standard 8:** The health facility provides quality services to all adolescents and youth irrespective of their age, sex, marital status, education level, ethnic origin, socio-economic status, sexual orientation and other characteristics.

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Rationale, intent and criteria for Standards

Standard 1:
Health empowerment of adolescents and youth

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

Rationale for Standard 1

Evidence suggests that adolescents and youth do not have adequate health literacy that would enable them to gain access to, understand and effectively use information to promote and maintain their good health (WHO, 2014a). Such knowledge is essential for increasing their motivation to engage in healthy behaviours, reduce risky behaviours, modify the influence of risk factors and enhancing the role of protective factors. However, adolescents and youth are often uninformed or have inadequate and inaccurate knowledge regarding health and disease, health-related behaviours, risk and protective factors and social determinants of health (WHO 2014a).

Moreover, they are not aware about the availability of health services geared to their needs, even when such services are placed in their vicinity. In a survey in Malawi, less than 33% of youth reported hearing of Youth Friendly Health Services in the districts where MOH had implemented AYFHS (E2A 2014). Only 24% of youth in a nationally representative survey in Bangladesh were aware of the AYFHS facility in their locality (ICDDRB 2010). Similar results have been reported from Sri Lanka in the recent field testing of National AYFHS standards at 3 AYFHS sites functioning in 2015. Health empowerment of adolescents and youth, as measured at the facility level, showed a score of only 36% across the three sites. This result was further validated by measuring accessibility coverage among adolescents in the 3 neighbouring schools. Only 23% of school-going adolescents were aware of AYFHS facilities in their localities. Even beyond health services, in general, the knowledge among adolescents and youth on other services being provided is inadequate (e.g. educational and vocational support, drug and alcohol counselling, legal and social support), including where they are provided and how to obtain them (WHO, 2011a; WHO, 2014a).

Intent of Standard 1

This standard seeks to improve the awareness of adolescents and youth on what health services are being provided where they are provided and how to obtain them. It stresses the importance of creating awareness and health education within the facility and through outreach by trained providers. It further emphasized on age-appropriate and individual behaviour-oriented communication, for developing the knowledge and skills of adolescents and youth regarding their own health, timely recognition of their needs and building their efficacy to act on such knowledge to maintain good health.

National AYFHS Standard 1

HEALTH EMPOWERMENT OF ADOLESCENTS AND YOUTH

STANDARD STATEMENT 1: The health facility implements systems to ensure that adolescents and youth are knowledgeable about their own health and healthy behaviours and they know where and when to obtain related services.

CRITERIA TO ACHIEVE THE STANDARDS

INPUT CRITERIA	PROCESS CRITERIA	OUTPUT CRITERIA
1. The health facility has health workers who are competent to create demand and provide health education to adolescents and youth and to communicate about health and available services (health, social and other services).	4. Health-care providers provide age and developmentally appropriate health education and counselling to adolescent and youth and inform them about the availability of health, social services and other services.	7. Adolescent and youth are knowledgeable about health
2. The health facility has outreach workers/peer educators that are trained to conduct health education for adolescents and youth in the community.	5. Group communication programmes conducted to create awareness among adolescent and youth in different settings (e.g. schools, universities, work places, youth clubs) to provide information and generate demand	8. Adolescent and youth are aware of what health services are being provided, where and when they are provided and how to obtain them.
3. The health facility has a plan for outreach activities and involvement of health workers in activities to promote health and increase the use of services by adolescents and youth.	6. Outreach activities are carried out to promote health and increase the use of services by adolescents and youth.	

While several sectors play a role in improving the health empowerment of adolescents and youth, school health programme is the key player in this regard. Within this collaborative effort, health care facilities and healthcare providers play an important role in providing health education, health check-ups, referrals and follow-up while maintaining health records of these visits.

Creating awareness and health education need to be carried out in both the health facility and the community (see also Standard 6). Health-care providers in AYFHS facilities need to have the skills and competencies to communicate, educate and empower adolescents and youth to be knowledgeable on their health and the availability of services in the community.

Standard 2:
AYFHS Facility characteristic

All service delivery points are accessible and acceptable to adolescents and youth to receive adolescent and youth friendly health services as perceived by them ensuring privacy and confidentiality. The centres are well managed and have the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents and youth.

