ADOLESCENT-FRIENDLY HEALTH SERVICES IN **TANZANIA**

Healthcare Workers' Perspectives on Barriers and Services Offered

sharp
Solutions for Supporting Healthy Adolescents

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HEALTHCARE WORKERS' PERSPECTIVES ON BARRIERS AND SERVICES OFFERED

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1. BACKGROUND

Access to sexual and reproductive health (SRH) services forms a crucial building block of health systems. Poor access to SRH services can result in early and unintended pregnancies, maternal mortality, HIV and sexually transmitted infections (STIs), as well as complications from untreated STIs, such as pelvic inflammation, specific types of cancer, and pregnancy and fertility issues. A health system is well equipped to provide SRH commodities and services when people are enabled to decide on pregnancy, to have a healthy pregnancy and safe childbirth, to protect themselves against STIs and HIV/AIDS, and are properly treated in a timely manner if transmission occurs. For a thriving society, it is also crucial that adolescents, a group often faced with additional challenges in accessing services, can access the SRH services they need to live healthy lives and protect themselves against key health risks.

Unfortunately, Tanzania experiences many challenges with the adequate provision of adolescent-friendly SRH (AFSRH) services. This research was conducted to study the provision of AFSRH services and attitudes of healthcare workers in Dodoma rural, Manyara and Morogoro in Tanzania.

2. METHODOLOGY

This study was conducted by The Eastern Africa National Networks of AIDS and Health Service Organizations (EANNASO) and Health Action International (HAI) as part of the Solutions for Supporting Healthy Adolescents and Rights Protection (SHARP) programme, funded by the European Union. The research was approved by the National Institute for Medical Research (NIMR) ethical clearance number: NIMR/HQ/R.8a/Vol.IX/4208.

This study used an adjusted version of the HAI/World Health Organisation Methodology[1] and gathered insights into the provision of AFSRH services in Tanzanian health facilities through a cross-sectional survey design. Teams of data collectors visited 144 health facilities from the public, private, faith-based and associative sectors to assess:

1. The type of SRH services being offered at the health facility.
2. To whom these services were offered, and whether parent/guardian consent was needed.
3. The measures in place at the health facility to improve access to SRH services for adolescents.
4. The attitudes and perspectives of the healthcare worker on AFSRH services.
5. Indicators on the general state of the health facility.

Health facilities that were included in the research ranged from dispensaries to national hospitals. One healthcare worker in every health facility was requested to provide the above information. In addition, nine questions were answered by the data collector based on their observations at the health facility. Healthcare workers were asked for their consent to participate in the study.

1. Measuring Medicine Prices, Availability, Affordability and Price Components. 2nd edition. World Health Organization, Health Action International. (2008). Geneva: Switzerland.

3. FINDINGS

Sample

Table 1 shows the distribution of surveyed healthcare workers across sectors and urban/rural locations. A total of 94 healthcare workers from the public sector, 25 from the private sector, and 25 from the faith-based sector were surveyed.

The specific findings from this report are presented in six different sections: Section 1 describes the provision of adolescent-friendly services, Section 2 goes into detail on the SRH services being offered as well as their costs, Section 3 highlights some of the processes for policies, management and oversight, Section 4 sets out the findings around training, education and outreach, and Section 5 shows statistics on visible characteristics of the health facility, as filled in by the data collectors. Finally, Section 6 focusses on recommendations from healthcare workers to improve the provision of AFSRH services.

Table 1. Number of surveyed healthcare workers per sector and urban/rural location.

	Public	Private	Faith-based	Total
Urban	8	5	3	**16**
Rural	86	20	22	**128**
Total	**94**	**25**	**25**	**144**

3.1 Provision of Adolescent-friendly Services

Overall, 91% of healthcare workers indicated that their health facility offered adolescent-friendly services, with the lowest percentage in the faith-based sector and highest in the public sector.

