GENDER LINKS
FOR EQUALITY AND JUSTICE

RAPID ASSESSMENT OF

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (ASRHR)

IN SIX SADC COUNTRIES

PRELIMINARY FINDINGS

AMPLIFYCHANGE

Table of key indicators

Indicator/Country	Botswana		Eswatini		Lesotho		Madagascar		Zambia		Zimbabwe	
	Yes	No/ N/A	Yes	No/ N/A	Yes	No/ N/A	Yes	No/ N/A	Yes	No/ N/A	Yes	No/ N/A
Logistic information on health facilities (%)												
Health facility within 10km from your home	78	22	29	71	68	32	65	35	89	11	67	33
Does the facility open after school?	22	78	27	73	43	57	77	23	76	24	63	37
Does the facility open on weekends	59	41	45	55	41	59	74	26	93	7	77	23
Does the facility have a comfortable waiting area?	70	30	92	8	80	20	82	18	80	21	77	23
Proportion of respondents who paid a fee?	0	100	87	13	42	58	83	17	80	20	72	28
How much is the fee in USD?	0		2		2		2		2		4	
Quality of care (%)												
Are peer counsellors available?	61	39	16	84	56	44	77	23	62	38	71	29
Young people are treated with respect	97	3	96	4	69	31	91	9	94	6	82	18
Young people have privacy and confidentiality	85	15	95	5	67	33	73	27	98	2	74	26
Young people are treated without parental consent	71	29	88	12	38	62	68	32	49	51	55	45
Do health workers spend sufficient time with young people?	54	46	95	5	42	58	80	20	94	6	68	32
Young people receive appropriate information	47	53	91	9	86	14	80	20	75	25	73	27
Sexual and reproductive health services (%)												
Maternal health												
Young people requested contraceptives	36	64	16	84	50	50	40	60	28	72	26	74
Young people received contraceptives	94	6	95	5	77	23	82	18	84	16	80	20
Young women requested a pregnancy test	31	69	22	78	35	65	37	63	27	73	24	76
Young women received a pregnancy test	74	29	92	8	65	35	82	18	71	29	57	43
Young women who are pregnant	4	96	20	80	15	85	4	96	1	99	9	91
Requested ante-natal care	31	69	59	41	73	27	66	34	77	23	72	28
Received ante-natal care	73	27	98	2	83	17	90	10	70	30	95	5
Requested prevention of mother-to-child transmission (PMTCT)	9	91	21	79	44	56	55	45	39	61	24	76
Received PMTCT	67	33	89	11	72	28	72	28	100	0	91	9
Requested for post-natal care	0	100	4	96	15	85	14	86	4	96	5	95
Received post-natal care	50	50	79	21	64	36	84	16	100	0	65	35
Requested help with breast feeding	0	100	3	97	21	79	12	88	3	97	6	94
Received help with breast feeding	0	100	100	0	64	36	76	24	100	0	83	17
Menstrual health												
Requested pads	2	98	7	93	24	76	9	91	6	94	29	71
Received pads	21	79	87	13	21	79	74	26	81	19	65	35
HIV and AIDS												
Requested male circumcision	33	67	23	77	79	21	22	78	56	44	49	51
Received an appointment	74	26	75	25	83	17	68	32	96	4	90	10
Requested PREP	0	100	0	100	7	93	16	84	2	92	6	63
Received PREP	0	0	0	0	38	62	74	26	55	45	69	31
Requested post-exposure prophylaxis (PEP)	0	100	1	99	3	97	9	91	9	91	2	98
Received PEP	0	100	100	0	31	69	78	22	54	46	67	33
Requested HIV test	30	70	81	19	69	29	22	52	59	41	37	61
Received HIV test	87	13	98	2	95	5	90	10	99	1	83	17
Requested sexually transmitted infection (STI) test	21	79	4	94	24	76	18	54	15	85	14	84
Received STI test	98	2	89	11	87	13	86	14	92	8	74	26
Requested anti-retrovirals (ARVs)	2	98	2	98	7	93	8	92	3	97	8	92
Received ARVs	100	0	43	57	59	41	68	32	90	10	84	6
Health worker asked about mental health	13	87	29	71	31	69	52	48	45	55	54	46
Follow up and referral												
Made a follow up appointment	6	94	79	21	80	20	77	23	45	55	54	46
Referred to a relevant facility	9	91	57	43	68	32	84	16	61	39	62	38

EXECUTIVE SUMMARY

Nearly two fifths of young people who sought Sexual and Reproductive Health (SRHR) Services in six Southern African countries were denied these services because they were not accompanied by a parent or family member. More than two thirds had to pay a fee for the health services they received. These services cost an average of $2, which is 9-20% of the daily income in the countries surveyed. But 89% of the those who accessed services said that health personnel treated them with respect. 81% said they were accorded privacy and confidentiality.

These are among the preliminary findings of the Adolescent Sexual and Reproductive Health and Rights (ASRHR) Rapid assessment undertake in Botswana, Eswatini, Lesotho, Madagascar, Zambia and Zimbabwe from November 2019 to April 2020. The study will be rolled out to Mauritius, Mozambique, Namibia and South Africa between June and August 2020.

The purpose of this research is to strengthen youth-led and focused efforts to promote ASRHR through gender and youth responsive local governance.

The research included 9984 adolescents between ages 10 and 19 in six countries, 5170 (52%) females and 4808 (48%) males. The survey is being carried out with the Centres of Excellence for Gender in Local Government with the support of Hivos and Amplify Change. Other key preliminary findings include:

- 70% of the sample had a health facility within 10km of their homes while 29% did not have a health facility within 10km of their homes.
- 64% of the respondents reported meeting peer counsellors in the health facilities they visited.
- 32% of the sample requested contraception and 84% of these received contraception.
- 6% of the female respondents requested a pregnancy test and 6% requested post-natal care.
- 42%, of respondents requested an HIV test and 16% requested a sexually transmitted infection (STI) test; most received these tests.
- 72% of the sample received materials tailor made for their needs. About a quarter of the sample did not receive youth friendly information that is relevant and responds to their needs.
- 51% of the sample received follow up appointments and 56% received a referral to another facility.

Currently five countries (Botswana, Lesotho, Madagascar, Zambia and Zimbabwe) have ASRHR policies in place, Eswatini does not have an ASRHR policy. Botswana's policy ended in 2016 and all the other countries' ASRHR policies expire in 2020. There is need to lobby for ASRHR policies that are youth friendly in all five countries.

At a policy and legislative level, it must be clear that young people can access SRH services without third party authorisation. Health workers insisting on a parent or family member being present will mitigate against young people going to health facilities. Only Madagascar provides for adoles-cent access to SRHR services without parental consent.

BACKGROUND AND CONTEXT

Young people constitute 60% of the population of the Southern African Development Community (SADC), yet face the most challenges in accessing SRHR services particularly outside capital cities. Cultural, religious and other barriers to ASRHR services is reflected in high levels of teenage pregnancies; unsafe abortion; early marriages; GBV; and the resurgence of HIV and Aids, especially among young women. Youth led advocacy to challenge social and gender norms on ASRHR needs to be strengthened.

Adolescents and youth face many risks as they navigate their lives - unemployment and economic exclusion, unwanted pregnancies, high maternal deaths, sexually transmitted infections (STIs) and gender-based violence.

