Mainstreaming Youth-Friendly Sexual and Reproductive Health Services in the Public Sector in Mozambique and Tanzania

Young people have the right to live healthy sexual and reproductive lives. Yet, adolescents and youth (those between the ages of 10 and 24) often face social, cultural, economic, and structural barriers to accessing sexual and reproductive health information and services at a time when they need these services the most, making them vulnerable to poor health outcomes. Emerging global guidance suggests that, to reach youth in a sustainable and scalable way, youth-friendly services must be mainstreamed in the community and health systems. However, there is little evidence from project implementation about how to integrate youth-friendly services on a large scale. This technical brief explores how youth-friendly services were mainstreamed within public sector facilities and communities supported by Pathfinder International’s cross-country project, MAIS Qualidade, Acesso, Saúde in Mozambique, and Chaguo la Maisha in Tanzania (January 2015 to December 2017), and offers recommendations for future youth-friendly services programming.
Context

Adolescence and youth is a time of significant biological, physical, emotional, and behavioral change—and a time during which individuals begin to mature sexually and explore sexual relationships. As such, adolescents and youth require access to quality sexual and reproductive health (SRH) information and services to meet their developing needs. However, adolescents and youth often face barriers—such as community member and provider stigma, social and cultural norms, prohibitive costs, transport and distance barriers, lack of privacy and confidentiality, lack of autonomy, and legal and policy barriers—to quality SRH services. As a result, adolescents and youth are often unable to exercise their right to healthy sexual and reproductive lives.

In past decades, the global health and development communities have increasingly recognized the importance of youth-friendly services (YFS) and have worked to identify and advance elements of effective youth-friendly service delivery. Experimental studies of YFS have been somewhat limited. However, sufficient evidence has been collected to suggest that YFS can increase adolescent and youth use of SRH services when they include training for providers on youth-friendly service provision and competencies for delivering adolescent health services; improvements in facilities to increase access to and quality of services for adolescents and youth; and community-based activities to foster an enabling environment and to create demand for adolescent and youth sexual and reproductive health (AYSRH) services. Additionally, research suggests that young people consistently prioritize privacy, confidentiality, and respectful care by providers as the most important elements of quality care.

Traditionally, these components of YFS have been implemented in separate space services for youth—meaning services offered in a separate consultation space within a larger private or public health facility, or in a separate youth clinic. However, in most cases, even well-designed separate spaces face challenges after projects that fund them come to an end. Often, at project end, providers are transferred to services with higher client volume and the rooms once reserved for separate space services are repurposed for other health issues, used for storage, or remain unused altogether.

Therefore, though separate space services can be effective in attracting and providing quality services to youth, they are difficult to sustain.

In response, WHO, USAID, and SRH implementing organizations—including Pathfinder International—have argued for the importance of considering mainstreamed YFS. Mainstreamed or integrated YFS require that all health providers and support staff in health facilities offer quality services to adolescents and youth as part of routine service delivery. In a mainstreamed model, any provider—whether offering HIV treatment and care, contraceptive services, maternal health services, or primary care services—provides non-judgmental care to all adolescent and youth clients, while ensuring privacy, and confidentiality. Conceptually, mainstreamed YFS are attractive because they are scalable and sustainable. In practice, however, there is little information available about how to systematically implement mainstreamed YFS.

In 2015, Pathfinder began implementation of the Strengthening Contraception and Safe Abortion Service Delivery in Urban Mozambique and Tanzania project, which aimed to strengthen quality, needs-responsive service delivery and to create an enabling environment for women of reproductive age to choose whether and when to bear children, through an integrated systems strengthening approach—Pathfinder’s approach for responsive, community-based service delivery. Though this project aimed to reach all women of reproductive age, it targeted three priority populations: postpartum and lactating women, postabortion women, and adolescents and youth with and without children.

The need for youth-friendly services

Investing in AYSRH and addressing the structures and norms that impact AYSRH are important not only because such actions could lead to the adoption of lifelong healthy behaviors, but also because health is a fundamental

(a) The WHO defines adolescents as those between the ages of 10 and 19, youth as between 15 and 24, and young people as between 10 and 24. (b) Notably, youth centers (i.e., recreation centers that sometimes offer a limited package of basic services to youth) have also been implemented. However, evidence strongly suggests that these are not effective models to increase access to SRH services for adolescents and youth and implementation of these centers is not recommended. (Zuurmond MA, Geary RS, Ross DA. “The Effectiveness of youth centers in increasing use of sexual and reproductive health services: a systematic review,” Studies in Family Planning 43, no.4 (2012): 239-254.) (c) In Mozambique, this project is known as MAIS Qualidade, Acesso, Saúde, which translates from Portuguese as “MORE quality, access, health.” In Tanzania, this project is known as Chaguo la Maisha, which translates from Swahili to “Lifetime Choice.” MAIS includes comprehensive and postabortion care in its programming, whereas Chaguo la Maisha includes postabortion care only.
human right, essential to the enjoyment of and access to all other human rights.