Rationale for Standard 2

Evidence suggests that the process of care can be confusing and daunting for adolescents and youth. In Malawi, youth reported that barriers for using health services included overcrowding in facilities, shortage of medicines and unavailability of certain services (E2A 2014). In Moldova, higher satisfaction was reported by adolescents and young people for AYFHS facilities that met the quality Standards for acceptability of the ambience, including cleanliness and the availability of relevant informational materials (Caria teal, 2015). This was re-confirmed by reviews which found that the facility's physical environment (cleanliness, design features that enable privacy and confidentiality) is a characteristic that is highly valued by adolescents and increases service utilization. The availability of relevant leaflets and up-to-date health information in the waiting room was also associated with a positive experience. Moreover, convenient operating hours (e.g. out side of school hours) and flexible appointment procedures (e.g. the possibility of a consultation without an appointment) were important for increasing access to services by adolescents and youth (Ambrosia A-E et al., 2012; Chandra mould 2015; WHO, 2010).

Intent of Standard 2

Standard 2 stresses the importance of the organizational and design features of thefacility for improving accessibility, efficiency, and safe clinical care in a secure and supportive environment.

Thus providers ensure:

- convenient operating hours, flexible appointment procedures and minimal waiting times
- A welcoming and clean environ ment with functioning basic amenities
- The availability of accurate, age appropriate, up-to-date and clear information, education and communication materials
- Policies and procedures to protect the privacy and confidentiality
- The availability of up-to-date decision support tools, necessary registers, equipment, and systems for ensuing the availability of medicines and supplies
- System for getting clients feed-back anonymously

National AYFHS Standard 2

AYFHS FACILITY CHARACTERISTICS

STANDARD STATEMENT 2: All service delivery points are accessible and acceptable to adolescents and youth to receive adolescent and youth friendly health services as perceived by them ensuring privacy and confidentiality. The centres are well managed and have the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents and youth.

CRITERIA TO ACHIEVE THE STANDARDS

INPUT CRITERIA	PROCESS CRITERIA	OUTPUT CRITERIA
1. The health facility is accessible and acceptable and has a signboard that mentions operating hours.	16. Health care providers ensure that the facility provides services at convenient operating hours.	25. The health facility has convenient operating hours, flexible appointment procedures and minimised waiting times.
2. Health care providers and supportive staff with required profile are in place.	17. Healthcare providers ensure flexible appointment procedures with less waiting times.	26. The health facility has a welcoming and clean environment.
3. An explicit policy is in place, including assigned responsibilities of healthcare providers to ensure a welcoming and clean environment, minimize waiting times, and ensure convenient operating hours and flexible appointment procedures.	18. Healthcare providers offer consultations to adolescent and youth in local communities, with or without an appointment.	
4. Availability of a separate waiting area for adolescents and youth with comfortable seating.		

5. In the waiting area accurate, age appropriate, up-to-date clear information, education and communication materials specifically developed for adolescents and youth to facilitate their informed choice are available.		
6. Explicit policies and procedures to protect the privacy and confidentiality of adolescents and youth are in place. Health-care providers are aware of those and their own roles and responsibilities in implementing them.	19. Health-care providers follow policies and procedures to protect the privacy and confidentiality of adolescents and youth. With exception in certain instances where needed, with consent to divulge the information.	27. Adolescents and youth are satisfied with privacy and confidentiality at all times during the consultation process at the facility.
7. Providers' obligations and adolescent and youth rights are clearly displayed in the health facility.	20. Health care providers ensure that adolescents and youth know their rights and service provider obligations.	28. Adolescents and youth who use the facility know their rights and service provider obligations.
8. The facility has basic amenities including electricity, communication, water supply for drinking and washing purposes, waste disposal and clean toilets that are separate for males and females and for disabled.		29. Healthcare providers are knowledgeable about up-to-date decision support tools (guidelines, protocols, algorithms) that cover topics of clinical care in line with the package of services.
9. Availability of up-to-date decision support tools (guidelines, protocols, algorithms) that cover topics of clinical care in line with the package of services.	21. Health care providers utilize decision support tools (guidelines, Protocols, algorithms) in the provision of services.	
10. Availability of relevant registers and records for service provision.		