Death in childbirth and HIV-related complications are the two main causes of mortality among young women in the region. A high proportion of girls do not want to fall pregnant but are not using contraception, and unsafe abortions continue to contribute to maternal deaths and injuries. When teenagers become mothers and fathers, they are often unable to reach their full potential.

Due to the sheer number of young people, their sexual behaviour will shape the course of the entire African continent. It is, therefore, critical to invest in young people's sexual and reproductive health. Research shows that investments in reproductive health protect the well-being of young people, maximise their potential for healthy and productive lives, and improve social and economic development.[1]

Despite considerable progress since the International Conference on Population and Development (ICPD) 25 years ago, millions of people especially youth, and mostly disadvantaged youth and adolescents still lack access to ASRH information and services. Key SRHR concerns relating to youth include:

- Significant percentages of sexually active adolescents below the age of 16.
- Multiple concurrent sexual relations; increasing trends of inter-generational sexual relations. Low levels of consistent condom usage during sex.
- High levels of maternal mortality amongst young mothers.
- Compromised quality of antenatal care to young mothers compared to older mothers.
- High levels of HIV and AIDS among young people, especially young women, and high levels of GBV.
- Child marriages remain a huge concern with an increasing number of adolescent girls being married to older men.
- Punitive policies and restrictive laws against vulnerable groups create barriers to their access to SRHR services.

Countries with stand-alone ASRHR policies across SADC[2]

Country	Stand-alone policy or strategy
Botswana	Yes, *Adolescent Sexual and Reproductive Health Implementation Strategy 2012-2016*
Eswatini	No
Lesotho	Yes, *National Health Strategy for Adolescents and Young People 2015-2020*
Madagascar	Yes, *Adolescent and Youth Health Strategy (2016-2020)*
Zambia	Yes, *National Adolescent and Youth Health Strategy (2016-2020)*
Zimbabwe	Yes, *Adolescent Sexual and Reproductive Health Strategy (2016-2020)*

Source: African Health Observatory

Ten SADC countries have stand-alone adolescent SRHR policies or strategies, these include Botswana, Comoros, DRC, Lesotho, Madagascar, Malawi, South Africa, Tanzania, Zambia, and Zimbabwe. In other countries, adolescent SRHR is included in the national SRHR policies, strategies or guidelines.

1 https://esaro.unfpa.org/en/topics/young-people
2 aho.afro.who.int/profiles_information/index.php/

Parental consent for ASRHR services in Southern Africa, 2018[3]

Country	Not required	Yes, if under age 14	Yes, if under age 16	Yes, if under age 18
Botswana			X	
Eswatini				X
Lesotho		X		
Madagascar	X			
Zambia			X	
Zimbabwe			X	

Source: UNAIDS

Only five countries (Madagascar, Mozambique, Namibia, South Africa and Tanzania) in SADC do not require parental consent for adolescents to access SRHR services. In Comoros, Lesotho, Malawi and Mauritius parental consent is required if you are under age 14, this applies to Botswana, Zambia and Zimbabwe if you under age 16. In Angola, DRC, Eswatini and Seychelles adolescents under the age of 18 cannot access SRHR without parental consent.

Although implementation of progressive laws and policies on SRHR is slow in SADC, there are strong institutional structures and an enabling environment necessary for the implementation of this programme. There is also an emergence of a new cadre of young leaders and youth organisations who are seeking to take the lead on advocating for tailored SRH services.

Through this Assessment GL will identify the key barriers to adolescent access to SRHR services and the gaps in services. The results of the assessment will provide local councils and health facilities with evidence to guide their SRHR interventions. The findings of the assessment will yield data that will be used to lobby for strengthened ASRHR policies and legislation at a national level.

What are youth friendly ASRHR services[4]

The International Planned Parenthood Federation (IPPF) provides guidelines on youth friendly services and the key elements that should be included for effective service delivery.

Youth-friendly services

Youth-friendly service delivery is about providing health services based on a comprehensive understanding of what young people in any given society or community want and need. It is also based on an understanding of, and respect for, the realities of young people's diversity and sexual rights. A youth-friendly approach requires offering young people a wide range of sexual and reproductive health services, including:

- Sexual and reproductive health counselling.
- Contraceptive counselling and provision (including emergency contraception).
- Abortion services.
- Prevention, testing and counselling services for HIV and other STIs.
- Prenatal and postpartum services.
- Sexual abuse counselling.
- Relationship and sexuality counselling.

Youth-friendly service delivery should also take into account the special needs of young people including:

- Where possible, these services should be provided in an integrated manner at the same delivery point to allow for ease of access for young people.
- The financial barriers that young people can face should also be recognised and services should be provided free of charge or at a discounted rate to young clients.
- Services are only truly youth-friendly if young people themselves are involved in determining the content, scope, and monitoring and evaluation of such services.

[3] http://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf
[4] http://www.ippf.org/our-work/what-we-do/adolescents/services

METHODOLOGY

The research questionnaire was designed to assess the extent to which ASRHR services are youth friendly in ten Southern African countries. The questionnaire is self-administered by adolescents after they have been to a health facility seeking services that they need. The questionnaire is available online through Survey Gizmo, an online data gathering technology. Internet access is facilitated through local councils or by providing resources for Internet access in the local councils. None of the young people received any payment to participate in the survey. GL assisted with local travel costs where needed.

Young people participating in a menstrual health campaign at the Lavumisa Town Board, Eswatini. Photo: Thandokuhle Dlamini

The questionnaire gathered the following demographic data on country; council; health facility; name and surname; sex; age and date. Quantitative data is gathered to assess the following areas:

- *Logistical information on the health facility:* distance to the facility; opening times and days; physical environment; fees.
- *Quality of care:* treatment with respect; privacy and confidentiality; observes the guidelines with regard to consent; provides appropriate information.
- *Sexual and reproductive health services:* contraceptives; maternal health; HIV and AIDS; sexually transmitted diseases (STIs); circumcision; sanitary ware; mental health.
- *Follow up and referral:* made a follow up appointment; referred to the relevant facility.

Research sites and sample

In the ASRHR Rapid Assessment GL employs purposive sampling. The main goal of purposive sampling is to focus on particular characteristics of a population that are of interest, which will best enable you to answer your research questions.

GL is conducting the Rapid Assessment in public health facilities in the local councils that are part of the GL Centres of Excellence for Mainstreaming Gender in Local Councils (COEs). The sample is a selection of councils from the COEs where GL rolled out SRHR training and planning as part of the #Voice and Choice campaign. In August 2018, senior local government officials and youth representatives from all the COE countries met to develop SRHR training materials for local councils. This meeting paved the way for training workshops in each country to develop SRHR strategies in local councils that are youth responsive).

The adolescents who comprise the sample are sourced through the junior councils and youth organisations that GL and the local councils have worked with on the SRHR campaigns.

Research sample to date

Country	No. of COEs	No. of clinics	Female	Male		Total
Botswana	10	59	924	932		1856
Eswatini	11	22	423	320		743
Lesotho	11	16	281	304		585
Madagascar	10	27	1079	912		1991
Zambia	4	58	920	893		1803
Zimbabwe	13	152	1544	1447	5	2996
Total	**59**	**334**	**5170**	**4808**	**5**	**9984**
Overall %			**52%**	**48%**	**0%**	

The total number of respondents from the six countries is 9984, 5170 (52%) young women and 4808 (48%) young men and five people identifying as gender non-confirming (GNC). Due to the low number of GNC persons GL could not draw any findings pertaining to the ASRHR needs.