According to the Guttmacher Institute, approximately 45 percent of pregnancies in girls between 15 and 19 years old in Africa in 2016 were unintended. Unintended adolescent pregnancies do not only impact the health of young women—complications of pregnancy and childbirth are among the leading causes of death for 15 to 19-year-old girls—but they also threaten the wellbeing of adolescents and youth and societies as unintended pregnancies are associated with lower educational and economic attainment. Use of effective contraception contributes to a reduction in unintended pregnancies. Yet, as Demographic and Health Survey data suggests, adolescents and youth in Tanzania and Mozambique have lower contraceptive prevalence rates—particularly, low uptake of more effective, longer-acting methods—when compared with their older counterparts. Further, the median age for girls at first sexual intercourse is 16.1 and 17.2 in Mozambique and Tanzania, respectively, demonstrating that adolescent and young girls require access to SRH information and services before these ages (see Table 1).

### Strategy and implementation planning

To improve access to and quality of youth-friendly SRH services for Mozambican and Tanzanian adolescents and youth, Pathfinder used a people-centered approach that focuses on a continuum of interventions in the community and the facility to deliver mainstreamed YFS in a sustainable and scalable manner.

This integrated systems strengthening approach focuses on working with providers, and their supervisors, creating mechanisms and processes to facilitate meaningful participation of both health system actors and community members to encourage dialogue, and build mutual accountability and shared responsibility for health. To support such linkages, Pathfinder works with communities to build capacity in the identification and communication of health needs, and works with health systems to strengthen their clinical skills, equip them to deliver AYSRH services, and ensure they can hear the needs of communities and deliver appropriate, high-quality services.

The MAIS and Chaguio la Maisha projects mainstreamed YFS through facility and community interventions, as well as through interventions linking the facility and community. Each intervention component aligned with WHO and Pathfinder’s YFS quality standards (see Figure 1).

### Site Selection

The project selected urban and peri-urban sites in each country for implementation. Project sites were characterized by a large concentration of youth, poor, and underserved people, as well as poor SRH outcomes. In Mozambique, the project was implemented in Maputo Province, where 31 percent of the population is between 10 and 24, and Maputo City Province, where 33 percent of the population is between 10 and 24. Data from the Demographic and Health Surveys suggests that the method mix uptake in these areas is skewed towards short-acting methods (13.8 and 17.4 percent of women of reproductive age in Maputo Province and Maputo City, respectively, use oral contraceptive pills, whereas 0.8 and 2.1 percent use IUDs) and unmet need is slightly higher than the national average (25.1 percent in Maputo Province compared to 23.9% percent nationally). In Tanzania, the project was implemented in the Temeke district, where 33 percent of the population is between the ages of 10 and 24, and in the Ilala district, where 32 percent of the population is between 10 and 24. Both districts are part of the Dar es Salaam Region, where current use of long-acting methods is lower than the national average (3.9 percent of women use implants in Dar es Salaam compared to 6.7 percent nationwide) and more women in Dar es Salaam rely on less effective traditional methods of contraception than women do nationwide (18.3 percent in Dar es Salaam compared to 6.4 percent).

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**TABLE 1: PERCENTAGE OF GIRLS AND WOMEN WHO CURRENTLY USE A MODERN METHOD OF CONTRACEPTION AND WHO HAVE UNMET NEED FOR CONTRACEPTION, BY AGE**

<table>
<thead>
<tr>
<th>AGE</th>
<th>MODERN CONTRACEPTIVE PREVALENCE RATE</th>
<th>INTRAUTERINE DEVICE</th>
<th>IMPLANTS</th>
<th>UNMET NEED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mozambique</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>8.3</td>
<td>0.0</td>
<td>0.0</td>
<td>18.0</td>
</tr>
<tr>
<td>20-24</td>
<td>15.1</td>
<td>0.0</td>
<td>0.0</td>
<td>22.0</td>
</tr>
<tr>
<td>25-29</td>
<td>15.9</td>
<td>0.2</td>
<td>0.0</td>
<td>23.5</td>
</tr>
<tr>
<td>30-34</td>
<td>14.8</td>
<td>0.4</td>
<td>0.0</td>
<td>24.0</td>
</tr>
<tr>
<td>15-49</td>
<td>12.1</td>
<td>0.2</td>
<td>0.0</td>
<td>23.9</td>
</tr>
<tr>
<td>Tanzania</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>8.6</td>
<td>0.0</td>
<td>1.5</td>
<td>10.8</td>
</tr>
<tr>
<td>20-24</td>
<td>28.9</td>
<td>0.2</td>
<td>7.6</td>
<td>17.7</td>
</tr>
<tr>
<td>25-29</td>
<td>35.2</td>
<td>0.7</td>
<td>8.7</td>
<td>20.1</td>
</tr>
<tr>
<td>30-34</td>
<td>36.1</td>
<td>1.0</td>
<td>7.8</td>
<td>18.5</td>
</tr>
<tr>
<td>15-49</td>
<td>27.1</td>
<td>0.7</td>
<td>5.6</td>
<td>16.8</td>
</tr>
</tbody>
</table>

*Please note that this row presents data for all women of reproductive age, as opposed to a select age group.