11. Availability of furniture and equipment according to the norms.	22. The equipment necessary to provide the required package of services to adolescents and youth are available, functioning and equitably used.	30. Clients are satisfied with the available facilities and services (equipment, medicines supplies and technology needed to ensure effective service provision)
12. A system of procurement and stock management of the medicines and supplies necessary to deliver the required package of services is in place in adequate quantities without shortages (stock-outs).	23. Medicines and supplies are utilized equitably.	
13. A system of procurement, inventory, maintenance and safe use of the equipment necessary to deliver the required package of services is in place.	24. Suggestion box is utilized by clients to forward suggestions and complaints regarding the service.	
14. A system to capture the clients concerns including suggestions and complaints regarding the service is in place.		
15. A system to ensure sustainable financial assistance to deliver services at the centre is in place.		

Standard 3:
Competencies and characteristics of service providers and supportive staff

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

Rationale for Standard 3

Knowledge, attitudes and skills of the healthcare workers are at the core of quality service provision (Ambresin A-E et al., 2012; Chandramouli 2015, Nair et al., 2015, WHO, 2010; WHO, 2015a) and for improving utilisation of health services by adolescents and youth (Nair et al., 2015). The factors that facilitated health service utilisation included improved interpersonal communication, continuous communication with providers and providing adequate information (Nair et al., 2015). Furthermore, comfort and support from providers, their cultural sensitivity and confidentiality in their care provision were keys to improved health service utilization. Thus, guideline-driven care was noted to be central to young people's positive experience of care (Ambresin A-E et al., 2012).

The challenges for utilization of health care services included judgmental, uncaring, and disrespectful attitude of providers which shaped the perceptions of adolescents and youth about the quality of care and increased their distrust on health care provision (Nair et al, 2015). Many healthcare professionals' report insufficient knowledge of and technical competence in adolescent specific aspects of health promotion, disease prevention and management. Many do not feel confident to communicate effectively about such issues such as domestic and school violence, family or intimate partner relationships, nutrition and substance use (WHO, 2014a). Others refuse to provide contraceptive information and services for unmarried adolescents and youth because they do not approve premarital sexual activity, even in countries where there are no such legal restrictions (Bankole, 2010; Chandra-Mouli et al., 2014). Furthermore, health workers show insufficient respect for adolescents and youth rights to information, privacy, confidentiality, non-discrimination and non- judgemental attitudes, which has already been noted to create major barriers to the use of services by adolescents and youth (Nair et al., 2015; WHO, 2014a). In addition to develop the technical competencies of health workers in adolescents and youth' health care, it is important to change providers' attitudes towards adolescents and youth healthcare (WHO, 2015a).

Intent of Standard 3

Standard 3 sets the expectations for the technical and attitudinal competencies required for effective care, including competencies related to human rights-based approach to adolescent and youth health care. Importantly, the latter also applies to supportive staff.

To ensure technical competence, the facility ensures that the desired number of trained staff with the required profile is in place to deliver the defined package of adolescent and youth care services (see Standard 4). They need to have access to up-to date guidelines, a system of supportive supervision an continuous professional education.

National AYFHS Standard 3

COMPETENCIES AND CHARACTERISTICS OF SERVICE PROVIDERS AND SUPPORTIVE STAFF

STANDARD STATEMENT 3:

Health care providers and supportive staff demonstrate the technical competencies required to provide effective health services to adolescents and youth. Both healthcare providers and supportive staff respect, protect and fulfil adolescent and youth rights to information, privacy, confidentiality, non-discrimination, non - judgemental attitude and respect.

CRITERIA TO ACHIEVE THE STANDARDS

INPUT CRITERIA	PROCESS CRITERIA	OUTPUTCRITERIA
1. Health care providers and supportive staff are trained on adolescent and youth friendliness and have the technical competencies necessary to provide the required package of services.	6.Service providers under go in service training on adolescent and youth friendliness and have the technical competencies necessary to provide the required package of services.	9. Clear, age-appropriate and accurate information is received by adolescents and youth to facilitate informed choice.
2. Health-care providers have been trained /sensitized on the importance of respecting the rights of adolescents and youth to information, privacy, confidentiality, and health care that is provided in a respectful, non-judgemental and non- discriminatory manner.	7. Health-care providers and supportive staff relate to adolescents and youth in a friendly manner, and respect their rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitudes, and respectful care.	10. The services received by adolescents and youth are friendly, supportive, respectful, non-discriminatory and non-judgemental.