Zimbabwe with the highest number of clinics in the research (152) had the highest number of respondents at 2996. Lesotho with only nine clinics had the lowest number of respondents at 585.

The World Health Organization (WHO) defines an **adolescent** as any person between ages 10 and 19. The research targeted adolescent females and males.

Age	Female	Male	GNC	Total	%
10	134	107		241	2%
11	151	152		303	3%
12	242	189		431	4%
13	322	244	2	566	6%
14	445	356	1	801	8%
15	626	552		1178	12%
16	867	751		1618	16%
17	775	789		1564	16%
18	871	862	2	1733	17%
19	738	806		1544	15%
Total	**5171**	**4808**	**5**	**9984**	**100%**

The largest proportion of the sample, female and male, were 18 years old, followed by 16, 17 and 19 year olds respectively. Small proportions 10, 11 and 12 year olds visited the clinics. Of the total sample 13 and 14 olds constituted 6% and 8% of the sample respectively.

Ethical considerations

Obtaining consent for young people (YP) to participate in research is often a more complex procedure than from older persons. Many researchers working with YP recognise the need to view them as autonomous individuals, capable of making their own decisions. However, in practice this is constrained by legislation, which limits those under certain ages from providing consent on the assumption that they are not able to make the decision on their own.

Generally, the approval of gatekeepers in the community such as teachers, religious leaders, local government representatives, and even health or education ministries, departments and agencies are necessary for Sexual and Reproductive Health (SRH) research involving YP.

However, according to UNFPA, adolescents enrolling in research must be capable of understanding the purpose, procedures, risks, benefits, and alternatives of the research, and consent must be voluntary. Researchers should seek assent of the adolescent according to his/her level of development and capacities.[5] GL held briefing sessions with all respondents to ensure that they understood that their participation in the research was anonymous and that the purpose of the research was to understand the challenges adolescents face in accessing SRHR services. The findings of the ASRHR rapid assessment will guide lobbying and advocacy for youth friendly ASRHR services.

[5] https://icop.or.ke/wp-content/uploads/2016/10/Adolescents-Guidance-on-HIV-SRH-Research.pdf

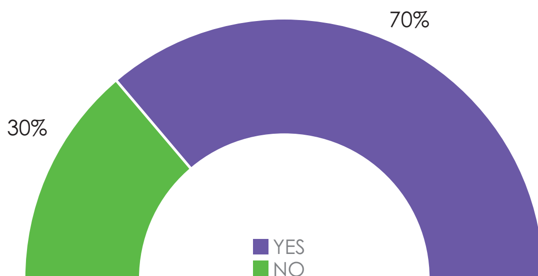
FINDINGS

All the data in the study is disaggregated by sex. The results are presented for the whole sample because the responses by female and male respondents did not have any substantial variations. In the final report that will include ten countries, further analyses will be done by sex and age.

Logistic information on health facilities

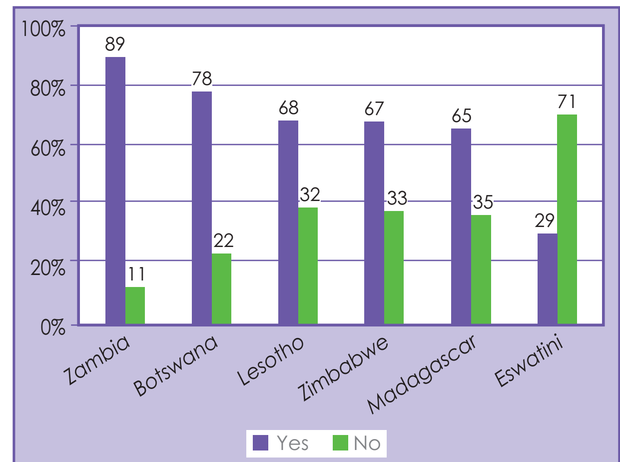
This section of the report covers the different aspect relating to accessibility of the health facility. These include physical distance and environment in the health facility as well as the cost of the service.

Is the health facility within 10km from your home?



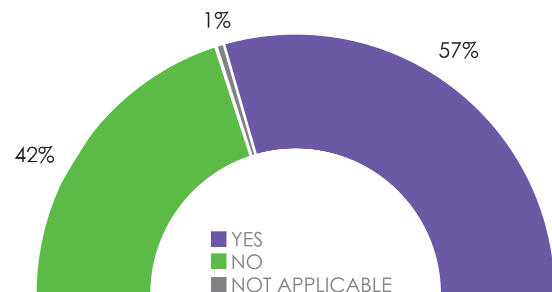
Of the total sample, 70% of young people had a health facility within 10km from their homes. It is of concern that almost 30% of the sample of young people have to travel further to access health care.

Is the health facility within 10km from your home in country



In Zambia, 89% of the young people had access to a health facility within 10km of their homes. Botswana at 78% follows Zambia. In Lesotho, Madagascar and Zimbabwe between 65 and 68% of the adolescents had access to health facilities within 10km of home. Only 29% of young people in the sample from Eswatini had access to a health facility within 10km of their homes. Young people generally will not have the resources to travel long distances to access health care. Ultimately as part of the push to increase universal health coverage all health facilities should offer free services.

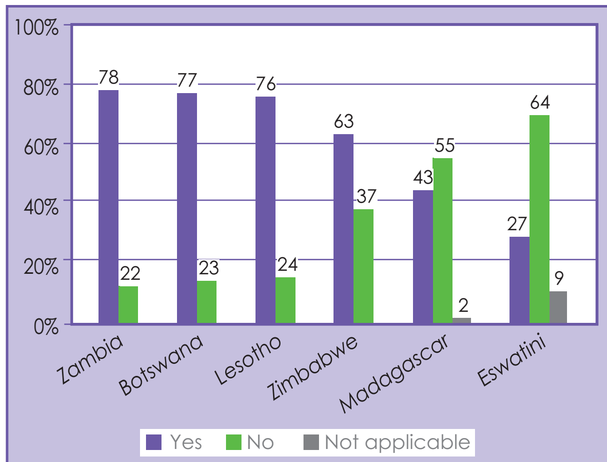
Does the facility open after school?



Of the total sample 57% of the respondents said that health facilities open after school.

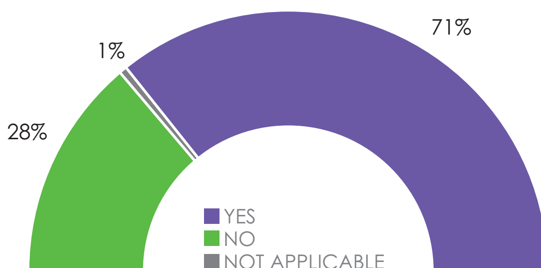
In the final report that will include ten countries, further analyses will be done by sex and age.