Data from the 2011 Mozambique Demographic and Health Survey and the 2015-2016 Tanzania Demographic and Health Survey. While data from Table 1 is from the 2011 Mozambique Demographic and Health Survey, data reported here is from the 2015 AIDS Indicator Survey. The AIDS Indicator Survey reports more recent data by province, but does not disaggregate by age or marital status as the 2011 Demographic and Health Survey does, thus, data from both surveys was used.
<table>
<thead>
<tr>
<th>PATHFINDER YFS QUALITY STANDARD</th>
<th>PROJECT INTERVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent knowledge and skills</td>
<td>Young people are able to access information and build skills that enable them to practice healthy sexual behaviors. Community health worker counseling and referrals, community health worker digital job aid, and community-based interventions.</td>
</tr>
<tr>
<td><strong>Community support</strong></td>
<td>Programs involve adult gatekeepers (e.g., parents, stakeholders, teachers, or health care providers) who influence the behaviors and decisions of young people. Community health worker counseling and referrals, and community-based interventions.</td>
</tr>
<tr>
<td><strong>Comprehensive package of services</strong></td>
<td>The health facility offers or refers for a full range of sexual and reproductive health services, including counseling on and offering the full range of contraceptive methods available in country and dual protection. Provider training, mentorship, facility rehabilitation, and commodity and equipment provision.</td>
</tr>
<tr>
<td><strong>Competent and unbiased providers</strong></td>
<td>Staff are trained in adolescent and youth sexual and reproductive health, and providers offer the client service(s) in a non-judgmental manner. Provider training and mentorship.</td>
</tr>
<tr>
<td><strong>Facility characteristics</strong></td>
<td>Health facilities are open during hours that ensure young people can access services, maintain privacy and confidentiality, and have the supplies needed to ensure effective service provision. Facility rehabilitation.</td>
</tr>
<tr>
<td><strong>Equity and non-discrimination in health services</strong></td>
<td>The full range of sexual and reproductive health services are provided to all young people, regardless of sex, age, marital status, and other factors. Provider training, mentorship, community health worker counseling and referrals, co-management committees, and the Citizen Report Card.</td>
</tr>
<tr>
<td><strong>Data and quality improvement</strong></td>
<td>Health facility collects and uses age- and sex-disaggregated data to support quality improvement. Provider training, mentorship, monthly and quarterly data reviews at facilities.</td>
</tr>
<tr>
<td><strong>Young people participation</strong></td>
<td>Young people are involved in program design and implementation. Co-management committees and the Citizen Report Card.</td>
</tr>
</tbody>
</table>
The project was implemented in 37 public health facilities in Mozambique and 68 public health facilities in Tanzania. In each country, the project supports 100 percent of the urban public health facilities in project-supported districts.

**Facility-based interventions**

To ensure providers, facility staff, and health facilities met quality standards—including YFS quality standards (see Figure 1)—the project decided to systematically train all providers and staff, and implement a mentorship program to support providers in provision of a full range of contraceptive methods, particularly long-acting reversible contraceptives (LARCs). Elements necessary for quality YFS were integrated into the trainings and mentorship. The project used a package of Ministry of Health curricula and WHO Medical Eligibility Criteria for Contraceptive Use to train providers and facility staff. Training included didactic and practical components on contraceptive counseling and provision for all contraceptive methods, infection prevention, comprehensive abortion and postabortion care, postpartum family planning, and referrals for service where necessary. Rather than hold separate trainings for YFS, the project decided to integrate YFS training into each training segment. For example, training on contraceptive counseling addressed important aspects to consider when counseling adolescents and youth, and all trainings included exercises in which providers were supported to reflect on and discuss their own biases to reduce provider stigma and bias around services for adolescents and youth.

Mainstreaming YFS means every component of health service delivery is youth-friendly—which can require a significant shift in behavior among facility staff and providers. To further support providers and facility staff after their initial training and to help ensure quality YFS are delivered, the project employed mentorship teams. These teams comprised project staff and Ministry of Health staff, who worked in health directorates and project-supported health facilities, with clinical and mentorship experience. Mentorship teams were supported by a tablet-based mentorship tool, visited each facility monthly in the first year and quarterly thereafter to observe project-trained providers and staff, offer on-the-job training, develop individual workplans for quality improvement over time, and monitor facility characteristics.

Pathfinder quality standards were integrated into the tablet-based mentorship tool as the basis for mentors’ guidance and support for providers and facility staff.* The tool was designed to support mentors’ ability to assess providers’ delivery of SRH services (including mainstreamed YFS), measuring them against quality standards. At each visit, mentors identified the provider observed, whether the provider had been trained by the project, the service offered, and the age category of the client. As the provider offered services, the mentor used a digitized checklist to indicate whether the provider met the quality standards, and highlighted areas for improvement.

Relating specifically to adolescents and youth, the project designed the tool to capture whether the provider offered adolescents and youth a full range of services and whether these services were offered in a non-judgmental and non-discriminatory manner.