3. Healthcare providers are competent to use the up-to-date decision support tools (guidelines, protocols, algorithms) that cover topics of clinical care in line with the package of services.	8. Healthcare providers follow evidence based guidelines and protocols in delivering care to adolescents and youth.	11. Adolescents and youth are knowledgeable on their rights regarding health care.
4. A system of supportive supervision is in place to improve the performance of healthcare providers.		12. Effective healthcare services are received by adolescents and youth.
5. A system of continuous professional education that includes an adolescent and youth healthcare component is in place to ensure lifelong learning.		

Standard 4:
Appropriate package of services

AYFHS facilities effectively provide the health service package which includes information, counselling, preventive, diagnostic and treatment services, with referral, follow up and linkages with other services.

Rationale for Standard 4

Comprehensive care is considered the key to ensure overall quality of care and is delivered to address the full range of health problems of an individual or in a given community (WHO, 2015b).Currently, the evidence suggests that particularly in primary care settings, important causes of mortality and morbidity and their risk factors do not get sufficient attention. Even in the initiatives such as "adolescent and youth friendly health services", the situation is the same. These services are often limited to issues related to sexual and reproductive health (WHO, 2014a). Thus, mental health problems, which are a major cause of illness and disability among adolescents and youth are often neglected (WHO, 2014a). Other problems that do not get sufficient attention relative to the burden of disease among adolescents include nutrition, substance use, intentional and unintentional injuries and chronic illness. HIV in adolescents does remain a critical health concern in many regions. For adolescents and youth particularly, the term "comprehensive" encompasses in a coherent way, not only care, but also health promotion and prevention, diagnosis, treatment and referral as relevant, for any condition pertaining to a full range of health problems (WHO, 2015b). Evidence shows that health services are often clinically oriented and that opportunities for promotive and preventive interventions are frequently overlooked. Furthermore, health-care providers often do not have clear guidance as to which services are important to provide to their adolescent and youth clients.

Intent of Standard 4

Standard 4 stresses four important elements. First, health care for adolescents and youth encompasses a range of services such as information, counselling, promotion and prevention, diagnosis, treatment and care. This package of services offered in the facility reflects the health-care needs of adolescents and youth in the community(ies). While priorities might vary from country to country, and from community to community, adolescents and youth need services in a range of areas: mental health, sexual and reproductive health, HIV, nutrition, physical activity, injuries and violence, substance use, and immunization.

WHO-recommended services and interventions for adolescents can be found in the WHO report: "Health for the world's adolescents: a second chance in the second decade."

Secondly, the facility determines exactly what services are to be offered on-site and what services are to be made available through referral. Thus within its service delivery area, the facility needs to identify the health and non-health related agencies that may serve as public or private referral sources for adolescents and youth. Thereby the facility, establishes a network of other care providers, governmental, NGOs and community agencies to meet the health needs of adolescents and youth in the community(ies) (see Standard 6).

Thirdly, within the health sector, strong links between the health facility and the community(ies), various levels of the health- care system and various specialties need to be existed. Good coordination and joint planning is required within the health system for transition from paediatric care to adult care. This has been noted to be one of the indicators of the quality of adolescent health care (Ambresin A-E et al., 2012).

Fourthly, successful care requires a close interrelationship between the health sector and the network of services outside the health sector. The coordination with social, educational, recreational, transportation, legal and other services outside the health sector ensure this.

In Sri Lanka, School Health Program (SHP) facilitates a clear system of linkages between the Health and Education Sectors. At the grass root level, Medical Officer of Health (MOH), Public Health Inspectors (PHIs) and Public Health Midwives (PHM) are responsible for both school health programme and the adolescent health programme. Further, more than 70% of the adolescents are within the schools.Even then, the low level of awareness of school going adolescents on the AYFHS facilities in their localities (23%), in the recent field testing of national AYFHS standards, is an issue that should be addressed. Clearly the linkages between the health and education sectors require revitalisation and refocus regarding AYFHS, through well developed and already interacting systems.

