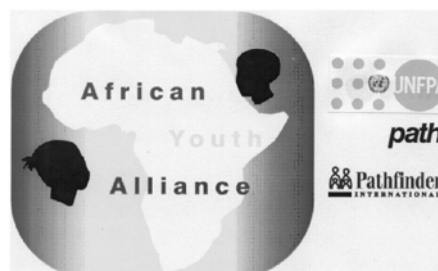




Integrating Youth-Friendly Sexual and
Reproductive Health Services in Public
Health Facilities: A Success Story and
Lessons Learned in Tanzania

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- Safe Motherhood Program – Ministry of Health Zanzibar
- Municipal and district councils: Ilala, Temeke, Kinondoni, Arusha, Kasulu, Kibondo, Tarime, Karagwe, Unguja and Pemba Island.
- Marie Stopes Tanzania
- The Family Planning Association of Tanzania (UMATI)
- University of Dar es Salaam
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About the African Youth Alliance Project

The African Youth Alliance (AYA) was an initiative implemented in Botswana, Ghana, Tanzania and Uganda. The five year project (2000 – 2005) was supported by the Bill and Melinda Gates Foundation and executed in partnership by the United Nations Population Fund (UNFPA), Pathfinder International, and the Program for Appropriate Technology in Health (PATH). The three partner agencies provided technical and financial support to strategically identified implementing partners. AYA also collaborated closely with respective governments in operationalizing and coordinating its project activities. The main aim of AYA was to improve overall sexual and reproductive health of youth aged 10-24 years and reduce the incidence of HIV/AIDS and other sexually transmitted infections.

The AYA project had six major component areas. Each partner agency supported two of these as follows: Youth-Friendly Services (YFS) and institutional capacity building (Pathfinder International); policy and advocacy, and coordination and dissemination (UNFPA); and behavior change communication and life and livelihood skills (PATH).

In Tanzania, the AYA initiative was established in 2001 and was implemented in 10 strategically-selected districts, targeting 1.2 million youth between 10 and 24 years of age in both urban and rural areas. Parents and policymakers were among secondary and tertiary beneficiaries of AYA in the country. The project sites in mainland Tanzania were the districts of Tarime, Karagwe, Kasulu, and Kibondo and the municipalities of Arusha, and Ilala, Temeke and Kinondoni in Dar es Salaam. In addition, the project was implemented in the Urban West region and Pemba Island, in Zanzibar.

The objective of the YFS component was to increase the use of quality, youth-friendly adolescent sexual and reproductive health services. The intermediate results from the component were as follows:

- Availability of quality YFS in the project districts increased
- Supportive environment for YFS provision increased
- Demand for YFS services increased
- Monitoring and supervision of YFS for clinic and outreach activities established
- Competence of facilities to deliver and sustain quality YFS activities improved

Introduction

Lack of accessibility to Sexual and Reproductive Health (SRH) information and services by young people is a problem that needs serious attention by program planners and service providers. Despite an increasing number of reports on youth SRH problems, the SRH needs of young people often fall through the cracks of many health and development plans and programs.

Because of the stigma attached to adolescent sexuality, there have been pockets of opposition to youth access to SRH information and services for fear of promoting promiscuity among the age group. For that reason, there have been few efforts by policymakers, government leaders, and SRH service providers to promote provision of youth-friendly SRH services. As a result of that lapse, there has been a feeling by SRH stakeholders that such services can only be provided by Non-Governmental Organizations (NGOs), rather than through the public health delivery system.

However, public health facilities have great potential for scaling-up and sustaining youth-friendly SRH services due to a variety of reasons, foremost of which is that these facilities already exist and are more likely than NGO facilities to exist in the future. This document is intended to share successes and lessons learned from integrating Youth-Friendly Services (YFS) into public health facilities.