Thus, this tool was designed to create an individual record of provider performance over time. Based on performance, mentors and providers discussed individual plans for improvement. In addition, the mentorship application prompted mentors to observe facility characteristics such as the availability of the full range of contraceptives in the facilities, and completeness of data collection tools. As provider skills and quality of service delivery improved over time, the frequency and intensity of mentorship decreased.

In addition, the project strategy included facility renovations and the purchase of new materials and equipment to ensure trained providers and staff also had the facility space and equipment necessary to deliver the care they were trained to provide. Further, renovations helped facilities ensure privacy and confidentiality during service provision. To ensure the project met the standard for data quality, the project supported local-level government teams to conduct quarterly data quality reviews of age-disaggregated facility data.

Finally, in Mozambique, owing to demand from youth for dedicated separate spaces, facility staff desire to meet that demand, and health facility resources available to meet that demand, the project supported four separate space service delivery sites. This aligns with previous Pathfinder experience in Mozambique which led the Ministry of Health to change its YFS approach such that, where context makes it appropriate and sustainable, and there is demand, separate spaces for YFS can be included at referral hospitals. In the case of these four separate space service delivery sites, there was sufficient youth client volume to warrant a separate room and provider for AYSRH services, sufficient physical space to accommodate private and confidential separate space services, and sufficient human resources to staff these separate spaces. Because of these conditions, separate space services were deemed an appropriate complement to the mainstreamed YFS at the lower-level health facilities.

**Community-based interventions**

Community-based activities that cultivate an enabling environment for AYSRH, and generate demand for SRH services are a critical component of YFS. The project planned a robust demand generation strategy through collaboration with nongovernmental organizations (NGOs) and community health workers (CHWs) to ensure that adolescents and youth had the information and skills to practice healthy sexual behaviors and that the community supported AYSRH. In each country, the project identified partner NGOs to manage project-affiliated CHWs in demand generation activities. In Mozambique, the project partnered with three local NGOs—Coalizão, Kutenga, and Muleide. In Tanzania, the project partnered with two local NGOs—

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*Quality standards from the Tanzanian and Mozambican Ministries of Health were also integrated into each country’s tool to ensure that services met the standards of the national health system, as well. For more information on Pathfinder’s Geração Biz program, visit: www.pathfinder.org/projects/geracao-biz*
MDH and UMATI. These five NGOs were selected for their technical and field experience, their advocacy experience, their focus on women and youth, and their absorptive capacity to adopt new strategies. In addition to managing the CHW teams, the NGOs utilized their technical and field experience to organize and foster community discussions on AYSRH topics.

To increase demand for SRH services, CHWs conducted individual home visits in facility catchment areas. Past Pathfinder research and implementation experience suggests that individual home visits are an effective way to reach adolescents and youth, who may face barriers to accessing health services (e.g., requiring permission from elders). The project recruited 216 CHWs in Mozambique and 165 CHWs in Tanzania, supported by 27 and 20 supervisors, respectively, to reach women of reproductive age—including adolescents and youth—in their homes with SRH information, counseling, and referrals for services, as requested. In Mozambique, the project determined that all CHWs should be women, and should be selected based on their ability to speak local languages, experience in counseling at the community level, literacy, SRH knowledge, and availability to serve in this position full-time. In Tanzania, the project also decided all CHWs should be women, and these women should be from the communities they would serve and should be secondary school graduates and have demonstrated positive attitudes toward SRH.

To ensure that CHWs provided quality, youth-friendly SRH information and counseling, the project trained and equipped all CHWs with a mobile-based job aid to assist with contraceptive counseling, making and confirming referrals, and reminders for scheduled follow-up visits. Notably, the job aid used a balanced counseling approach—meaning it supported counseling in order of method effectiveness based on a client’s medical eligibility, needs, and preferences. Finally, the project included a performance-based incentive program that rewarded CHWs based on the number of new clients registered by the mobile application, the percent of clients that completed referrals to the facility, and timely follow-up visits to clients who visited a facility.

**Strengthening linkages for adolescent- and youth-responsive health services**

Through its integrated systems strengthening approach, Pathfinder aims to strengthen the linkages between communities and health systems—building the community’s capacity to hold the health system accountable, and the health system’s capacity to hear and respond to such feedback. Further, understanding quality of service delivery for adolescents and youth—particularly how to elicit feedback from youth regarding quality of service delivery—has been a challenge for the global health community. Considering this, the project decided to ensure that its monitoring of quality incorporated youth perspectives directly, through engaging youth to participate through the use of specific integrated systems strengthening tools: the Citizen Report Card and the co-management committees.

Integrated systems strengthening tools build meaningful dialogue between the community and facility, and in doing so, help ensure that project activities follow a rights-based approach. There are six guiding principles, drawn from WHO guidance, that Pathfinder follows to ensure its SRH programming promotes and upholds the rights of all people: equity and non-discrimination, autonomy and bodily integrity, confidentiality and privacy, participation and inclusion, availability and accessibility, and quality. Integrated systems strengthening tools, such as the Citizen Report Card and co-management committees, address participation and inclusion. Specifically, these tools provide venues for community members to participate in discussions on SRH programming and they elicit community feedback on programming.