Table 2. Health facilities offering AFSRH services.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Health facility provides adolescent-friendly services	96	84	77	**91**

If health facilities did not offer AFSRH services, the healthcare worker was asked for the reason why. Eleven healthcare workers answered this open question. A Word Cloud specifying these reasons can be found in Figure 1. The reason healthcare workers mentioned most often was that AFSRH goes against their religion. In addition, two mentioned the health facility lacked staff or didn't have the required license/permission. Finally, the reasons that staff lack training and that adolescents are referred to nearby health centres were mentioned by single healthcare workers.

Figure 1. Reasons health facilities do not offer AFSRH services (Word Cloud).

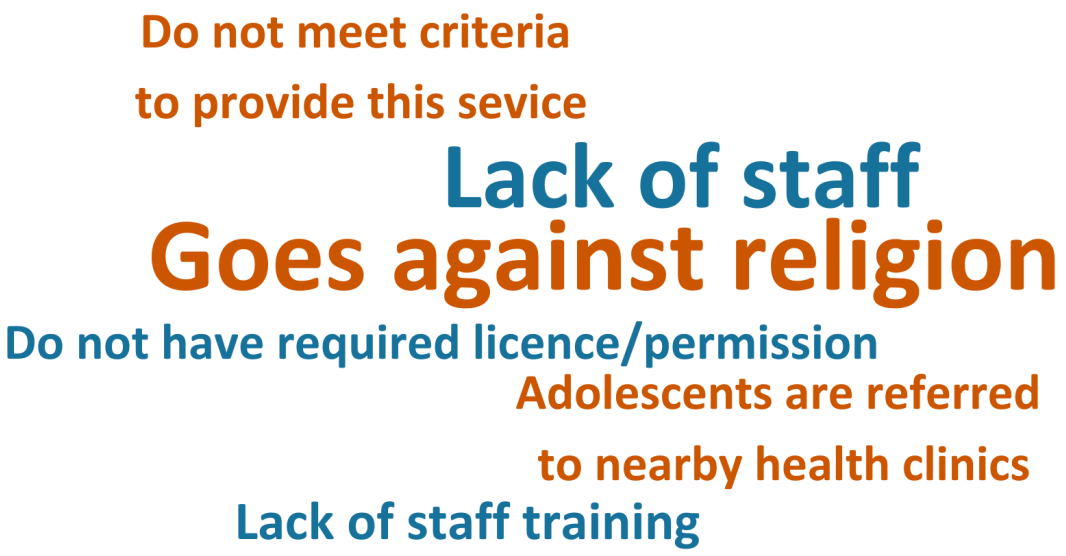


Figure 2 lists some common characteristics of adolescent-friendly health services. The study found that, overall, health facilities in Tanzania scored well on some indicators, and lower on others. For instance, while at 94% of health facilities adolescents could see a healthcare worker without a formal appointment, and 85% had a private examination room, only 62% were open during the weekend and/or evening, and only 23% of health facilities had staff who are younger than 25 years old that could offer SRH services to adolescents.

When comparing the findings on adolescent-friendly organisation of care across the sectors, the public sector scored highest on most indicators (see Table 3). The survey also asked whether information about the SRH of adolescents who visit the health facility was shared with anyone. Interestingly, in the public sector, sharing of information is happening at larger scale than in the private and faith-based sector. 16% of all public health facilities share SRH information with the adolescent's parents, and 13% share it with their schools.

Figure 2. Adolescent-friendly organisation of care.

Table 3. Adolescent-friendly organisation of care, per sector.

	Public (%)	Private (%)	Faith-based (%)
Dedicated staff offering AFSRH services	89	68	68
Facility open for SRH services during the evening and/or weekend	71	40	48
Adolescents can see a healthcare worker without a formal appointment	100	92	76
Adolescents can request to be seen by a same-sex healthcare worker	88	76	76
Private examination room at the facility where healthcare workers meet with clients to discuss SRH issues and services	93	76	64
Staff working at the health facility who are younger than 20 years and can offer SRH services to adolescents	27	21	5
Information about the SRH of adolescents who visit the health facilities is shared with:			
Their parents/guardians	16	4	0
Their schools	13	8	0
Community/faith leaders	8	8	0
No one	82	92	100

When zooming in on the ways in which clients could make an appointment for SRH services, we found, this time, that in 69% of health facilities no appointment was needed (see Figure 3). Other available ways of making appointments which were relatively commonly were at the reception (37%) and over the phone (32%). When comparing the sectors, the private sector more commonly used a walk-in policy where no appointment was required and less often used any of the other methods for making appointments (see Table 4).