National AYFHS Standard 4

APPROPRIATE PACKAGE OF SERVICES

STANDARD STATEMENT 4:

AYFHS facilities effectively provide the health service package which includes information, counselling, preventive, diagnostic and treatment services, with referral, follow up and linkages with other services.

CRITERIA TO ACHIEVE THE STANDARDS

INPUT CRITERIA	PROCESS CRITERIA	OUTPUT CRITERIA
1. A defined healthcare service delivery package is in place, including health information, counselling, primitive, preventive, diagnostic, treatment, referral and follow up services.	7. Healthcare providers provide the required package of health information, counselling, primitive, preventive, diagnostic, treatment and care services in the facility and/or in community settings, in line with policies and procedures.	10. A package of health services is provided in the facility and/or through referral linkages and outreach, that fulfil the needs of all adolescents and youth.
2. Policies and procedures are in place that describes the referral system for services within and outside the health sector including back referrals from those sectors.	8. Service providers refer adolescents and youth to the appropriate services and levels of care according to local policies and procedures, and follow the policies for transition care.	
3. Policies and procedures are in place that describes joint care / multi-disciplinary care during the transitional care period for adolescents and youth with chronic condition.	9. Service providers provide joint care /multi-disciplinary care during the transitional period for adolescents and youth with chronic condition.	
4. A system to deliver the service package is in place in liaison with the area public health staff.		

5. Linkages established/ strengthened with other organizations working with adolescents and youth.		
6. Policies and procedures are in place that identifies which health services are provided in the health facility and which in community settings such as schools and other centres where there are youth and adolescents.		

Standard 5 :
Information systems and quality improvement

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

Rationale for Standard 5

Effective policy and programme design requires strategic information on the health issues and related behaviours of adolescents and youth and on the health services available for them. At the programme delivery level, information is needed on the reasons and health conditions for which adolescents and youth seek services, by age groups, sex, geographic location (rural, urban, estate), ethnicities and other vulnerabilities, including disabilities. Such demographic and health related data on: "Who is using services? Which groups of adolescents and youth are using them and for what health problems? to be complemented by "Service Readiness" data, i.e. "Is the facility ready to provide quality health services to adolescents and youth and are they effective in meeting their health needs? Coverage data needs to be collected as the "best run" facilities may not be reaching a sufficient proportion of adolescents and youth. Such data can be collected from routine facility level data collection, complemented by facility level self and externally organised assessments of service availability and quality. This data can be used for program planning, implementation and monitoring (WHO, 2014a).

Health management information systems (HMIS) collect data that includes client information on age, sex, presenting problem, diagnosis and services provided. However, in most low and middle income countries, by the time these data are reported at the national level, they are aggregated, making it impossible to identify data specific to adolescents and youth. Even in high income countries where HMIS are well developed, the data are not sufficiently disaggregated by age to be able to focus on the subgroups of 10 –14 and 15 – 19 years of age (WHO, 2014a). In addition, data on quality of care often lack a focus on adolescents and youth specific elements of quality. Reviews are increasingly showing that for countries which have made progress in measuring the quality of health services for adolescents based on nationally developed standards, improved utilization of services.

Intent of Standard 5

This standard 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. The four major categories for data collection are:

1. Service data providing utilization sta tistics disaggregated by age, sex, socio-demographic characteristics, and disease/conditions
2. Data on referrals to provide informa tion on health system functions and linkages, particularly from primary to secondary or tertiary levels supporting "seamless functioning".
3. Data on outreach is particularly import ant for monitoring linkages to other sec tors which is crucial for adolescents and youth who inherently need to inter act with various sectors (e.g. health, education, youth development, employ ment, justice, social services) in order to ensure their health and well-being.
4. Data on management of stocks of equipment, medicines and other sup plies and commodities are important markers of "Service Readiness".

These data can be used for self-assessments, quality improvement, reporting and identifying areas for supportive supervision and ensures accountability. Such an approach change attitudes towards data collection and use as a management function rather than a cause for punitive action, thus enhancing staff motivation and pride.