The Citizen Report Card is a survey tool designed to provide insights into user perceptions on: the accessibility, quality, and reliability of public services; whether there are hidden costs for services; and satisfaction with SRH services at public facilities. Notably, the project developed a digital version of this survey that was integrated into the tablet-based CHW job aid. After a CHW has referred a client for service and the referral has been completed, an automated reminder is sent to the CHW via the tablet-based application to follow up with the client, seven
days after the facility visit. At the follow-up visit, the CHW is prompted by the job aid to ask a series of questions about the facility visit, through the Citizen Report Card. Data from the Citizen Report Card is shared with the variety of health and community committees with which the project works. This data can be disaggregated by age, enabling the project to understand whether youth are likely to provide feedback on services through digital methods, and enabling committees, CHWs, NGOs, and facility staff to understand how adolescents and youth perceive the SRH services they receive.

In each country, the project established, re-vitalized, or initiated working relationships with different committees, dedicated to mobilizing community, facility, and health system representatives to collaboratively identify service delivery challenges, gaps, and solutions. In Mozambique, the project worked with both health committees—committees composed entirely of volunteer community members—and facility/community co-management committees—often composed of a facility director or administrator, director of nursing, a representative from the community health committee, a CHW, a representative from the district, and other governmental representatives as needed. Similarly, in Tanzania, the project worked with council health service boards—composed of community members, representatives from both not-for-profit and private-for-profit health facilities, a district medical officer, council planning officer, representatives from the regional health management team—and health facility governing committees—composed of representatives from the community, representatives from not-for-profit and private for-profit health facilities, representatives from the council health service board, representatives from the district medical office, and the medical officer in charge of the facility. The project used these forums to increase members’ awareness of AYSRH, contraception—particularly LARCs—and comprehensive abortion and postabortion services. In addition, the project intended to promote youth participation in these meetings and to use these forums to discuss project data and feedback from youth on the quality of service delivery.

**Implementation experience**

Real world complexities often cause even the most carefully planned projects to deviate from implementation plans. Most of the project’s core activities unrolled as planned, with some requiring mid-course adaptations. What follows is a brief description of implementation followed by an exploration of the project’s significant adaptations at the facility level and community level, as well as adaptations with regard to tools and activities to strengthen the linkages between the facility and community.

Implementation began in January 2015. During the first six months of implementation, the project conducted baseline assessments of facilities using a Pathfinder tool that integrated assessments for YFS, contraception, abortion, and postabortion care services; reviewed training curricula; established partnerships with local NGOs; oriented trainers; developed the CHW job aid; and created an assessment tool to identify the existence of and facilitators of and barriers to the functionality of co-management committees. The project used a phased approach for facility-based interventions, meaning it started with a select number of facilities in each site during the first six months of implementation and expanded thereafter to a total of 37 facilities in Mozambique and 68 in Tanzania. Between July and December of 2015, the project conducted facility renovations and trained trainers, mentors, and CHWs. During the same time, CHWs began conducting individual home visits and collecting data from the Citizen Report Card. In the second year of project implementation, additional facilities were added to the project in each country and mentorship visits and on-the-job training workshops began.

Capturing mid-implementation adaptations helps develop programming more suited to the unique contexts in which we work while also providing useful insights for future programming. Halfway through the implementation of MAIS and Chaguo la Maisha, project teams met in Mozambique to collectively identify project challenges, successes, and adaptations, and to learn from each other’s experiences. During this meeting, both countries identified challenges and adaptations regarding mainstreaming YFS from the facility and community levels, as well as within the activities and tools used to strengthen linkages between the two.
Facility-level adaptations: 
**DATA COLLECTION AND PROVIDER TRAINING**
As indicated by Pathfinder and WHO YFS quality standards, age-disaggregated data is an integral component of youth-friendly SRH programming. However, during project implementation, the Mozambican Ministry of Health issued new logbooks for health facility use that changed how age-disaggregated data was captured. Whereas, previously, new contraceptive users had been collected by age, the new logbooks captured new users by contraceptive method. To ensure that the project continued to collect age-disaggregated data, project staff paired data on new users by contraceptive method with data on SRH consultation visits, which is collected by age.

An element of unbiased service delivery is ensuring that youth are offered the full contraceptive method mix. To complete their practical training component, providers in Tanzania were required to practice IUD insertions on real clients. However, the low demand for IUDs significantly reduced the opportunity for trainers and mentors to observe providers’ practical IUD training. As a result, the project adapted the training program so that trainers observed individual providers at their own facilities, rather than exclusively during a designated training session.