Methodology

Data and information for this case study was collected through the review of existing documents, through interviews with AYA project staff, Ministry of Health representatives, and YFS and district coordinators, and through field visits. Documents reviewed included the following project reports: quarterly, annual, implementing partner quarterly (including achievement charts), and facility assessment reports. Interviewees included four AYA project staff (country coordinator, YFS program technical officer, YFS program associate, and the institutional capacity building technical officer) and two Ministry of Health representatives (information, education, and communication/adolescent sexual and reproductive health coordinator of reproductive and child health section of Dar and the AYA/YFS coordinator of the safe motherhood programme of Zanzibar). In addition, field visits and interviews with YFS and district coordinators occurred in Ilala, Temeke and Kinondoni. Data was collected and analyzed from March to April 2005.

The Problem

Young people in Tanzania are at risk for a broad range of health problems. Among these problems are early sexual debut, unwanted pregnancies, unsafe abortion, pregnancy-related complications, Sexually Transmitted Infections (STIs) and HIV/AIDS. Youth are especially vulnerable to these problems because they are more likely to engage in unplanned and unprotected sex, they lack the skills necessary to negotiate for safer sex, they engage in sexual activity with multiple partners, and they have limited awareness of STI prevention. Furthermore, Tanzanian youth have typically found it difficult to access reproductive health and HIV/AIDS services because most facilities are not youth friendly and are generally

geared toward adults.¹ To make matters worse, young people commonly have little or no money, are without transportation, have a lack awareness of available services, are restricted from seeking sexual and reproductive health services, and fear being stigmatized by adults who may see their behavior as irresponsible and their presence in a clinic as a possible indication of sexual activity.

Family planning and reproductive health services have been provided as part of maternal and child health services in Tanzanian public health facilities since their introduction in 1974. This has led to the perception of the community that SRH services are for adult women thereby creating barriers to access for both men and youth.

In addition, negative attitudes and lack of information about youth sexuality have resulted in the failure of most Tanzanian SRH service providers to provide YFS. It should be noted that YFS is not included in the pre-service training that health staff receive at training institutions.

Although the Tanzanian National Policy Guidelines for Reproductive Health and Child Health Services (2003) support young people's access to SRH information and services, there are many gaps in its implementation. Due to fears of community opposition, the government had been willing to let NGOs take the lead in providing SRH information and services to young people. However, the majority of Tanzanians (nearly 80 percent) live in rural areas, where there are few NGOs that have the capacity to run district-wide interventions. Most of the NGO-run youth SRH programs are urban-based and donor dependent, making them less sustainable than public health facilities

Because of past reliance on NGOs for the provision of YFS, the government system did not have an adolescent health and development strategy. There was no standardized training for YFS, nor any YFS service delivery standards and guidelines. At the district and council levels, YFS was not a priority and therefore not part of the comprehensive health or development plans.

Steps taken to address the problem

Despite the challenges of instituting YFS service provision at government facilities as described above, it was believed that the government facilities would be the best poised to offer and sustain services for youth. The government has a very extensive network of public health facilities throughout the country with qualified service providers, and given that those health facilities are covered within government budgets, there is a very high likelihood of sustaining services once established. Therefore, AYA decided to work within the government health system in an attempt to establish sustainable quality, youth-friendly SRH services that would be available to a larger percentage of the youth population.

At the beginning, the government of Tanzania requested a Memorandum of Understanding (MOU) from the AYA partners. Although the government was involved in writing the initial AYA proposal, an MOU was critical to clarify the mechanisms for distributing AYA funding within the country. Several consultative meetings with government officials were conducted to produce a MOU that clarified roles and responsibilities and to ensure harmony and understanding of the operational modalities of AYA. On September 5, 2000, a stakeholders'