National AYFHS Standard 5

INFORMATION SYSTEMS AND QUALITY IMPROVEMENT

STANDARD STATEMENT 5: The health facility continuously collects analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff participates in continuous quality improvement.

CRITERIA TO ACHIEVE THE STANDARDS

INPUT CRITERIA	PROCESS CRITERIA	OUTPUT CRITERIA
1.A system is in place to collect and report data on service utilization that is disaggregated by age, sex and relevant socio-demographic characteristics and disease/condition.	9. The health facility collects and reports data while ensuring confidentiality, on service utilization disaggregated by age, sex, and socio-demographic characteristics which are disease/condition specific.	17. The health facility reports data on utilization of services by adolescents and youth that is disaggregated by age,sex, socio-demographic characteristics and disease/condition to divisional /district/central level.
2. A system is in place to collect and report data on outreach activities.	10. The health facility collects and reports data on outreach, while ensuring confidentiality.	18. The health facility reports data on outreach.
3. A system is in place to collect and report data on referrals.	11.The health facility collects and reports data on referrals, while ensuring confidentiality.	19. The health facility reports data on referrals.
4. A system is in place to maintain data on stocks and supplies.	12. The health facility maintains data on stocks and supplies.	20. The health Facility reports data on stocks and supplies.
5. Health-care providers are trained to collect and analyse data for monitoring and quality improvement initiatives.	13. Regular reviews and self-assessments of quality of care, experience sharing and clinical audits are conducted & minutes documented.	21. Facility reports data on the number of programmes conducted, number participated and problems encountered to relevant levels.
6. Tools and mechanisms for self monitoring of the quality of health services for adolescents and youth are in place.	14. Health-care providers use data on service utilization and quality of care for planning and implementation of quality improvement initiatives.	

7. Mechanisms and tools are in place to link supportive supervision to address the gaps identified during the monitoring of the implementation of standards.	15. Returns are submitted regularly through the identified channels and feedback systems.	22. Health facility staff feel supported by supervisors and motivated to comply with standards
8. Mechanisms are in place for the reward and recognition of highly performing healthcare providers and supportive staff, best performing centres and responsible person.	16. Healthcare providers receive supportive supervision in areas identified during self-assessments and reviews.	23. Good performance is recognized and rewarded.

Standard 6:
Community support

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

Rationale for Standard 6

Parents, guardians, family, community and religious leaders play an important role in supporting adolescents and youth to access and use services. Evidence suggests that support from gatekeepers and community members improves the use of sexual and reproductive health services by adolescents and youth (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).

In Sri Lanka, the recent field testing of National AYFHS Standards showed that community support scored the lowest with a score of 35%. The same assessment revealed that 100% of parents would support adolescents and youth visiting AYFHS. In fact, 98% reported that they had visited "any" healthcare provider in the last year. However, as noted under the rationale for standard 1, only 23% of them were aware of AYFHS facilities in their localities.

Intent of Standard 6

This standard emphasises the importance of ensuring that parents, guardians, family and community members are knowledgeable and supportive of the provision of health services to adolescents and youth. The health facility informs community members about the value of providing health services to adolescents and youth either during visits to the facility or through outreach. However, merely informing community members about the importance of use of healthcare services by adolescents and youth is not enough. To ensure that parents, guardians and other community members support all adolescents and youth – married and unmarried, younger and older – to use the health services they need, it is essential that the facility engage in partnerships with community members and organizations to develop health education and communication strategies and materials, to get their buy-in and to plan service provision. Involving adolescents in this work is also essential.

National AYFHS Standard 6

COMMUNITY SUPPORT

STANDARD STATEMENT 6:
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 youth and support such provision and the utilization of services by adolescents and youth.