Figure 3. Ways in which clients can make appointments for SRH services.

Table 4. Perspectives of healthcare workers on AFSRH services.*

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
At the reception	44	16	30	**37**
Over the phone	37	16	26	**32**
Via text messaging/WhatsApp	17	4	17	**15**
Online	11	0	17	**10**
No appointment needed/walk in	67	76	70	**69**

*Multiple answers were possible.

The survey further asked healthcare workers about their personal opinions on 11 different statements. Their perspectives on these statements can be seen in Table 5. A large majority of healthcare workers (88%) believe that adolescents feel welcome and safe at the health facility, and at ease to access SRH services. However, this percentage differed significantly between the sectors, with 98% of public sector healthcare workers believing that adolescents felt welcome and safe, versus 75% of private and 59% of faith-based sector healthcare workers. Further, 81% of healthcare workers said that they have enough time to sufficiently treat and answer questions of adolescents accessing SRH services, with again higher numbers in the public sector, compared to the private and faith-based sectors. In addition, 91% of healthcare workers indicated the health facility was easily and safely accessible for adolescents by foot or public transportation. Waiting times at the health facility were seen as a barrier for adolescents by 20% of surveyed healthcare workers. Interestingly, none of the private sector healthcare workers thought costs of SRH services were a barrier to adolescents, compared to higher numbers among those working in the public (16%) and faith based (14%) sectors.

Regarding attitudes of healthcare workers, 72% of healthcare workers said they are okay with providing contraceptives to unmarried women, and 70% said they are okay with providing contraceptives to adolescents under 18. Percentages differed considerably between the sectors with the faith-based sector having much lower scores on both indicators and the public sector scoring highest. Interestingly, more healthcare workers say they feel comfortable talking about contraceptive and SRH matters with adolescents (total 86%). Further, a notable 95% of healthcare workers in the public sector, 64% of healthcare workers in the private sector, and 65% of healthcare workers in the faith-based sector advise adolescents to abstain from sex when they seek contraceptives at the health facility. The percentages of healthcare workers who believe adolescents should not have sex is lower in the public and private sectors, with 24% of public- and 36% of private sector healthcare workers believing this. In contrast, 71% of healthcare workers in the faith-based sector hold the opinion that adolescents should not have sex. Overall, about a third of the surveyed healthcare workers indicated contraceptive use goes against their religion and should therefore not be provided to adolescents, with again the highest percentage found in the faith-based sector (50%).