Does the facility open after school by country



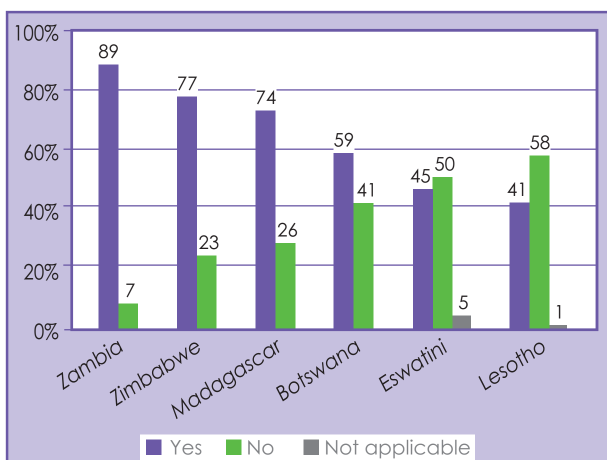
In Botswana, Madagascar and Zambia between 76% and 78% of the respondents said the health facilities were accessible after school, 63% of the sample state health facilities in Zimbabwe open after school. More than 50% of respondents in Lesotho (55%) and Eswatini (64%) reported that health facilities were not accessible after school.

Does the facility open on weekends?



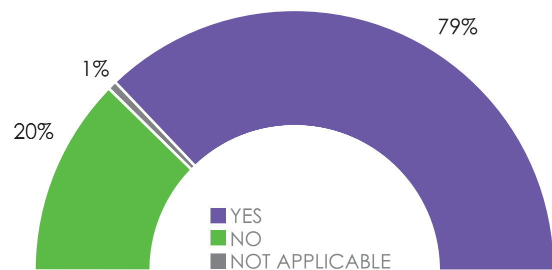
A high proportion, 71%, of the sample stated that health facilities open on weekends.

Does the facility open on weekends by country?



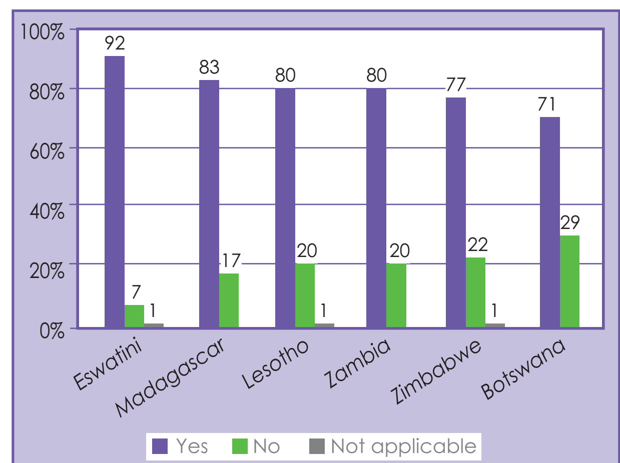
In Zambia, 89% of the respondents reported that the health facilities open over weekends. In Zimbabwe and Madagascar between 74% and 77% of respondents said the health facilities are accessible during weekends. A lower proportion of respondents (59%) stated that health facilities are open during weekends. Half the sample in Eswatini and 58% of the respondents on Lesotho reported that health facilities do not open over weekends.

Is there a comfortable waiting and consultation area?



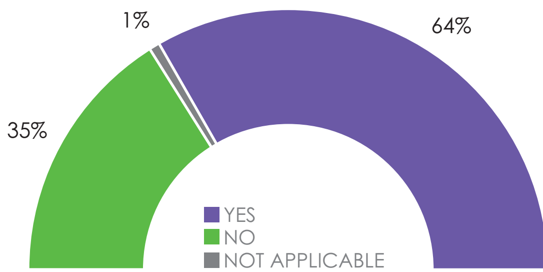
A high proportion of the respondents (79%) reported a comfortable waiting area in the health facility.

Is there a comfortable waiting and consultation area in country?



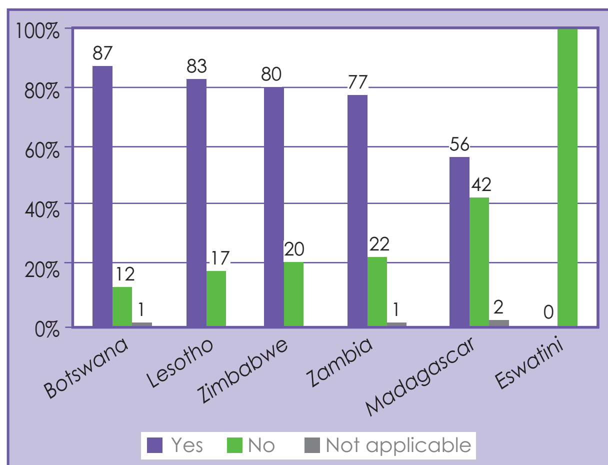
Most adolescents in the sample reported that the waiting areas in health facilities were comfortable. Eswatini (92%) had the highest proportion of adolescents reporting a comfortable waiting area. Botswana (71%) had the lowest proportion of respondents that found the waiting area in the health facilities comfortable.

Proportion of respondents who paid a fee



64% of young people in the sample had to pay a fee for health services.

Proportion of respondents who paid a fee by country



This varied widely by country. In Botswana, the services were free. 56% of respondents in Lesotho did not have to pay. In Eswatini (87%), Madagascar (83%), Zambia (80%) and Zimbabwe (77%) of respondents paid fees for health services.

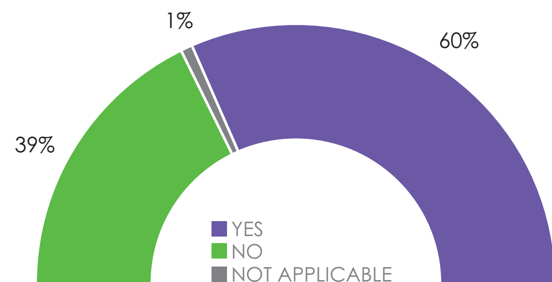
Country	Fee in USD	Average daily income in USD[6]	Fee % of daily income
Botswana	$0	$33	0%
Eswatini	$2	$9	22%
Lesotho	$2	$22	9%
Madagascar	$2	$11	18%
Zambia	$2	$11	18%
Zimbabwe	$4	$20	20%
Average	**$2**	**$18**	**11%**

Fees for health services range from $4 in Zimbabwe to $0 in Botswana. The average fee is $2 across all six countries. In Eswatini the $2 fee constitutes 22% of the average daily income of $9 while the $4 constitutes 20% of the average daily income in Zimbabwe. In Madagascar and Zambia, the $2 is 18% of the average daily income and 9% of the average daily income in Lesotho.

These relatively high fees for ASRHR services are likely to be a disincentive to young people to seek out such facilities. Many young people seek health services independently of their parents. Acquiring fees for health services will be difficult as most adolescent do not earn an income. There is an urgent to lobby and advocate for free health services for adolescents in all countries.

Presence of parents

Health care worker treated young person without parent present

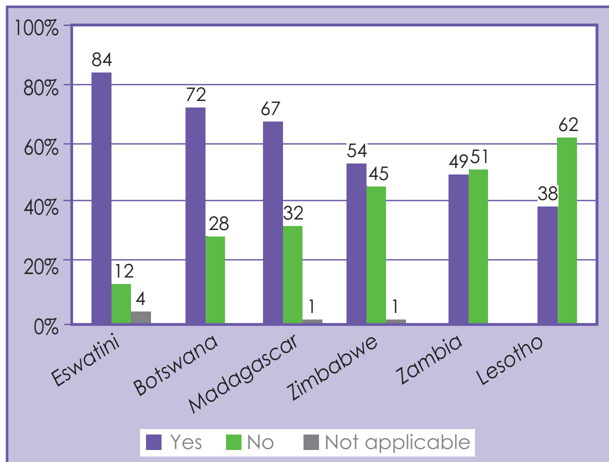


Adolescents are generally not comfortable discussing their SRHR needs in the presence of their parents. One of the main lobbying and advocacy points on adolescent SRHR is to access SRHR services without parental consent. Of the total sample only 60% received the services they requested at the health facility without a parent present, 39% of the sample did not receive any services.