Community-level adaptations: 
**RESPONDING TO UNEXPECTED LEVELS OF DEMAND**
Unexpected demand from very young adolescents in Mozambique, and low demand from adolescents in Tanzania influenced adaptations in demand-generation activities at the community level. While there is no Mozambican policy requiring adult accompaniment or consent for youth under 15 seeking SRH services, Mozambican policy states that youth between the ages of 10 and 15 who seek HIV testing and counseling services must have consent from an adult. Because of this policy, the project in Mozambique decided that the CHW job aid should only capture data for adolescents 15 years and older. However, in coordination and technical update meetings between the CHWs and NGOs, CHWs reported that very young adolescents, between the ages of 10 and 14, were approaching CHWs for information on contraception. As a result of this unexpected demand, the project modified the job aid so that it captured data on this age group and CHWs were prompted to provide information specific to clients younger than 15 years of age. The project hopes to use data collected on this age group to advocate with the Ministry of Health for guidelines that improve access to SRH information and services for very young adolescents.

In Tanzania, data from the second year of implementation showed that while the total number of new users between 15 and 19 years had increased during implementation, the proportion of new users between 15 and 19 (out of all new clients) remained steady and lower than the project had expected. In response, the project initiated a school-based demand generation component, in which CHWs and peer educators worked with existing extracurricular clubs to provide SRH information to Tanzanian students. In small group settings, CHWs, peer educators, and adolescents engaged in discussions on SRH prompted by activity cards. These activity cards were adapted from the USAID-funded Gender Roles, Equality, and Transformations project (GREAT), where they were used to promote discussions among adolescents to transform gender norms, promote gender-equitable attitudes, and promote sexual and reproductive health. This adaptation was particularly important for students who attend boarding schools, as they are not typically reached by CHW home visits otherwise. Of note, the Tanzanian Ministry of Education permits information and referrals for services to be provided in school settings, but not services themselves.

Adaptations to activities and tools that strengthen linkages between the community and facility:
**ENSURING YOUTH PARTICIPATION**
In Tanzania and Mozambique, co-management committees were missing the voices of CHWs and youth, respectively, prompting the project to adapt to ensure that both voices were adequately represented in project implementation. Tanzanian Ministry of Health guidelines indicate who should participate in council health service boards and health facility governing committees. These guidelines do not include CHWs despite CHW experience with youth, the facilities, and the NGOs. To address this problem, the project focused on building consensus around CHW participation at the district level. At the time of this publication, resolution of this issue is ongoing.

Mozambican Ministry of Health guidelines do require community members be included in health committees and facility/community co-management committees. To ensure that these interventions meet Pathfinder standards for quality YFS, youth should have the opportunity to participate in project design and implementation through feedback. However, youth participation in these venues has been low. Reports from the project’s cross-country learning opportunity in Mozambique reveal that youth participation is low likely due to a belief that some adults maintain that youth lack sufficient experience and knowledge to contribute to these meetings. In response, the project supports NGO representatives to attend these meetings to represent youth voice while advocating for increased youth participation. Representatives from project-affiliated NGOs are typically under 30 years of age, and have experience with and knowledge of communities and youth through their work with CHWs and regularly scheduled community meetings.

Finally, anecdotal evidence shared by project staff during the cross-country learning meeting suggests that explicit bias persists in some

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(i) SRH consultations are appointments that girls and women have when seeking SRH services outside of maternity or gynecological emergency visits.

(j) Through the GREAT project in Uganda, Pathfinder, the Institute of Reproductive Health, and Save the Children sought to transform gender roles, promote gender equality, and reduce gender-based violence among 10- to 19-year-olds in post-conflict Uganda. At the community level, the project used activity cards to discuss gender roles and sexual and reproductive health with adolescents and youth. For more information on GREAT, visit www.pathfinder.org/our-work/projects/gender-roles-equality-and-transformations-uganda.html
facilities and this implicit bias cannot currently be captured by the Citizen Report Card. For example, an adolescent or youth client may report that she was satisfied with the services provided. Currently, the Citizen Report Card cannot distinguish whether she was satisfied because she received her contraceptive method of choice, or because the provider ensured privacy and confidentiality, treated her with respect, and provided her contraceptive method of choice. The project continues to discuss how to address this issue.

Performance

The project sought to create an enabling environment for women of reproductive age to choose whether and when to bear children, and to mainstream YFS to promote an increase in uptake of effective contraceptive methods and other SRH services. To measure progress towards these objectives, the project collected data on: 1) number of new contraceptive users, by age, over time (shown in Figures 2 and 3); 2) contraceptive method mix, by age, over time (shown in Figure 4); 3) number and percentage of clients receiving method of choice by age (shown in Table 2); 4) non-judgmental service provision by age; and 5) client satisfaction with services, by age.

Data collected between 2015 and December 2016 reports 93,691 new contraceptive users in Tanzania, and 65,537 new SRH consultations in Mozambique. Of these new users in Tanzania, 29,659—or 31.7 percent—were between the ages of 10 and 24. In Mozambique, 34,840—or 53 percent—were between the ages of 10 and 24. Figure 3 shows the increase in new contraceptive users and SRH consultations over time.