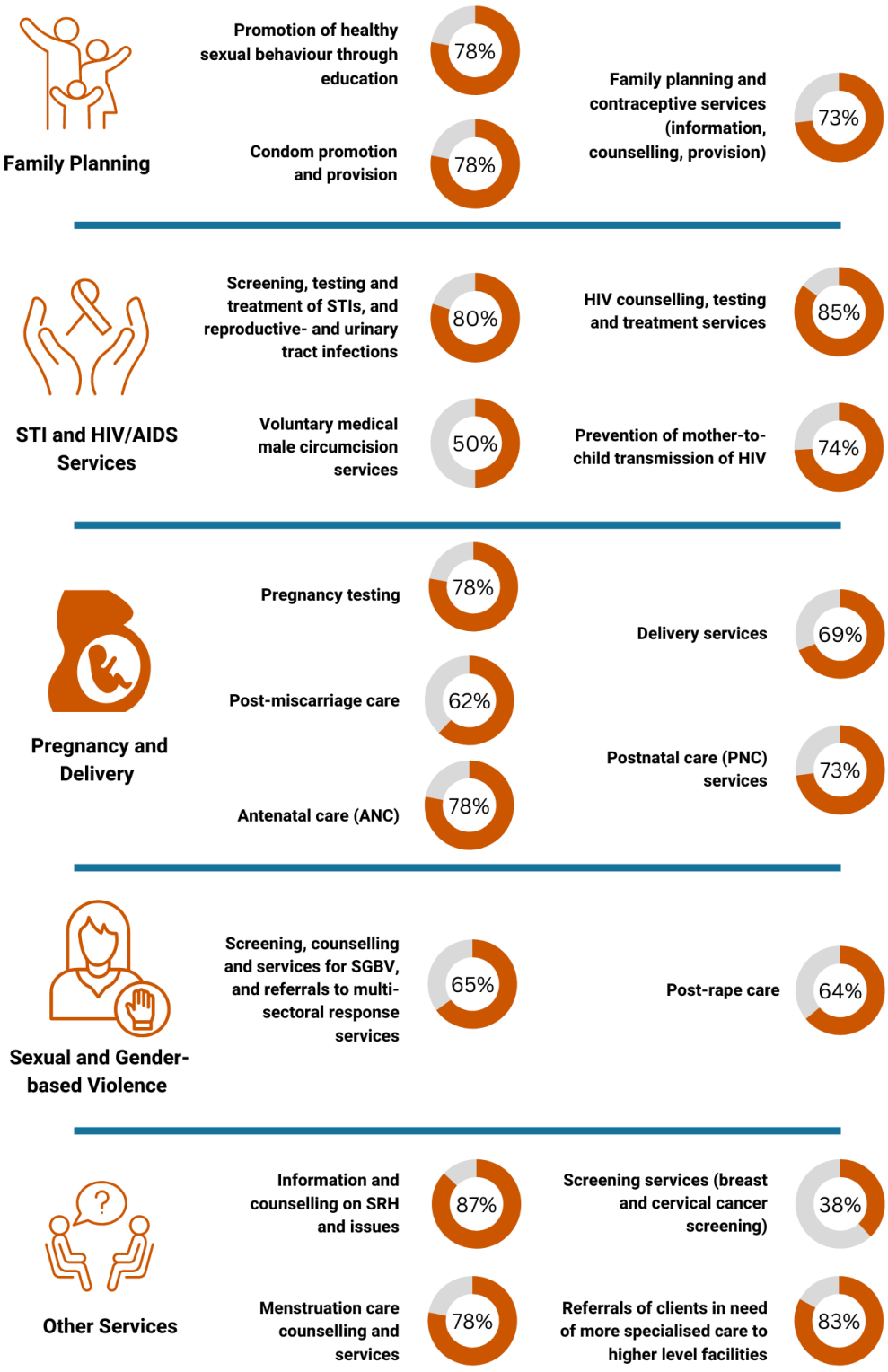
Table 5. Perspectives of healthcare workers on AFSRH services.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
I advise adolescents to abstain from sex when they seek contraceptives at the health facility	95	64	65	**84**
Adolescents should not have sex	24	36	71	**34**
I am okay with providing contraceptives to women who are not married	89	50	25	**72**
I am okay with providing contraceptives to adolescents younger than 18 years	86	48	33	**70**
Contraceptive use goes against my religion and should therefore not be provided to adolescents	24	42	50	**32**
I feel comfortable talking about contraceptives and sexual health matters with adolescents	98	72	50	**86**
This facility is generally easily and safely accessible by foot or public transportation for adolescents	94	88	81	**91**
Costs of SRH services are a barrier to adolescents at this facility	16	0	14	**13**
Waiting times at this facility to receive SRH services are a barrier to adolescents	20	17	23	**20**
Adolescents feel welcome and safe at this facility, and feel at ease to access SRH services	98	75	59	**88**
When offering SRH services to adolescents, I have enough time to sufficiently treat and answer their questions	88	79	55	**81**

3.2 Provision of SRH Services

Figure 4 shows the provision of a broad spectrum of SRH services in all surveyed health facilities. Overall, four of 18 services were offered in at least 80% of health facilities, and five more services were offered at almost 80% of health facilities. The most offered SRH services are information and counselling on SRH and issues (87%) and HIV counselling, testing and treatment services (85%). The least offered SRH services are screening services for breast- and cervical cancer (38%) and voluntary male circumcision services (50% of health facilities).