Adolescents are generally not comfortable discussing their SRHR needs in the presence of their parents

[6] http://www.salaryexplorer.com/?loc=208&loctype=1#browsesalaries

Health care worker treated young person without parent present in country

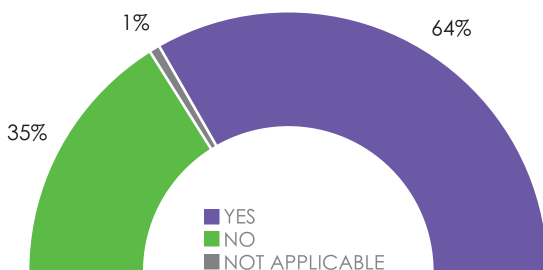


There are however variations between countries. In Eswatini 84% and in Botswana 72% of the respondents received treatment without a parent present. In Lesotho 62% of the sample were refused treatment because there was no parent present, followed by Zambia (51%) and Zimbabwe (45%).

Quality of care

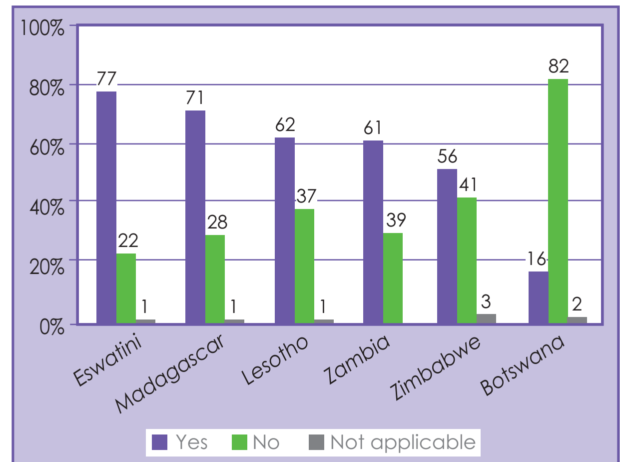
This section of the report explores whether health facilities are youth friendly. The section includes analyses on how young people are treated and personnel available to service their needs.

Are there peer counsellors available?



Of the total sample 64% of the respondents indicated that there were peer counsellors in the health facilities visited. The presence of peer counsellors is an important component of youth friendly services. One of the challenges young people face in accessing SRHR is the inability to speak openly with older health workers.

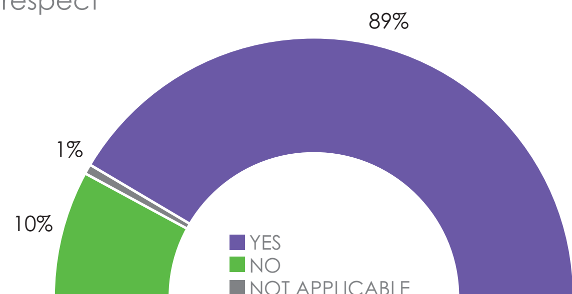
Are there peer counsellors available in health facilities in country?



In Madagascar and Zimbabwe over 70% of respondents indicated that there were peer counsellors in the health facilities visited. In Lesotho, Botswana and Zambia between 56% and 62% of respondents reported that there were peer counsellors at the health facilities visited. At 16%, Eswatini had the lowest number of respondents that reported there were peer counsellors at the health facility visited. This is an area that needs urgent attention in Eswatini.

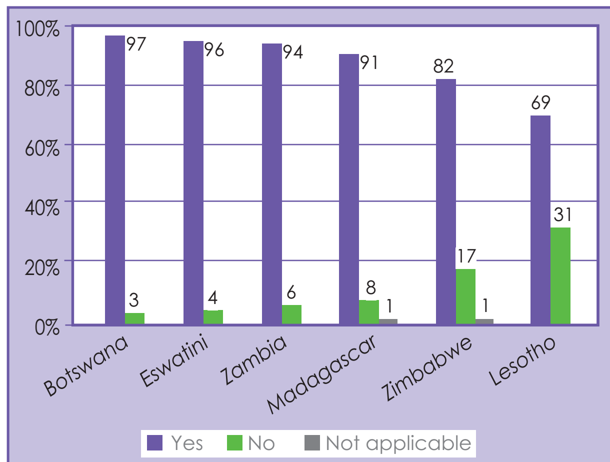
Only 10% of adolescents felt disrespected

Health care worker treats young person with respect



A vast majority (89%) of respondents in the sample indicated that they had been treated with respect with 10% of adolescents in the sample feeling disrespected.

Health care worker treats young person with respect in country

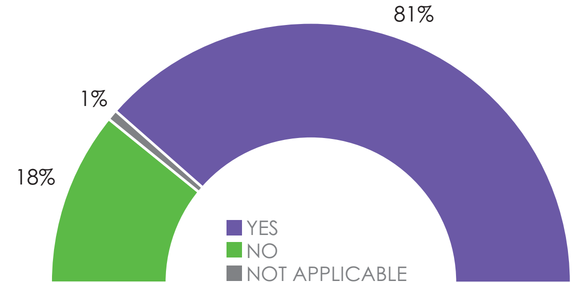


The highest proportion of respondents (between 91% and 97%) that felt respected in their treatment at health facilities came from Botswana, Eswatini, Zambia and Madagascar. A lower proportion of respondents (82%) from Zimbabwe felt that they had been treated with respect. At 69%, Lesotho registered the lowest proportion of respondents that they felt respected during their visit at the health facility.

Why respondents felt disrespected?	%
My sessions was interrupted several times	36%
Told I was too young	19%
The staff did not want to answer my questions	15%
Did not trust the person I spoke to	14%
Told I needed to be accompanied by an adult	10%
Told I was naughty	10%
They couldnot answer my questions	9%
I felt like they lied to me	8%
Told I was a drug user	4%
Not given services because I was a boy	1%
Not given services because I was a girl	1%
Based on religion	1%
Other	5%

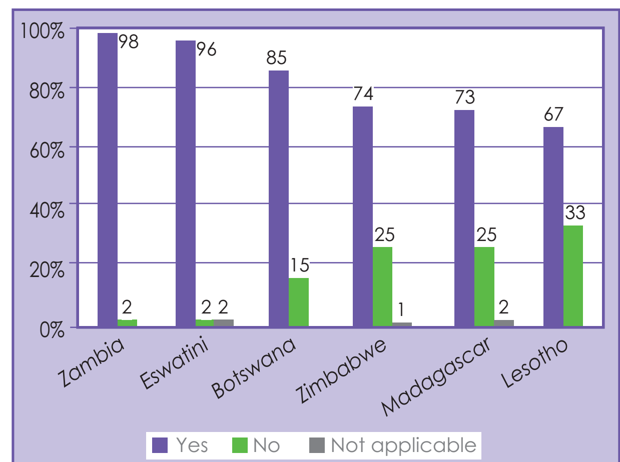
The reasons provided for why 10% of the sample felt disrespected range from being constantly interrupted (36%) to religious concerns (1%). In addition to constant interruptions, being told they were too young (19%), health personnel did not want to answer questions (15%), respondents felt that they could not trust the health personnel (14%) and equal proportions (10%) of respondents were told they needed to be accompanied by an adult and that they were naughty featured amongst the top six reasons why respondents felt disrespected.