In addition, data suggests that project interventions contributed to a significant shift in method mix—specifically, a major shift towards LARC uptake—in both Tanzania and Mozambique. Data from the 2015-2016 Demographic and Health Survey reports low uptake of implants and IUDs in Tanzania—0.7 percent and 5.6 percent for women between the ages of 15 and 49 currently using contraception, respectively. Project data, however, from January 2015 to December 2016 reports that, of all new contraceptive users aged 15 to 49, 15.7 percent selected IUDs and 25 percent of these new IUD users were between the ages of 10 and 24. Though the project was not able to capture new users by method and age after April 2016 due to a change Ministry of Health data collection methods, the project used referrals for users

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**FIGURE 2: NUMBER OF NEW CONTRACEPTIVE USERS IN PROJECT-SUPPORTED SITES IN TANZANIA, BY AGE, OVER TIME**

As this figure demonstrates, there was an overall increase in new users in Tanzania. Service delivery and data collection began in July 2015. In addition, facilities in Ilala were added to the project between January and March 2016, possibly causing the spike in new users between April and June 2016. While data was collected for users between 10 and 14, because of comparatively low uptake and a primary focus on users of reproductive age, this group was not included in the figure below.

**FIGURE 3: NUMBER OF NEW CONTRACEPTIVE USERS AND SRH CONSULTATIONS IN PROJECT-SUPPORTED SITES IN MOZAMBIQUE, BY AGE, OVER TIME**

Data from April 2015 to March 2016 shows new contraceptive users, and data from April 2016 to December 2016 shows new SRH consultations (appointments that girls and women have when seeking SRH services outside of maternity and emergency gynecological visits) due to a change in the Ministry of Health reporting systems. Despite the change in data collection during implementation, data suggests an increase in both new users over time and new SRH consultations over time.
by method as a way of estimating new users by method. In Mozambique, of the 69,710 referrals for contraceptive services made by CHWs in 2016, 3,870 were referrals for IUDs and 31,245 were for implants. Thus, approximately half of the referrals were for LARCs. Of the referrals for IUDs, 907 (23.4 percent) were for clients between 10 and 24 years of age. Of the referrals for implants, 11,961 (98.3 percent) were for clients between 10 and 24 years of age. This project data, when compared with data from the 2011 Mozambique Demographic and Health Survey, indicates the project’s success in reaching the youngest cohort of women of reproductive age in project sites.

To better understand persisting judgment and bias in SRH services provision for adolescents and youth, the project collected data on the methods clients were referred for in comparison to those that they received at the facility, by age. Data from Tanzania shows that, of the 41,543 clients referred by CHWs for contraceptive methods in 2016, 24.4 percent were between the ages of 10 and 24 and 89 percent of these clients received the method for which they were referred. Similarly, 85 percent of clients ages 25 and older received the contraceptive method for which they were referred. In Mozambique, 69,710 clients were referred by CHWs for contraceptive methods in 2016. Of these clients, 34 percent were between the ages of 10 and 24, and 71 percent of these clients received the method for which they were referred—compared to 68 percent of clients ages 25 and older.

To understand whether providers were offering quality contraceptive services to youth, mentors tracked whether providers offered the full contraceptive method mix to youth. In Mozambique, of the 12 provider-client interactions that mentors observed in 2016, in which clients were youth between the ages of 10 and 24, providers offered the full method mix to 83 percent of clients. Similarly, in Tanzania, mentors reported that providers offered the full method mix to 87 percent of the clients in the 71 provider-client interactions mentors observed in which clients were between the ages of 10 and 24.

Finally, project data from 2016 shows that similar proportions of 10 to 24-year-olds and those 25 years and older responded to Citizen Report Card questions about satisfaction with facility-based SRH services. In Mozambique, 39 percent of clients over 25 who were offered the survey responded to: “Is the client satisfied with the family planning services she received at the facility?” Similarly, 40 percent of clients between the ages of 10 and 24 responded to the same question. In Tanzania, 60 percent of adults offered the survey responded to questions about satisfaction with services, and 59.5 percent of youth did so.

In Mozambique, of the 9,591 youth that responded to the Citizen Report Card and for whom age data was recorded, almost all responded that they were highly satisfied or satisfied with the family planning services they received at the facility, and almost all respondents reported that they were treated with respect by the provider. Data from Tanzania tells a similar story—almost all the 6,054 youth respondents were satisfied with the family planning services provided and almost all respondents report being treated with respect, suggesting that provider training and mentorship contributed positively to how youth experience SRH services.

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**TABLE 2: NUMBER OF YOUTH REFERRED FOR CONTRACEPTION, AND NUMBER OF YOUTH WHO RECEIVED THE CONTRACEPTIVE METHOD FOR WHICH THEY WERE REFERRED.**

The high percentage of youth who received the method for which they were referred suggests a lack of the explicit bias which manifests through service provision to youth.