Figure 4. Overall percentage of health facilities offering specific SRH Services.



In addition to the SRH services provided, the survey also assessed whether these services are offered to certain specific population groups, including married versus unmarried women and adolescents. Table 6 shows to whom specific SRH services are offered. The study found that, married women and unmarried women (18+ years of age), have equally good access across the four SRH services. In addition, between 91 and 99% of health facilities that provide these four SRH services, say they also offer this service to adolescents. Therefore, according to the healthcare workers, these groups have reasonably good access to these services. When further looking at sub-groups of adolescents married girls have slightly lower access than unmarried girls and adolescent boys. The health facilities which offer education on healthy sexual behaviour to adolescents were asked whether they provided other means or information to prevent pregnancy besides abstinence. In total, 95% of these health facilities said that they do (99% public; 80% private; 88% faith-based). In addition, when the health facility offers contraceptives, the survey asked whether adolescents could decide on the type of contraceptive they want to use, which was the case in 88% of health facilities (88% public; 100% private; 86% faith-based).

Table 6. Provision of SRH services by health facilities including to specific adolescent groups.

	Information and counselling on SRH and issues	Promotion of healthy sexual behaviour through education	Family planning and contraceptive services	Condom promotion and provision
HFs offering service (%)	87	78	73	78
HFs that offer the service, offer it without permission of guardian/spouse to (%):				
Unmarried women (18+)	98	100	98	99
Married women (18+)	99	98	100	99
HFs offering service to adolescents under 18 (%)	91	99	97	93
HFs that offer the service, offer it without permission of guardian/spouse to (%):				
Boys (10-17 years)	100	98	98	100
Married girls (10-17 years)	95	93	95	96
Unmarried girls (10-17 years)	100	97	100	100

When comparing the differences in provision of SRH services between sectors, some differences were found (See Table 7). Across the services, the public sector scored considerably better compared to the private and faith-based sector, with 13 out of 18 services being offered at least 80% of public facilities. The private sector scored notably lower on offering of cervical and breast cancer screening services (8%) and voluntary male circumcision services (20%) compared to the other two sectors. Both the private- and the faith-based sector scored poorly on provision of family planning and contraceptive services, with only 32% of health facilities offering this service in both sectors. Finally, the faith-based sector scored lowest on provision of condoms, which was offered at a mere 28% of health facilities.

Table 7. Percentage of health facilities offering specific SRH services per sector.

	Public (%)	Private (%)	Faith-based (%)
Information and counselling on sexual and reproductive health and issues	98	68	64
Promotion of healthy sexual behaviour through education	96	60	32
Family planning and contraceptive services (information, counselling, provision)	95	32	32
Condom promotion and provision	99	52	28
Menstruation care counselling and services	89	60	52
HIV counselling, testing and treatment services	99	60	56
Prevention of mother-to-child transmission of HIV	93	32	44
Screening/testing and treatment of STIs, and reproductive- and urinary tract infections	90	64	56
Post-abortion care	71	32	56
Pregnancy testing	91	32	72
Antenatal care (ANC)	95	28	68
Delivery services	87	32	40
Postnatal care (PNC) services	91	32	44
Screening services (HPV, breast and cervical cancer screening)	46	8	36
Screening, counselling and services for sexual and gender-based violence, and referrals to multi-sectoral response services	79	32	48
Post-rape care	74	44	44
Voluntary medical male circumcision services	57	20	52
Referrals of clients in need of more specialised care to higher level facilities	91	60	72

The survey also asked how much supply of the birth control pill clients are given per visit; 70% of health facilities provide supply for three months, while 5% provide clients with a one-month supply. 25% of health facilities provide clients with a supply of six months or more (see Table 8).

Table 8. Percentage of health facilities offering specific SRH services per county.

Number of months' supply of birth control pill	% of health facilities
1 month	5
3 months	70
6 months	15
9 months	9
12 months	1

Some common long-acting contraceptives are intra-uterine contraceptive devices (IUDs) and implants. They require a trained healthcare worker to insert the product. In the public sector, 68% of the health facilities had a trained health-care worker who could insert an IUD, compared to lower numbers in the faith-based sector (41%) and very low numbers in the private sector (20%) (see Table 9). The same pattern was present for contraceptive implants. Eighty-three percent of public health facilities had someone who could insert contraceptive implants, versus 36% in the faith-based sector and 24% in the private sector.