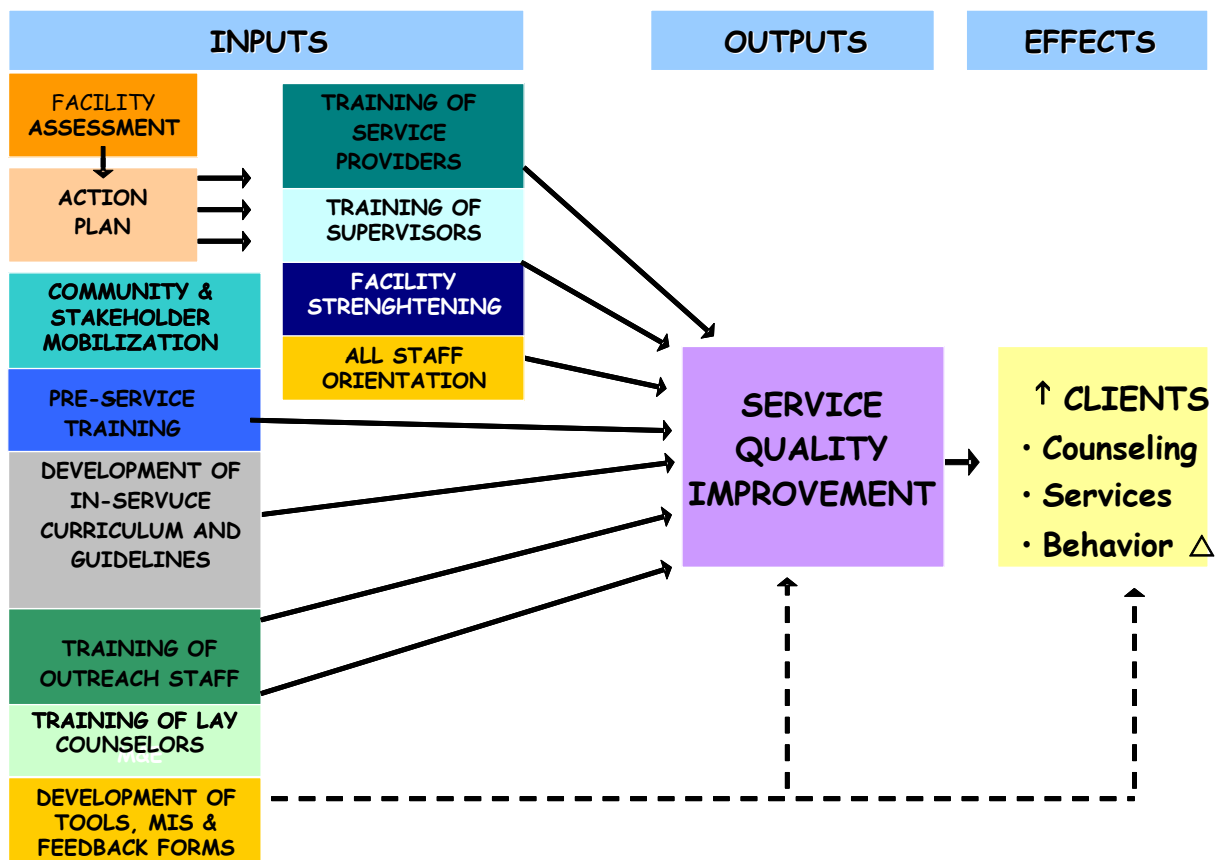
¹ AYA/Pathfinder (2003). *Youth-Friendly Sexual and Reproductive Health Services: An Assessment of Facilities*. Pathfinder International: Watertown, MA.

meeting was conducted in Zanzibar and on September 12 a meeting was held in Dar es Salaam to discuss the implementation of the AYA project in Tanzania. The final MOU draft, in consultation with five government ministries, was finalized by the end of the year.

In collaboration with the National Reproductive and Child Health Section of the Ministry of Health (RCHS) in the mainland and the safe motherhood program of Ministry of Health in Zanzibar, AYA aimed to achieve the following:

- Increase sustainable outlets of quality YFS in the districts
- Obtain government commitment and support in provision of YFS in the districts
- Demonstrate that public health facilities can equally provide quality YFS and in a more sustainable manner than NGOs
- Increase collaboration among government, NGO, and private organizations in promoting YFS

The first round of implementing partners were comprised of two leading reproductive health NGOs (Marie Stopes Tanzania and Umati), the University of Dar es Salaam, and the Infectious Disease Center. Pathfinder subsequently provided subgrants to ten individual AYA districts: Kinondoni, Temeke, Ilala, Kasulu, Zanzibar, Kibondo, Arusha, Karagwe, and Tarime. As a result, AYA worked with 58 facilities across the country, including 44 public facilities. The following diagram illustrates the framework of Tanzania’s YFS intervention:



As shown above, the following key activities were undertaken under AYA:

- Facility assessments for YFS integration were undertaken in each facility. Assessment teams were comprised of selected service providers and youth. Findings

were shared with service providers and management of each facility to ensure their buy-in and support for the effort. The feedback contributed to development of YFS action plans for facility-strengthening efforts.