Health care worker ensures there is privacy and confidentiality



Of the total sample of respondents 81% believed that their privacy and confidentiality had been respected. It is important that young people feel they can trust the health care facility and personnel with their SRH concerns. Of the total sample, 18% of respondents who received services indicated their privacy and confidentiality had not been respected.

Health care worker ensures there is privacy and confidentiality in country

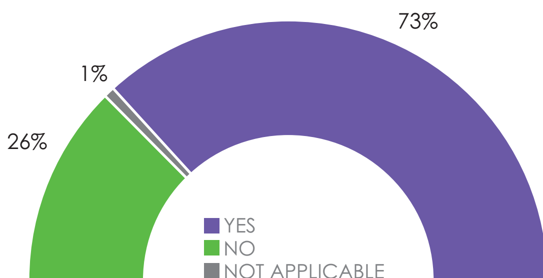


In Zambia, Eswatini and Botswana had the highest number of respondents, between 85% and 98%, that indicated that their privacy and confidentiality were respected. Approximately three quarters of the respondents in Zimbabwe and Madagascar felt that there was privacy and confidentiality during their visit to the health facility. The lowest proportion of respondents (67%) in Lesotho felt that they experienced privacy and confidentiality.

Reasons cited for a lack of privacy and confidentiality	%
My file was left open for others to see	33%
No confidential/private space	32%
They verbally announced which services I came for in public areas	27%
Told that they were going to tell my family that I was there	13%
They called my parents/family	13%

The three key concerns in relation to confidentiality and privacy were that their files were open for others to see, there was no private or confidential space for the consultation and that health personnel announced publicly which services they were there for. A lower proportion of respondents (13%) reported that health personnel told them that they were going to tell family about the visit and that they had called the parents or family.

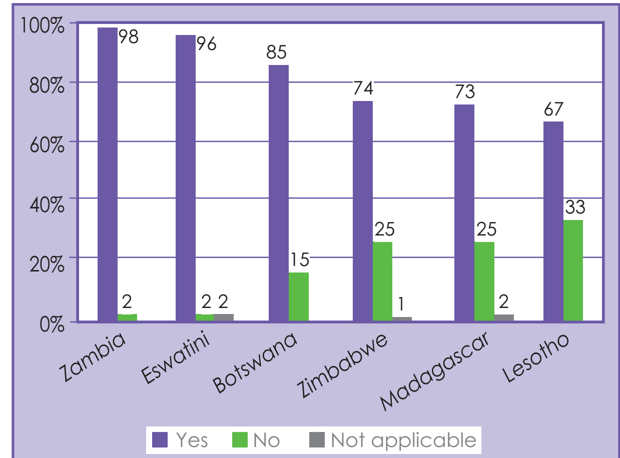
Health care worker spends sufficient time with young person



Junior Councillors at Harare City Council assisted with the ASRHR research.
Photo: Colleen Lowe Morna

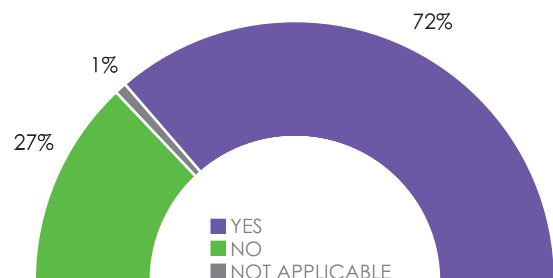
About three quarters of the respondents indicated that the health personnel spent sufficient time with them. Of the total sample, 23% of the respondents felt the health care workers did not spend sufficient time with them.

Health care worker spends sufficient time with young person in country



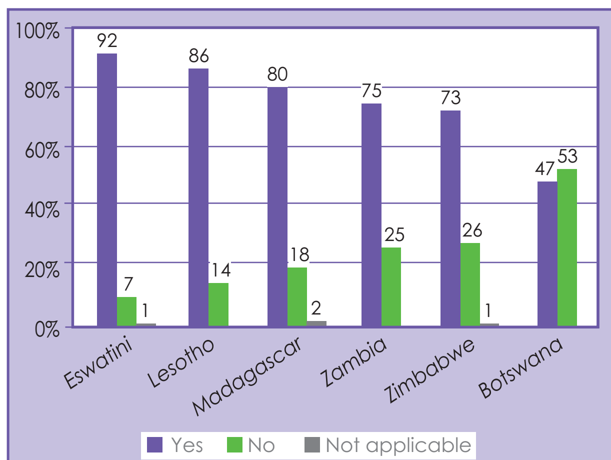
In Botswana, Eswatini and Zambia between 85% and 98% of respondents reported that they felt that the health workers had spent sufficient time with them. About three quarters of the respondents in Zimbabwe and Madagascar reported that they had sufficient time with the health personnel. The lowest proportion of respondents (67%) in Lesotho indicated that the health personnel spent sufficient time with them.

Health care worker provides information tailored to young person's needs



About three quarters (72%) of the sample indicated that they received relevant and appropriate information while 24% of the sample felt they did not receive required information targeted to adolescents.

Health care worker provides information tailored to young person's needs



In Eswatini, 92% of respondents reported that the information they received was tailored to their needs. In Lesotho and Madagascar, 86% or 80% of the respondents respectively, indicated they received relevant and accessible information. About three quarters of respondents in Zambia and Zimbabwe indicated that the information they received was tailored to their needs. Less than 50% of the respondents in Botswana felt that they had received information tailored to their needs.

While overall the findings are encouraging it is a major concern that almost a quarter of the sample felt they did not have the information they needed to make decisions. This an area that needs to be addressed. Targeted information particularly on adolescent access to SRH, contraception and HIV and AIDS amongst others is critical for young people. The Sex Rights Africa Network, managed by the AIDS Foundation of South Africa in partnership with Hivos, suggests that appropriate youth centred information must:

- Address the differences between facts and opinions (also cultural myths and sensitive issues such as sexual preferences).
- Give young people full, complete and up-to-date information and they are encouraged to make informed choices about their own life (as opposed to abstinence-only/ fear-based and prescribing approaches).[7]

Sexual and reproductive health services

This section of the report covers maternal health, menstrual health, HIV and AIDS and mental health.

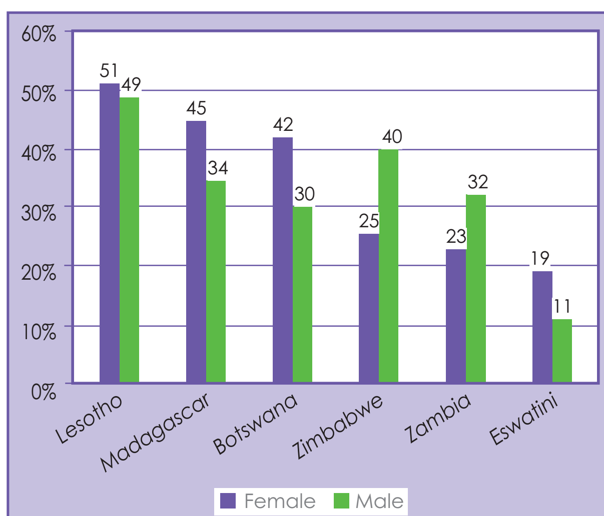
Maternal health

Young women and men requested and received contraceptives

	Female	Male
Requested contraception	40%	38%
Received contraception	88%	89%

An examination of the data shows that 40% of female and 38% of male respondents requested contraception. Of those 88% of female and 89% male respondents received contraception.