Table 9. Capability insertion and removal of intra-uterine contraceptive devices (IUD) and implants.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Someone at the health facility is trained, and can insert and take out an IUD	68	20	41	**55**
Someone at the health facility is trained, and can insert and take out contraceptive implants	83	24	36	**65**

Table 10 displays for which SRH services clients have to pay. Only in 7% of public health facilities, clients pay for family planning services and HIV/AIDS services. In 9% of public health facilities, they pay for maternal health services. In the private sector, family planning is also almost always for free (payment needed at 4% of health facilities), but the other SRH services more often require payment. Interestingly, in the faith-based sector, also relatively high numbers of health facilities require payment, and there is no health facility offering all SRH services for free (See Table 10). Another notable finding is that across the three sectors, in many health facilities clients need to pay for STI treatment services, ranging from 78% of public- to 100% of private health facilities.

When looking at the type of products and procedures that clients have to pay for, in every sector they commonly pay for a range of things. Across the three sectors, almost everywhere patients pay for prescription medication (95-97% of health facilities). Again, in most health facilities across the sectors clients have to pay for a consultation fee and lab tests. In the private sector, low numbers of health facilities require payment for imaging diagnostics and surgical procedures, but this is likely due to the fact that these are not commonly offered in private facilities surveyed (see Table 7).

Table 10. Costs of services.

	Public (%)	Private (%)	Faith-based (%)
SRH services at the facility which clients need to pay for			
Family planning	7	4	13
Maternal health services	9	26	39
STI treatment services	78	100	91
HIV/AIDS services	7	35	17
All the services are for free	24	4	0
If any, type of products clients have to pay for			
Prescription medications	97	96	95
Over the counter (non-prescription) medications	13	26	19
Disposable medical equipment (gloves, needles, personal protective equipment)	47	70	67
Consultation fee	82	83	67
Day charges for hospitalisation	46	35	71
Imaging diagnostics	18	0	29
Surgical procedures	33	9	38
Lab tests	85	83	100

3.3 Policies, Management and Oversight

Table 11 provides information on policies and monitoring of the health facility. Overall, the availability of policies at health facilities is sub-optimal across the sectors, although the public sector has slightly higher availability compared to the private and faith-based sectors. The exception is the Standards for adolescent-friendly reproductive health services (2020), which interestingly has the highest availability in the faith-based sector (71%). The study further found that monitoring of the health facility's SRH services by government officials was done irregularly. In 31% of health facilities, government officials visited at irregular intervals. Only in 46% of health facilities, government officials visited at least quarterly. Furthermore, community committees that provide input into the facilities' services and activities were available at only 46% of public health facilities compared to 24% of private and faith-based health facilities.
Lastly, the involvement of adolescents in the design and implementation of SRH services was suboptimal, with 60% of public health facilities doing this, compared to again 24% of private- and faith-based facilities. If adolescents are involved, it is mostly done via meetings and having a box for comments and suggestions. However, also a few interesting responses came up, including that opinions are collected through peer educators, that healthcare workers participate in sports with young people to get their opinions, and that campaigns are organised in which young people are highlighted through village leaders.