- City and municipal authorities were sensitized on unmet SRH needs of youth and the rationale for government involvement and support.
- Doctors and nurses involved in provision of SRH were trained on YFS and participated fully in the facility assessment. Their participation helped them assess and identify gaps in the quality of the services being offered to youth. Supervisors, lay counselors, and other facility staff also received training on YFS to support the facility efforts.
- Peer service providers were trained to provide SRH information and contraceptives to their peers to complement and create demand for facility services.
- AYA also worked to develop monitoring and evaluation tools and systems, and to build staff capacity in this area.

Achievements

Although some AYA districts had less than two years of YFS implementation in Tanzania, numerous significant achievements have been made by the project at the national level, including:

- ***Increased awareness of the rationale and need for YFS provision***, especially by public health facilities, and among Council Health Management Teams (CHMTs) and service providers. During field visits, staff from almost all of the sites expressed concern regarding the end of AYA project funding at the time that public health facilities are becoming known as a reliable source for YFS.
- The AYA project has led to ***strengthened capacity for national-level coordination of YFS***. AYA project funds supported staff to coordinate YFS, provided vehicles to the Ministry of Health in the mainland and Zanzibar, and covered other YFS-related expenses. AYA also supported the strengthening of provider supervision through training and the introduction of supervision tools.
- In Zanzibar, there was ***provision of services to youth where existing policy does not yet stipulate support for such access***. Although Zanzibar policy prohibits service provision of SRH needs to unmarried youth, in collaboration with the safe motherhood program of the Ministry of Health in the Island, AYA integrated youth-friendly SRH services were made available in selected public health facilities. AYA began its efforts by providing services to youth attending MCH clinics for antenatal care or family planning, and as a result of both the training and experience of service providers in youth issues, as well as demand for the services by youth, service provision to the group has expanded. This development has increased advocacy efforts for the adolescent sexual and reproductive health rights that AYA and other programs have been promoting. It is anticipated that this positive development will also influence the review of the policy that prohibits unmarried youth from accessing SRH services.

- In the mainland, through its RCHS, the Ministry of Health has *developed YFS training manuals* for health providers, peer service providers and paramedical counselors, including a training of trainers guide. In collaboration with the College of Health Sciences, the Ministry of Health in Zanzibar now includes YFS as part of the practical training requirement for pre-service health staff.
- Numerous *youth-friendly facility strengthening efforts were accomplished* over the course of the project. Renovations of the facilities were done to make them attractive and create special rooms for serving youth. In some facilities, youth have their own waiting and consulting rooms equipped with television, video, newspapers, and behavior change communication materials, providing added privacy for youth. In fact, as a result of its facility assessment, and with their own funding, the clinic in Kasulu split one room into four to better serve youth and to guarantee the privacy that youth visits require. Clinics changed their hours to allow for better youth access and have improved advertising of YFS through the erection of signposts outside their facilities.



A billboard at Kayanga Rural Health Centre in Karagwe advertises integrated youth-friendly SRH services that are available at the center. Youth and health service providers perceived this as a historical development in making SRH services accessible to youth in the community.