Proportion of female and male respondents requested contraception in country



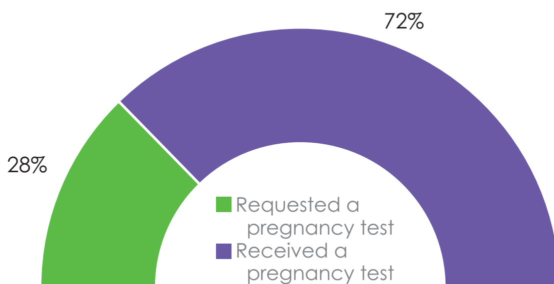
A further review of the data on contraception shows that almost equal numbers of female and male respondents in Lesotho request contraception. In Madagascar and Botswana higher

[7] https://www.sexrightsafrica.net/wp-content/uploads/2016/10/ASK-manual-2016_web.pdf

proportions, between 42% and 45%, of female respondents as opposed to between 30% and 34% male respondents requested contraception. Higher proportions of male respondents in Zimbabwe and Zambia requested contraception. Overall the proportion of adolescents requesting contraceptives in Eswatini is very low at 19% for female and 11% for male respondents.

Teenage pregnancies

Proportion of female respondents that requested and received a pregnancy test

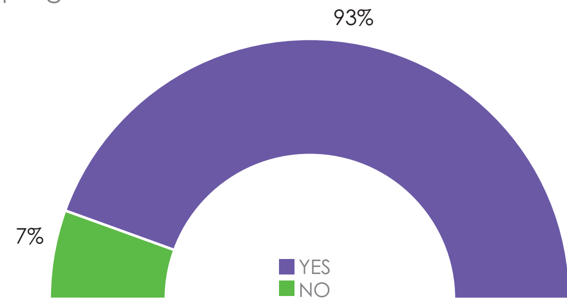


Of the total number of female respondents, 28% requested a pregnancy test and 72% of those received a pregnancy test.

Query	Bots	Esw	Les	Mad	Zam	Zim
Requested a pregnancy test	31%	22%	35%	37%	27%	24%
Received a pregnancy test	74%	92%	65%	82%	72%	57%

The highest proportion of female respondents requesting pregnancy tests was Madagascar and Lesotho at 37% and 35% respectively. While 82% of those requesting a pregnancy test received one in Madagascar a much lower proportion (65%) of female respondents who requested a pregnancy test in Lesotho received one. The highest proportion of female respondents (92%) who requested a pregnancy test received a pregnancy test in Eswatini and the lowest proportion of female respondents (57%) who requested a pregnancy test received one in Zimbabwe.

Proportion of female respondents who are pregnant



Of the total sample of female respondents 7% were pregnant at the time of conducting the survey.

Country	Proportion of female respondents who are pregnant	Percentage of adolescent live births per 1000 population
Botswana	4%	0%
Eswatini	20%	1%
Lesotho	15%	1%
Madagascar	4%	1%
Zambia	1%	1%
Zimbabwe	9%	9%

Source: Gender Links, 2020.

The highest proportion of female respondents who reported being pregnant were in Eswatini and Lesotho (20% and 15%) respectively. A comparison of the proportion of adolescent live births per 1000 population shows that the proportion of female respondents who are pregnant in Zambia and Zimbabwe correlate. However, the data in Madagascar and Botswana have some variation, between 3% and 4%. The figures of 20% and 15% of female respondents being pregnant in Eswatini and Lesotho is substantially more than the official data for adolescent live births per 1000 population at 1% in both countries.

Category	Six countries	Bots	Esw	Les	Mad	Zam	Zim
Ante-natal care							
Asked for an ante-natal check-up - while pregnant	65%	31%	59%	73%	65%	77%	72%
Received an ante-natal check up	91%	72%	98%	83%	90%	70%	95%
Requested PMTCT	28%	9%	21%	44%	55%	38%	24%
Received PMTCT	84%	67%	89%	72%	79%	100%	91%

Of the total sample of female respondents who reported being pregnant 65% asked for and 91% received ante-natal care. Of the total proportion of female respondents who were pregnant 28% requested and 84% received PMTCT. The highest proportion of female respondents who were pregnant were in Madagascar (55%) and Lesotho (44%) followed by Eswatini at 21%.

Only Zambia provided 100% of the female respondents who requested with PMTCT. Zimbabwe and Eswatini at 91% and 89% respectively follow. Botswana is a concern, with amongst the most effective HIV and AIDS strategies in the SADC region, only provided 67% of those who requested PMTCT with the service.

Category	Six countries	Bots	Esw	Les	Mad	Zam	Zim
Post-natal care							
Asked for a post-natal after giving birth	6%	0%	4%	15%	14%	4%	5%
Received a post-natal check up	78%	0%	79%	64%	84%	100%	65%
Asked for help with breastfeeding from a health care worker	6%	0%	3%	21%	12%	3%	6%
Received help on breastfeeding from a health care worder	79%	0%	100%	64%	76%	100%	83%

Out of the total sample of young women, 6% requested post-natal care. Of those 78% received post-natal care while 6% requested help with breastfeeding and 79% received help with breastfeeding.

A total of 12% of the female respondents are either pregnant or have recently had a baby. A key concern is this regard is if the young women are still in the schooling system or have had to leave and how they are supporting themselves and their babies.

Menstrual health

Access to sanitary ware	Six countries	Bots	Esw	Les	Mad	Zam	Zim
Asked for sanitary pads	14%	2%	7%	24%	9%	6%	29%
Received sanitary pads	64%	21%	87%	21%	74%	81%	65%

Only 14% of the female respondents requested pads from the health facility and 64% of those received pads. In Eswatini and Zambia the health facilities provided pads to between 81% and 87% of the female respondents.

The call for the removal of value added tax (VAT) and provision of free sanitary ware is central to effective menstrual health management. Schools and health facilities should be amongst the critical sites for the provision of free sanitary ware.

HIV and AIDS

Access to sanitary ware	Six countries	Bots	Esw	Les	Mad	Zam	Zim
Asked for sanitary pads	14%	2%	7%	24%	9%	6%	29%
Received sanitary pads	64%	21%	87%	21%	74%	81%	65%

Of the total sample of young men, 43% requested circumcision. Of those, 85% secured an appointment and 15% did not get an appointment or were referred to another facility. The highest proportion of requests for male circumcision in the sample were from Lesotho (79%) and lowest proportion of requests were in Eswatini (23%).

There is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. Three randomised controlled trials have shown that male circumcision provided by well-trained health professionals in properly equipped settings is safe.[8]

Category	Six countries	Bots	Esw	Les	Mad	Zam	Zim
Pre-exposure prophylaxis							
Requested PREP	5%	0%	0%	7%	16%	2%	6%
Received PREP	68%	0%	0%	38%	74%	55%	69%
Post-exposure prophylaxis							
Requested PREP	4%	4%	0%	3%	9%	0%	2%
Received PREP	69%	69%	0%	31%	78%	0%	67%

Pre exposure prophylaxis (PREP) is the use of anti-HIV medication, taken prior to any engagement that could potentially expose a person to HIV, that keeps HIV-negative people from getting HIV. Overall only 5% of the sample requested PREP. There were no requests in Botswana and Eswatini.