Table 11. Policies and monitoring.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
The HF has soft or hard copies of the below guidelines/ policies available for use:				
National Adolescent Health and Development Strategy (2018)	71	63	44	**65**
National Guidelines for Initiating and Managing Community Based Reproductive and Child Health Services (2003)	61	38	46	**55**
Antenatal Care Guideline (2018)	73	47	71	**68**
Reproductive Health for Young People Peer Educator Guideline (Afya ya Uzazi kwa vijana rejea ya muelimishaji rika; 2020)	63	50	38	**57**
A national curriculum for health service providers on adolescent and youth friendly reproductive health (2019)	66	50	47	**60**
Standards for adolescent-friendly reproductive health services (2020)	65	47	71	**63**
Processes are in place at the HF to ensure that staff is updated and informed about changes when a new policy is developed	94	68	80	**87**
Frequency at which a government official visits to monitor how the health facility is performing with regards to SRH service provision:				
Zero times during the year	1	16	9	**5**
One time during the year	2	4	5	**3**
Two times during the year	4	12	9	**6**
Three times during the year	8	0	0	**5**
Four times during the year (quarterly)	39	40	41	**39**
Five or more times during the year	11	0	0	**7**
At irregular intervals	33	28	27	**31**
Don't know	2	0	9	**3**
The HF has a community committee that provides input into the HF's services and activities	46	24	24	**38**
Adolescents are asked for input into or feedback on the design, planning, implementation and evaluation of SRH services at the HF	60	24	24	**47**
How adolescents are involved:				
Healthcare workers visit them in community/school	4	25	0	5
Participation in discussions/social events/public meetings	40	0	60	39
Comment/suggestions box	37	75	40	39
Through peer educators	2	0	0	2
During medical consultations	10	0	0	8
At health committee meetings	4	0	0	3

3.4 Training, Education and Outreach

Overall, the public sector again scored considerably higher on all indicators regarding provision of training, education and outreach compared to the private- and faith-based sectors. Healthcare workers seemed to receive recurrent training on AFSHR in half of public sector health facilities, where healthcare workers had received a refresher training in the last 24 months, compared to 28% of private and 27% of faith-based facilities (see Table 12). According to healthcare workers, educational SRH materials for adolescents were available at 83% of public facilities, compared to only 44% of private and 24% of faith-based facilities. Education materials for parents/guardians on adolescent SRH services to increase their support were available at similar percentages of public and private health facilities, but interestingly, at a higher number of faith-based facilities (44%), when comparing with the materials for adolescents. Regarding outreach and education on SRH, again a high number of public health facilities provided this (90%), with lower numbers of private and faith-based facilities (both 32%). A similar pattern was observed for health facilities organising group discussions on SHR for adolescents, with 73% of public health facilities doing this but fewer private and faith-based facilities. The frequency at which health facilities organised these group discussions varied, but many did it once per month (51%). Finally, the percentage of health facilities making use of peer educators followed the same pattern of high public- with contrasting lower numbers of private and faith-based facilities.

Table 12. Training, education and outreach of the health facility.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Staff have received a refresher training on how to provide AFSRH services in the last 24 months	51	28	27	**42**
Educational materials on SRH and healthy sexual behaviour, such as posters, pamphlets, videos or booklets, targeted at adolescents are available at this facility	83	44	24	**66**
Educational materials with key messages on adolescent SRH targeted at parents/guardians to support adolescents to access services, are available at this facility	76	40	44	**64**
The facility provides outreach and/or education on SRH for adolescents within the community	90	32	32	**70**
If yes, frequency per year:				
Less than one time				5
One time				53
Two times				13
Four times				9
Seven times				1
Eight times				1
At irregular intervals				10
The facility organises group discussions or talks for adolescents on SRH	73	20	12	**53**
If yes, frequency per month:				
Less than one time				62
One time				15
Two times				9
Four times				10
At irregular intervals				4
The facility works with adolescent peer educators to provide outreach services to other adolescents	84	42	44	**70**

3.5 The State of the Health Facility

The information in Table 13 was collected based on observations made by the data collectors when they visited the health facilities. It shows that health facilities, overall, scored highly. An area of improvement across the three sectors is having materials on SRH targeted at adolescents visible or provided at the health facility, but especially for the private and faith-based sector. Further on, about 20% of private- and faith-based health facilities didn't have private consultation room. Finally, when comparing the three sectors, the public sector scored lowest on having soap and running water, as well as clean toilet facilities.