CRITERIA TO ACHIEVE THE STANDARDS

INPUT CRITERIA	PROCESS CRITERIA	OUTPUTCRITERIA
1. Availability of promotional materials (e.g. Handouts, leaflets, posters and booklets) to create awareness among community members regarding service provision.	5. Healthcare providers make aware parents/guardians visiting the health facility about the value of providing health services to adolescents and youth.	9. Gate keepers, community members and organizations support the provision of health services to and their utilization by adolescents and youth.
2. Healthcare providers have competencies to communicate with parents, guardians and other community members and organizations on the value of providing health services to adolescents and youth.	6. Healthcare providers and/or outreach workers make aware parents/ guardians and teachers during school meetings/in other institutions where there are adolescents and youth about the value of providing health services to adolescents and youth.	
3. The health facility has an updated list of agencies and organizations with which the facility liaise to increase community support for use of services by adolescents and youth.	7. The health facility engages in partnerships with adolescents and youth, gatekeepers and community organizations to develop health education and behaviour-oriented communication strategies and materials and plan service provision.	
4. The health facility has a plan for outreach activities and/ or involvement of outreach workers in activities to increase gatekeepers' support for use of services by adolescents and youth.	8.Meetings and discussions are organised and held with heads of educational institutions, employment agencies, formal and informal community leaders, other responsible stakeholders to strengthen linkages.	

Standard 7:
Paticipation of adolescents and youth

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

Rationale for Standard 7

Adolescents and youth have the right to participate in decisions that affect their lives. The meaningful involvement of them is an integral component of effective adolescent and youth 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 and youth can be involved, all of which can influence both the quality of services provided as well as health outcomes. Adolescents and youth 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 empowerment and training, they could be effective peer educators, counsellors, trainers and advocates. Adolescents and youth 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 healthcare solution or management option to their personal circumstances. Ignoring their views regarding their own care can lead to disengagement (e.g. discontinuation of a treatment), and loss to follow-up. In turn, upholding adolescents' and youths' participation in their own care supports the provision of sustainable, acceptable, locally appropriate and more effective solutions, which ensures that more adolescents and youth will seek and remain engaged in care. The use of theoretical frameworks related to adolescents and youth participation and systematic methodologies to monitor and evaluate youth participation is however scarce. Overall, there is little consensus on the effectiveness of adolescent participation in health programs and only a few interventions have provided research data to illustrate that this leads to better sexual reproductive health outcomes or improved program impact (Villa-Torres etal, 2015). The participation in decision making is a right and should not only be evaluated in terms of effectiveness and impact.

Intent of Standard 7

This standard emphasizes three important areas for participation of adolescents and youth:

- It highlights participation in the planning, monitoring and evaluation of health services.
- It stresses participation in decisions regarding their own care.
- It emphasizes participation in certain aspects of service provision.

There are a number of ways that adolescents and youth can participate, all of which can influence both the quality of services provided as well as health outcomes (WHO 2002):

1. Participation as a way for them to access services and / or get direct benefits from programs, for example, HIV testing or condoms.

2. Participation as a component of the program planning process,including needs assessment, design, implementation, monitoring, and evaluation.

3. Participation as a way to lead changes in the implementing institutions and organizations, such as the creation of organizations' youth councils or the inclusion of them in governing bodies.

4. Participation as an approach to improve adolescents'and youths' personal traits and social resources such as self-esteem, confidence, autonomy, greater initiative, team work, networks, and social capital, independently of the specific policy or program objectives.

5. Participation as a key component to achieve program objectives. It can include direct effects on them, such as increased knowledge of HIV prevention, and direct effects on institutions that serve this group, such as the increased capacity of the health sector to provide youth-sensitive sexual reproductive health services.
6. Participation as a way to increase policies' and programs' efficiency, by weighting the costs of participatory processes versus its benefits.

7. Participation as an environment changing factor that positively impacts the context in which young people live.

Health-care providers have an obligation to make sure those opportunities are available for adolescents and youth to exercise these rights.

To ensure their participation in the planning, monitoring and evaluation of health services, the facility regularly solicits adolescents' and youths' perceptions of its services. Including adolescents and youth 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. In addition, the perceptions of current and potential adolescent and youth 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 and youth have the right to participation in the processes of their own care. Unless the adolescents and youth lack decision-making capacity, or the decision-making capacity is delegated by law to a third party, the adolescent and youth can make decisions about all aspects of care, including refusing care. The facility supports and promotes adolescent and youth involvement in all aspects of care by developing and implementing policies and procedures to enable an informed choice. A choice made by adolescent or youth regarding elements of his / her care is a result of adequate, appropriate and clear information in order to understand the nature, risks and alternatives of a medical procedure or treatment and their implications for health and other aspects of the adolescent's or youths' life. In some situations a documented consent for a procedure or treatment is required. The facility has policies and procedures on how to handle an informed consent, and to make sure the providers know and respect them.