- *Monitoring and evaluation tools and systems were developed* and used under AYA to improve the facilities. Youth were trained as mystery clients to monitor YFS and peer service providers, and a facility assessment tool was used at baseline and at endline to monitor improvements made over the course of the project. The Ministry of Health of Zanzibar is planning to adapt the AYA tools for island-wide use.
- *Management Information Systems (MIS) were strengthened* through training of staff on tools developed under AYA and institutionalized in the facilities. These tools were developed with participation of district coordinators and service providers and

integrated with already existing Ministry of Health forms. In addition, the Infectious Disease Center (IDC) was able to computerize its MIS, with technical support from AYA, making it the only public health facility with computerized MIS for SRH service provision in the country.

- In all 10 districts where AYA was operating, there is ***high enthusiasm among Council Health Management Teams (CHMTs) to scale-up integration of YFS in as many public health facilities as possible***. For example, as a result of successful integration of YFS at the IDC, the authorities in Dar es Salaam City committed their own resources, in addition to AYA resources, to scale-up integration of YFS to three additional public health facilities (Mbagala (Temeke Municipal), Tandale (Kinondoni Municipal) and Vingunguti (Ilala Municipal)), with the IDC serving as a referral centre. Efforts towards the creation of the referral system included: introduction and promotion of referral cards; the creation of a list of linked partner institutions with contact names, telephone numbers, and addresses; and the provision of escorts for referral cases.
- There is ***increased technical capacity at the district level for integrating YFS*** in reproductive health services as a result of cross-fertilization. For example, AYA Tanzania used the IDC as a model facility for others to learn from. District medical officers from Tarime, Pemba, Unjunga, and Arusha undertook a study visit to the IDC. Districts continued to provide technical assistance to each other on an ongoing basis. The Tarime district medical officer provided technical assistance on YFS integration to CHMTs to Kasulu and Kibonde on facility assessment and to Karagwe on provider training, the YFS team from the University of Dar es Salaam trained service providers in Kibondo and Kasulu. The IDC team provided technical assistance to Arusha, and the Karagwe CHMT undertook a study visit to Tarime to learn from their work. This development shows that YFS can be integrated in public health facilities using technical resources that exist in the public sector.
- In the Tarime district, the public sector ***provided both technical and material support to local NGOs*** in establishing their YFS. This turn in the development of YFS provision shows the potential of public health facilities to provide high-quality YFS.
- The facilities saw ***increased youth visits*** throughout the course of the project. For example, the number of youth visits for facility based SRH services increased from 113,083 in 2003 to 243,070 in 2004².
- Service providers from the YFS facilities reported experiencing ***increased trust from both youth and parents*** in the communities they serve or live. “[As] much as we have now been enabled to provide counseling to youth, youth themselves and their parents are increasingly recognizing our contribution towards improved adolescent health. That recognition alone is enough, regardless of lack of monetary incentives,” a YFS service provider explained.
- ***Increased personal commitment for YFS provision among facility staff and management*** has been reported. Service providers have, in many cases, volunteered to extend their working hours and days to meet the needs of the youth without

² This data may not represent data for all facilities and all quarters.

requesting salary increases or overtime pay. “With the introduction of the anti-retroviral program in the city, my responsibilities have increased. Despite the coordination role that I have, no matter how [busy] I become, I strive to ensure that I dedicate my time from 14 hours [on] to serve youth at the center,” said one health care provider.

- **Youth input and involvement has increased in YFS service provision.** In addition to youth serving as mystery clients, assessment team members, and peer service providers, they have increasingly provided feedback through suggestion boxes and feedback registers at the facilities, served on youth or health boards (two youth were subsequently employed by the Municipal Council), and are otherwise discussing their needs and issues with community members and service providers. “The quality of reproductive health service has changed. It is no longer a matter of being told what to do and what not to do by the service providers. Nowadays clients are given an opportunity to explain themselves and their needs; and there is now a more open dialogue between service providers and clients about issues that traditionally have not been discussed during medical consultations,” said a young female attending group counseling sessions at IDC.