Table 13. Information on the state of the health facility based on observations of data collectors.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Signage with services offered is available and visible at the health facility	92	79	82	**88**
Signage with operating hours is available and visible at the health facility	91	83	92	**90**
Materials targeted at adolescents on SRH are visible or provided at the facility (posters, leaflets, videos, etc.)	78	42	27	**63**
The health facility is clean	96	100	100	**97**
The health facility has private rooms where consultations are held	94	79	80	**89**
The health facility has electricity	96	100	96	**97**
The health facility has soap and running water	84	96	100	**89**
The health facility has toilet facilities	99	100	100	**99**
The health facility has clean toilet facilities	82	100	91	**87**

3.6 Recommendations by Healthcare Workers

Thirty-seven healthcare workers gave suggestions on how to improve policies to access SRH services for adolescents. A Word Cloud based on their responses can be found in Figure 5. From this Word Cloud it becomes clear that the many healthcare workers talked about the need for education, provision of services, and training. Below are specific quotes from healthcare workers who voiced what could be done:

"The presence of regular training for health workers and the addition of workers who are specialized in providing these services. "- **Public clinic**

"Conferences for young people [should be organised] to give health education on contraception and safe sex."- **Private dispensary**

"Our traditions and customs conflict with some policies because many policies have been brought to us. I suggest that we find the policies that match our Tanzanian traditions and customs."- **Private dispensary**

"To ensure the increase of products or equipment needed for the provision of these services."- **Private dispensary**

"There should be no cost for reproductive health services, we ask the government to put in place a mechanism to cover [expenses] when they come to get those services." – **Faith-based dispensary**

"Allowing contraceptive services to be provided at every health facility." – **Faith-based dispensary**

Figure 5. What could be improved to enable better access to AFSRH services at the health facility (Word Cloud).

4. RECOMMENDATIONS

Despite the fact that this study showed that in general, the provision of adolescent-friendly SRH services in Tanzania is relatively high, the report still laid bare some gaps which should be improved. The following recommendations were constructed to help improve access to SRH services for adolescents in Tanzania.

1. **Adolescent-friendly service provision:** This survey shows that health facilities score inadequate on the provision on some adolescent friendly services. For example, only few facilities had staff under the age of 25 providing SRH services to adolescents. In addition, 84% of healthcare workers say they advise adolescents to abstain from sex when they seek contraceptives at the health facility. We therefore recommend the advancement of adolescent & youth friendly services units. Concretely, this means the number of youth friendly service units should increase as well as the number of healthcare providers who are championing youth services. This should be healthcare providers who can overcome stigma and discrimination and motivate youths to attend the facilities wherever they need or wish to, and should also include healthcare workers below the age of 25.
2. **Human resources:** Insufficient numbers of healthcare providers are trained on AYFS, we therefore recommend the number of trained health care providers on adolescent and youth friendly services to increase at least up to 80%. In addition, the enrolment of highly skilled health service providers should be stimulated.
3. **Health policies:** There are gaps in implementation of Policies and Guidelines that promote SRH services. The Ministry of Health should establish a proper system for Monitoring and Evaluation of SRH Policies and Guidelines, and should have an independent policy department in the Ministry structure. This department will be responsible for follow ups on the implementation of the developed policies and guidelines. For instance, the "National Standards for Quality Health Services for Adolescents" of 2020 has not yet been well implemented and such department would have been able to express the need of abiding to it. Their work can also include trainings to different stakeholders on the existence of policy frameworks and their contents. Further, the Ministry should establish an 'Adolescent and youth health coordination framework for health facilities at Regional, District and Ward level.

4. **Adolescent friendly health services monitoring:** Strengthen health facilities' structures to promote adolescent engagement in community- and health facility meetings. This will increase prioritisation and demand creation in the public sector. There is a need to form a community health committee in each health facility, which shall be responsible for monitoring the provision of adolescent services in the facilities. This committee should also attend the facility meetings on quarterly basis and should include adolescents.
5. **Budgeting:** The MoH should prioritise SRH budget allocation for the general population, and for adolescents and youth specifically, and should realise a budget increment of least 3% per year.
6. **Measuring needs:** As mentioned before, it is essential that every health facility has a well-functioning community health committee whose role will be to monitor the provision of comprehensive SRH services to adolescents, to identify gaps, to monitor availability and ordering of SRH Commodities from the Medical Sores Department (MSD), to inform responsible government authorities of any weakness in the service provision and shortage of commodities in their respective localities.

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