<table>
<thead>
<tr>
<th></th>
<th>TANZANIA</th>
<th>MOZAMBIQUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients referred for contraception</td>
<td>41,543</td>
<td>69,710</td>
</tr>
<tr>
<td>Number of clients referred for contraception, ages 10 to 24</td>
<td>10,170</td>
<td>23,781</td>
</tr>
<tr>
<td>Number of clients referred for contraception, ages 10 to 24, who received the methods for which they were referred</td>
<td>9,004</td>
<td>16,850</td>
</tr>
</tbody>
</table>
Recommendations

Performance data as well as implementation experience and resulting adaptations support important recommendations to promote future YFS mainstreaming and AYSRH programming.

Expand solicitation of youth feedback on service delivery

A crucial component of a rights-based, youth-friendly approach to SRH services involves youth participation and feedback on SRH services and programming. However, how to encourage and elicit such participation and feedback has traditionally been a challenge. Implementation experience and project data from Mozambique and Tanzania show that the project was successful in eliciting feedback from youth—digital health tools elicited almost identical rates of participation from youth and adults, suggesting that future efforts could consider digital methods to ensure youth participation in implementation. However, adaptations to this approach could also be considered to elicit more nuanced feedback from more youth. Because the Citizen Report Card was integrated into the CHW job aid, only youth clients who were reached by CHWs could provide their feedback. Youth who sought SRH services but were not visited by CHWs were not represented by data from the Citizen Report Card. Further, future programming should consider asking questions—such as why youth were or were not satisfied with services—that would elicit more nuanced feedback and help capture any persisting implicit bias to help improve programming.

Collaborate with government for youth-friendly and responsive systems-level interventions

By integrating youth-friendly and responsive approaches into the systems and practices of MAIS and Chaguo la Maisha, the project was able to increase uptake of SRH services and LARCs among youth. Further, because these approaches were embedded into how SRH services are provided—rather than unique and discrete interventions targeting specific populations—this mainstreamed approach is sustainable and scalable. To increase sustainability and scalability, the health system as a whole must be responsive to the needs of adolescents and youth. During implementation, the project identified systems-level barriers to age-disaggregated data collection and youth participation. In Mozambique, a change in how the Ministry of Health collected data through its logbooks required the project to look at different data points and sources to estimate the number of new users by age. In addition, despite Mozambican Ministry of Health guidelines that permitted youth participation in co-management committees, youth participation remained low. In Tanzania, CHWs were not included in the Ministry of Health guidelines regarding participation in the health center committees, and thus, the committees lacked the insights from individuals with significantly relevant experience. Building a health system that is fully responsive to the needs of adolescents and youth requires further advocacy with governments around age-disaggregated data collection and youth participation.

Shift from one-size-fits-all toward context- and youth-responsive models of service delivery

Implementation experience and performance data from this project suggest that alternative models of service delivery should be considered to meet the needs of adolescents and youth. Context-specific elements—such as high demand for information and services among very young adolescents in Mozambique, and low demand for IUDs and low demand among secondary-school aged youth in Tanzania—caused the project to adapt implementation to ensure that providers were adequately trained and youth were reached with information to build skills to practice healthy SRH behaviors, thus meeting YFS quality standards. Such adaptations are supported by the lessons and research that led to the development of the Pathfinder-led Evidence to Action project’s Thinking outside the separate space: A decision-making tool for designing youth-friendly services, in which different models of youth-friendly service delivery are recommended depending on the characteristics of the context in which a project is working. Shifting away from a separate spaces model represents a significant conceptual shift for project staff, local implementing partners, and government
partners—who, first and foremost, want to ensure that adolescents and youth are receiving services that are private and confidential. Findings from this project suggest that making this conceptual leap, and fully integrating YFS into every component of a project from inception, can lead to increased uptake of SRH services and LARCs by adolescents and youth.

Future mainstreamed AYSRH programming should consider going further: efforts to strengthen national systems around serving young people can enhance sustainability and scalability of YFS and can ultimately lead to health systems that are responsive to adolescents and youth and that reach the largest number of young people possible.

ENDNOTES

Conclusion and next steps
The MAIS and Chaguio la Maisha approach represents a thoughtful shift away from a one-size-fits-all model of youth-friendly service delivery, to a more context-specific, mainstreamed approach—an approach that allows for longer-term sustainability and scalability of YFS. As demonstrated by the project experience, such systematic decision-making in the design and implementation stages of service delivery models can yield impressive results, such as significant youth uptake in services—particularly for LARCs.

ABOUT THE PROJECT
Funded by an anonymous donor, the Strengthening Contraceptive and Abortion Service Delivery in Urban Mozambique and Tanzania project (2015-2017) was designed to create an environment that enabled women of reproductive age to choose whether and when to bear children. Working with facilities in the public sector, communities, and the spaces in which the two interact, the project aims to increase effective contraceptive uptake specifically among postpartum and lactating women, postabortion women, and adolescents and youth, and to ensure that high-quality abortion services are provided to those who intend to terminate their pregnancies. The project is implemented in the Temekte and Ilala districts of Tanzania, and Maputo City and Maputo Province in Mozambique.

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cover: Mother and baby outside a health facility in Maputo, Mozambique.  photo: Anna Tomasulo