Challenges faced

AYA faced a number of challenges. The following table summarizes these challenges and the actions taken to overcome them.

| Challenges | Actions taken |
|--|--|
| <p>Low awareness of need for YFS integration - SRH service providers were not aware of the concept and rationale behind integration of YFS. - Lack of understanding that YFS improves the quality of existing SRH services offered to youth and is not a vertical stand-alone service. Therefore, integrating YFS was perceived as a new service to be offered to the clinics, which implied additional pay for the staff.</p> | <ul style="list-style-type: none"> ▪ Orientation and training activities ▪ Study visits to successful sites ▪ Successful sites provided technical assistance to other sites, building internal capacity. |
| <p>Number and location of the facilities -AYA resources could not support the entire number and geographical diversity of clinics interested in YFS. -The number of sites and the fact that four of the 10 districts were located far from the capital in hard to reach areas made it difficult for AYA project staff to undertake regular supervision to project sites</p> | <ul style="list-style-type: none"> ▪ Set up model facilities for learning purposes ▪ Scaled-up in phases based on available resources ▪ Sensitized and lobbied council authorities for resource allocation for scaling-up ▪ Promoted public – private partnership in increasing accessibility to YFS in the district |

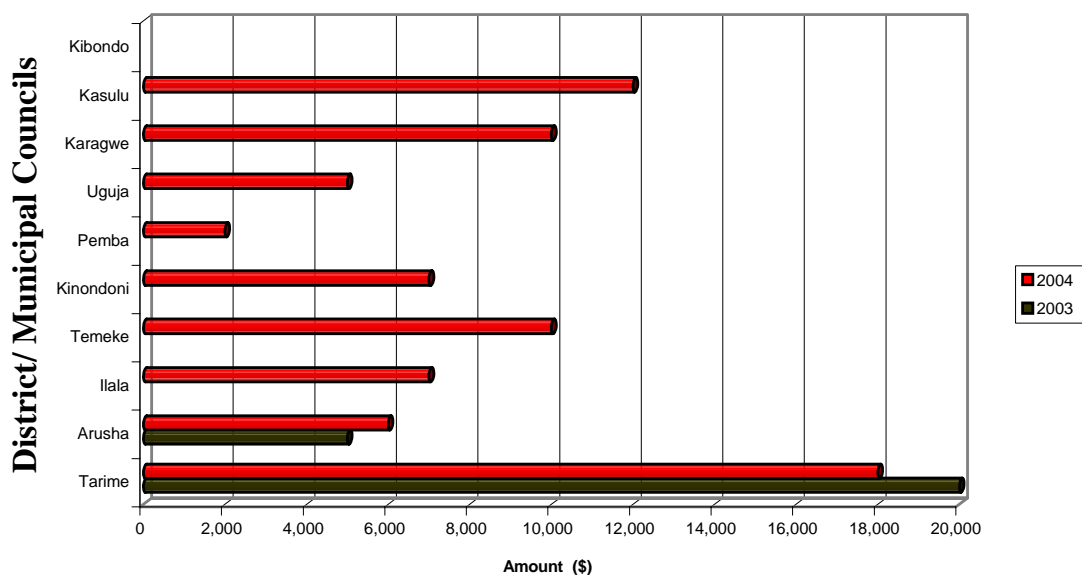
| Challenges | Actions taken |
|--|--|
| <p>Data collection and its use for decision making</p> <ul style="list-style-type: none"> - Available data was not segregated according to AYA target age groups (10-14, 15-19, 20-24). - Data was inconsistent and it was difficult to obtain. - Implementation plans and decisions were not based on data. | <ul style="list-style-type: none"> ▪ Developed tools for data collection and reporting ▪ Oriented service providers and other relevant staff on MIS forms and data collection ▪ Monitored implementation of the MIS and provided feedback ▪ Built capacity for supervision at district level (i.e., YFS Coordinators and District AYA Coordinators) ▪ Introduced checklists for supervision at district level |
| <p>Meeting expectations created by the project</p> <ul style="list-style-type: none"> - Increased workload of the staff, including staff time on weekends - Irregular availability of condoms, reagents and antibiotics | <ul style="list-style-type: none"> ▪ Provided non-monetary incentives (e.g., trainings, technical assistance) to sites. ▪ Linked with other sources of commodity supply (e.g., social marketing sources). |