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

National AYFHS Standard 7

PARTICIPATION OF ADOLESCENTS AND YOUTH

STANDARD STATEMENT 7: Adolescents and youth are involved in the planning, monitoring and evaluation of health services and in decision making regarding their own care, as well as in certain appropriate aspects of service provision.

CRITERIA TO ACHIEVE THE STANDARDS

INPUT CRITERIA	PROCESS CRITERIA	OUTPUTCRITERIA
1. A policy is in place to engage adolescents and youth in AYFHS planning, monitoring and evaluation.	4. The health facility carries out activities to build capacity of adolescents and youth in certain aspects of health service provision such as health education and in the planning, monitoring and evaluation of health services.	7. The planning, delivery, monitoring and evaluation of health services have involved adolescents and youth.
2. Health care providers are aware of laws and regulations that govern informed consent and the consent process and are clearly defined by facility policies and procedures in line with laws and regulations.	5. Health-care providers provide accurate and clear information on the medical condition and management/treatment options and explicitly take into account the adolescents' and youths' decision on the preferred option, management and follow up actions.	8. Adolescents and youth are involved in decisions regarding their own care.
3. The Governance and Management structure of the facility includes Adolescents and youth.	6. The health facility involves adolescents and youth' in the management process to identify their expectations about the service and to assess their experience of care.	9. Adolescents and youth are involved in certain aspects of health service provision.

Standard 8:
Equity and non-discrimination

The health facility provides quality services to all young people irrespective of their age, sex, marital status, education level, ethnic origin, socio-economic status, sexual orientation or other characteristics.

Rationale for Standard 8

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

Intent of Standard 8

This standard emphasises the importance of providing equitable care to all adolescents and youth, not just certain groups. It stresses that equity underlies all the dimensions of quality of care included in these eight standards. Thus, equity needs to be ensured not just in the levels of service use by various groups of adolescents and youth, but also in the respect provided to them, and in ensuring that technical competence and rational and guideline informed use of medicines and technologies are applied for their care as well. Furthermore, all adolescents and youth have the right to be involved in the processes of planning, implementing, monitoring and feedback on the services provided at facility and community level.

This standard requires that policies and procedures are implemented to ensure that providers are aware of and follow the laws and policies of equity and non-discrimination. Particularly regarding vulnerable groups of adolescents and youth, the facility needs to works collaboratively with other agencies and organisations to identify them in their community(ies), understand their needs and involve them in the planning, implementation, monitoring and feedback on health services.

National AYFHS Standard 8

EQUITY AND NON-DISCRIMINATION

STANDARD STATEMENT 8: The health facility provides quality services to all adolescents and youth irrespective of their age, sex, marital status, education level, ethnic origin, socio-economic status, sexual orientation or other characteristics.

CRITERIA TO ACHIEVE THE STANDARDS

INPUT CRITERIA	PROCESS CRITERIA	OUTPUTCRITERIA
1. Policies and procedures are in place stating the obligation of facility staff to provide services to all adolescents and youth irrespective of their age, sex, marital status, schooling, race/ ethnicity, sexual orientation or any other characteristics.	4. Healthcare providers and supportive staff demonstrate the friendly, non-judgemental and respectful attitude to all adolescents and youth, regardless of age, sex, marital status, sexual orientation, cultural background, ethnic origin, disability or any other reason.	7. All adolescents and youth irrespective of their age, sex, marital status, education status, ethnic origin, socio-economic status, sexual orientation or other characteristics report similar experiences of care.
2. Healthcare providers and supportive staff are aware of the above policies and procedures, and know how to implement them.	5, Healthcare providers and supportive staff provide services to all adolescents and youth without discrimination, in line with policies, guidelines and procedures.	8. Vulnerable group(s) of adolescents and youth are involved in the planning, monitoring and evaluation of health services, as well as in certain aspects of health service provision.
3. Healthcare providers know who are the vulnerable group(s) of adolescents and youth in their community(ices).	6. The health facility involves vulnerable group(s)of adolescents and youth in the planning, monitoring and evaluation of health services, as well as in certain aspects of health service provision.	

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