PEP is the use of anti-HIV medication, taken after to any engagement that potentially exposed a person to HIV, that keeps HIV-negative people from getting HIV. Only 4% of the sample requested PEP and 69% received the medication. There were no requests in Eswatini and Zambia and very low levels of requests in the other countries. There should be increased awareness raising on the role of PREP and PEP in HIV prevention across all countries.

Category	Six countries	Bots	Esw	Les	Mad	Zam	Zim
HIV testing							
Requested HIV test	42%	30%	81%	69%	22%	59%	37%
Received HIV test	93%	87%	98%	95%	91%	99%	83%
Sexually transmitted infections (STIs)							
Requested a STI test	16%	21%	4%	24%	17%	15%	14%
Received a STI test	90%	98%	89%	87%	86%	92%	74%

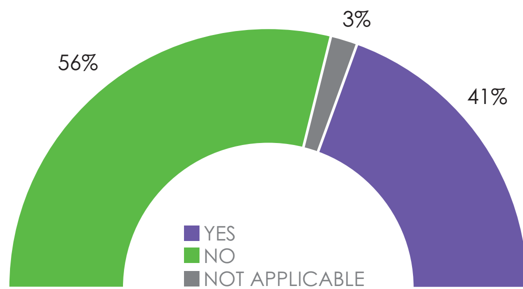
Of the total sample 42% requested an HIV test. There is no significant difference between the number of young women (36%) and young men (38%) requesting HIV testing. The highest proportion HIV tests were requested in Eswatini (81%), Lesotho (69%) and Zambia (59%). Of the total sample 16% requested an STI test and 90% received a STI test. The highest proportion of requests for STI tests were Botswana (21%) and Lesotho (24%).

Anti-retrovirals	Six countries	Bots	Esw	Les	Mad	Zam	Zim
Requested ARVs	7%	2%	2%	7%	8%	3%	8%
Received ARVs	78%	100%	43%	59%	68%	90%	84%

Of the total sample 7% of the sample requested ARVs and 78% received them.This is problematic as ARVs should be available at all facilities to everyone who needs them. The levels of provision of ARVs in Eswatini (43%), Lesotho (59%) and Madagascar (68%).

[8] https://www.who.int/hiv/topics/malecircumcision/en/#:~:text=There%20is%20compelling%20evidence%20that,properly%20equipped%20settings%20is%20safe.

Mental health

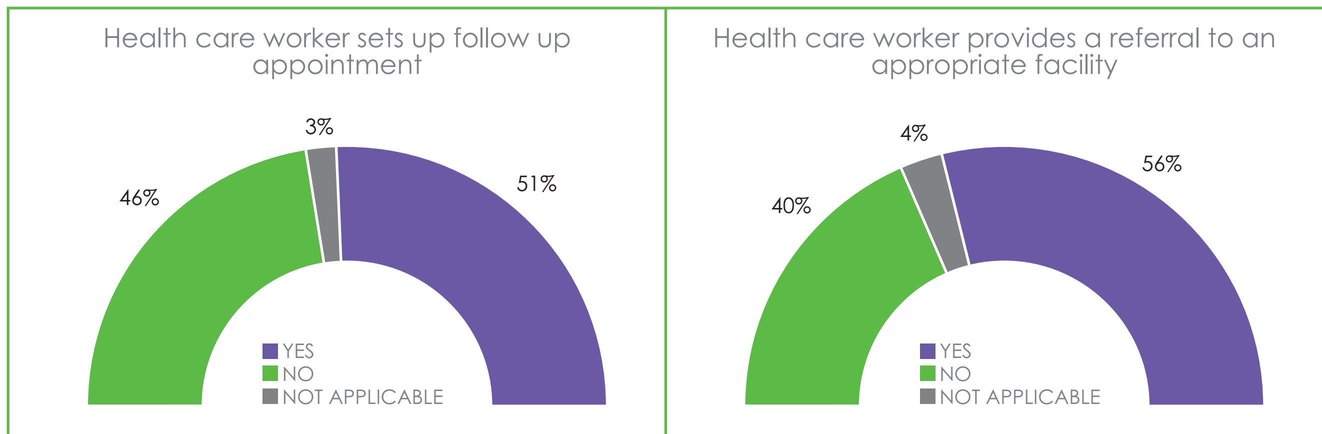


According to the World Health Organisation (WHO), adolescence is a crucial period for developing and maintaining social and emotional habits important for mental well-being. These include adopting healthy sleep patterns; taking regular exercise; developing coping, problem-solving, and interpersonal skills; and learning to manage emotions. Supportive environments in the family, at school and in the wider community are also important. An estimated 10-20% of adolescents globally experience mental health conditions, yet these remain underdiagnosed and undertreated.[9]

Of the total sample, only 41% of the respondents were asked about their mental health. Mental health is emerging as a significant concern amongst adolescents and must be part of integrated adolescent SRHR services.

Follow up and referrals

This section covers follow up care and referrals for additional interventions.



A total of 57% respondents received a follow up appointment while 41% did not get any follow up. Only 2% of the sample indicated that a follow up appointment was not applicable. It is concerning to note that 41% did not get options for follow up care.

Botswana is a serious concern as only 6% of respondents received a follow up appointment followed by Zambia with 37%.Of the total sample 61% were referred to other facilities for additional health care, 3% did not need a referral while 36% did not receive a referral. As with the follow up appointment Botswana is of concern with only 9% of the sample referred to another health facility.

[9] Kessler RC, Angermeyer M, Anthony JC, et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry 2007; 6: 168-76.

CONCLUSIONS AND RECOMMENDATIONS

- ***ASRHR Policies:*** Currently five countries (Botswana, Lesotho, Madagascar, Zambia and Zimbabwe) have ASRHR policies in place, Eswatini does not have an ASRHR policy. Botswana's policy ended in 2016 and all the other countries' ASRHR policies expire in 2020. There is need to lobby for ASRHR policies that are youth friendly in all five countries.
- ***At a policy and legislative it must be clear that young people can access SRH services without third party authorisation:*** Health workers insisting on a parent or family member being present will mitigate against young people going to health facilities. Only Madagascar provides for adolescent access to SRHR services without parental consent. In Botswana, Zambia and Zimbabwe parental consent is required for those under 16 and required for those under 18 in Eswatini and Lesotho
- ***There is a need for a set of standards that define what a youth friendly health facility should have in place:*** All health facilities should subscribe to these standards. The standards must include accessibility, respect, privacy, provision of peer counsellors, quality SRH services; health worker conduct and follow up care.
- ***Youth friendly communication and awareness campaigns*** moving from judgemental messaging to messaging that recognises that young people are sexually active and assist them with making informed choices.
- ***Campaigning and awareness on safe sex*** must be integral to all adolescent sexuality campaigns.
- ***Menstrual health*** must be central to services offered at health facilities.
- ***There is need for education on the role of PREP and PEP in HIV prevention***. From low levels of uptake amongst young people there appears to limited knowledge on the availability and purpose of PREP and PEP.
- ***Teenage pregnancy is a crisis that needs a multi-faceted response***. In Botswana, Eswatini, Lesotho and Madagascar the proportion of female respondents who are pregnant is much higher the official figures for the proportion of live births per 1000 adolescents.

Adolescents participating in the ASRHR Rapid Assessment in Fort Dauphin, Madagascar. Photo: Zotonantenaina Razanadratefa