Beyond results

As a result of the efforts of and enthusiasm generated by AYA, there are a number of achievements that go beyond the project period, including:

- As noted earlier, the Ministry of Health has been able to develop YFS training guides and manuals for clinic service providers, peer service providers and paramedical staff. This development will enable ***standardization of YFS training and also help control the quality of training*** being given. Previously, each organization or project had its own guides and manuals.
- In financial year 2004/2005, the ***Central Government for the first time allocated funds (US \$100,000) for youth SRH activities*** through the RCHS of the Ministry of Health in the mainland. The RCHS started using the funds for activities tailored to integrate YFS in public health facilities of Mwanga and Moshi Rural in the Kilimanjaro region. These districts have been identified as centers of excellence for exchange of experiences (see annex 1: YFS story from Moshi, Tanzania).
- An increased number of council authorities in AYA implementing sites have ***integrated YFS into their development plans and allocated funding for it***, albeit still in somewhat small amounts. The number of council-supported YFS activities for youth initiated by AYA Tanzania increased from two out of ten sites (20 percent) in 2003 to nine out of ten sites (90 percent) in 2004, as seen in the chart below.

Districts/ Municipal Councils Support in Cash to Adolescent Sexual Reproductive Health (ASRH) 2003 & 2004



Source: AYA Tanzania – Year 2003 Annual Highlights

Lessons learned

Several important lessons can be drawn from the experience, including:

- Public health facilities have great potential to scale-up youth-friendly SRH services and sustain them.
- Demonstration projects can complement advocacy efforts. Successful integration of YFS at the IDC made it possible for local government authorities in Dar es Salaam City to replicate the IDC’s YFS in other public health facilities using their own resources.
- Once capacity for YFS provision is built at district/municipal levels, YFS can successfully be provided in public health facilities. Remaining existing facilities need to be renovated to obtain adequate space for youth, these facility staff need to be trained in YFS, and CHMTs oriented on YFS and commissioned to monitor and supervise integration.
- Rationales for integrating YFS in existing reproductive health services are not sufficiently well-conceived by policy makers nor health officials, including CHMTs. Youth SRH is often seen as a non-governmental issue, and is therefore not included in development plans. Advocacy for YFS provision and resource allocation for its promotion needs to go hand-in-hand with service promotion.
- Sensitization seminars should be as well-planned as possible in order to gain community support, and not just awareness, especially in the case of a youth project such as this one. Some districts failed to hold sensitization seminars with sufficient planning, which did not yield adequate community support in the end. Also, seminars did not always include enough of the community’s key stakeholders, such as teachers

and religious leaders, whose support can be so essential. Districts that had the strongest sensitization efforts found program implementation to be much easier as a result of having garnered true support and commitment.

- As with all projects like AYA, sufficient staffing, time and funding are necessary for close and regular follow-up with project sites to ensure progress and quality of the work.
- Even though the national policy guidelines for SRH provision stipulate eligibility to the services by youth, the policy needs to be applied at district and community levels, and especially at the service provision level. Such policies should be translated into Swahili so as to be better understood by all health staff.

Conclusion and Recommendations

AYA in Tanzania, together with the Ministries of Health of the mainland and Zanzibar Island, have demonstrated that it is possible to integrate youth-friendly SRH services in public health facilities. This is contrary to the popular perspective that NGOs are always better placed to offer youth-friendly SRH services. About 80 percent of Tanzanians are living in rural areas where there are few NGOs, private, or voluntary agencies that have wide coverage. As public health facilities provide coverage for the majority of the country, including the rural areas, integrating YFS in public health facilities will increase access for the majority of Tanzanian youth.

Integration of YFS in public health facilities was rolled out in different phases. Those sites that have implemented YFS for at least two years have built their capacity and provided technical assistance to those sites that began implementation in a later phase. It is therefore important during scale-up to capitalize on the technical capacity already built.

In view of the above, it is recommended that:

- The Ministries of Health in Zanzibar and the mainland should take over and solicit funds for scaling-up the initiative in the implementing districts and scale-up as many sites as possible.
- The two ministries of health should make use of existing technical capacities in the AYA-supported districts to scale-up the initiative to new sites. That would help to sustain the capacity already built and provide recognition to the sites that have successfully implemented the project.
- The CHMTs should follow-up on political commitments obtained in their districts. The teams should ensure that the political will becomes practical by having financial resources made available to support YFS integration and scaling-up.
- Integration of YFS should no longer be treated as a project, but rather as a routine service that is provided by the health facilities. That will reduce the tendency to depend upon external funding for continuation of services. The councils need to understand that they have the responsibility to provide client responsive services, including youth-friendly SRH services.

- Even though integration of YFS was well-conceived at the district level, more advocacy and capacity building is needed at the ministry level. That will ensure that integration of YFS in pre-service training programs will become possible in an accelerated fashion. For that reason, both technical and financial external support should still be sought.

**Annex 1: YFS story from Moshi, Tanzania –
Observed Differences between AYA and Non-AYA Implementing Districts**

When the Ministry of Health saw the effects of AYA efforts in the first 10 districts it encouraged and set aside funding for efforts in additional districts. “We in the reproductive health section of the Ministry of Health would wish to encourage Council Health Management Teams to visit AYA supported districts and learn how successful they have been in integrating YFS in their public health facilities. It is true that public health facilities can equally provide quality YFS and in a more sustainable manner than NGOs because the facilities are not donor dependent,” said the Ministry of Health adolescent sexual and reproductive health coordinator.

In March 2004, with Ministry of Health funding, the Reproductive and Child Health Section organized an advocacy meeting in Moshi town for integration of YFS into public health facilities. Council health management teams of Mwanga, Moshi Rural Districts, and the Regional Health Management Team were targeted. Others invited were regional medical officers, district education officers and community development officers. A representative from AYA Tanzania was invited to facilitate the meeting and share lessons learned from AYA-supported districts.

It was important for participants to be oriented on the SRH of young people concept before planning for the integration of YFS. During the meeting, AYA’s impact was described vividly:

- Participants from two non-AYA supported districts did not know the definition of adolescence, what sexuality meant, and its difference from sexual intercourse. In addition, many did not know what reproductive health was all about. “For the first time I have been made aware of adolescents and SRH. I used to group patients as children and adults. If she or he acquires an STI then she or he is an adult and therefore no special care about that. Now I realize that we are too late and in fact we have missed our train,” said the district medical officer from Moshi Rural.
- The teams did not understand the concept that YFS is not a new service, but improving the quality of already existing SRH services for youth. Therefore they initially thought YFS could not be established within their available clinic space and that they must have additional buildings and staff. After sharing the experience from the AYA districts with them, there was a consensus that with good programming, staff training, and equipment, YFS could still be provided within existing facilities and infrastructure. This has been the case in selected model facilities in AYA-supported districts.
- The two teams were pleased to learn that in AYA-supported districts, the respective council authorities are financially supporting YFS activities initiated by the project. Tarime District was mentioned as an example where the council was contributing nearly half of the AYA-supported budget. In Dar es Salaam the respective councils had used their own resources to scale-up integration of YFS from one supported by AYA to three sites in one year and to more than six public health facilities by the end of the project.

- The teams admitted that there is not effective coordination of youth SRH activities and services being provided in their districts. They were surprised to hear that in AYA-supported districts, the AYA initiative is implemented under coordination by the respective local government authorities through planning offices.
- The teams admitted that they do not generate data categorizing youth who receive SRH related services including STI management. They only record them as adults because they are above 0-5 ages. In AYA-supported districts the age of clients is categorized. Therefore data on youth aged 10 –24 years can be obtained disaggregated by gender, age, and type of services rendered.
- Compared to AYA supported districts, the teams reported that the facility and community-based services are not linked as well, and youth are not involved in planning for the services as often.

The meeting created enthusiasm among the teams from the two districts to visit AYA-supported districts to learn how to integrate youth-friendly SRH within their existing reproductive health services. This appeared in their plan of action as a first step towards the integration.



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