UGANDA YOUTH DEVELOPMENT LINK (UYDEL)

"EASY U25" PROJECT

YOUTH FRIENDLY SEXUAL REPRODUCTIVE SERVICE PROVIDERS SURVEY: A FACILITY-BASED ASSESSMENT

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LIST OF ACRONYMS

AFCs	Adolescent Youth Friendly Corners
AFSs	Adolescent Friendly Services
HFCs	Health Care Facilities
MOU	Memorandum of Understanding
SRHs	Sexual Reproductive Health Services
STIs	Sexually Transmitted Infections
UNFPA	United Nations Family Planning Association
USAID	United Nations Agency for International Development
UYDEL	Uganda Youth Development Link
YFHs	Youth Friendly Health Services

EXECUTIVE SUMMARY

"EASY-U25" is a project being implemented by Uganda Youth Development Link (UYDEL) in partnership with Lutheran World Federation and financial support from Bread for the World. The project aims at addressing poverty, commercial sexual exploitation of children and young people, teenage pregnancy, Sexually Transmitted Infections (STIs), including HIV/AIDS and gender stereotypes among 3,000 adolescents both boys and girls aged 12-18 years living in the slums of Kampala, Uganda.

Globally, there are over 1.8 billion young people, of whom 90% live in low-income countries (United Nations Family Planning Association (UNFPA), 2020). In particular, Uganda has been cited as a country with the most youthful population in the world, with 78 percent of its population below the age of 30 (USAID, 2011). Although Uganda has got clear adolescent Sexual Reproductive Health services (SRHs) guidelines that set out the minimum acceptable level of performance and expectations for provision of SRH services such as expected functions of service providers, the various levels of service delivery and basic training content required, many young people continue to face sexual health-related challenges while seeking SRH services for quite many reasons. These barriers relate to the availability, accessibility, acceptability and equity of health services (World Health Organization, 2012). Such barriers have continued to undermine the friendliness of SRH services among youth and hence failure to address their SRH needs.

As a result, young people have continued to engage in risky sexual behaviors such as early sex, having unprotected sexual intercourse, having multiple sexual partner which predispose them to sexually transmitted infections like HIV/AIDS, unintended pregnancies, abortion making them to compromise their health and future aspirations. (Bukenya et al, 2017; Mulugeta et al, 2019).

Recent studies done in Uganda have shown that there is need for a critical assessment of Adolescent Friendly services (AFS) to gain insights on current practice and inform future interventions. Most of the available information is focusing on the quality of the services and factors which influence utilization of the services. To cover up this gap, UYDEL conducted a service provider's survey to determine the friendliness of the youth friendly corners at the 7 hospitals that they partner with in the three Divisions of Kampala including Makindye, Nakawa and Lubaga. The health centers where the survey was conducted included; Kitebi health center III, Kisugu health center III, Kisenyi center IV, China Uganda friendship hospital, Kiswa health center III and Naguru teenage center.

SECTION 1: STUDY METHODOLOGY

1. 1: Survey objectives

The survey sought to address the following objectives;

a). To identify whether youth friendly corners have adequate space and sufficient privacy.

b). To determine if the facility environment is comfortable for providing service for youth.

b). To determine whether providers and staff are specially trained to work with youth issues.

c). To determine whether the attitudes of providers and staff are supportive toward giving services to youth.

d). To find out if both boys and girls welcomed and served?

1.2: Study design

A facility-based cross-sectional survey supplemented by qualitative records was conducted at 7 public health care facilities.

1.4: Sample size

A purposive sampling procedure was used to select both the study respondents the public health centers. This was because UYDEL signed Memorandums of Understanding (MOUs) with them to provide youth-friendly services to adolescent girls and boys under the EASY U25 Project.

1.5: Study measures

According to the World Health Organization (WHO) (2012), Adolescent Youth-Friendly services are those that are accessible, acceptable, appropriate and effective for adolescents. In this survey, we only focused on three measures and these included; accessibility, quality and effective.

Structural quality of health facilities was measured in terms of availability of adequate space, capacity in terms of number of young people served on a daily basis, sufficient privacy, confidentiality and comfortability

We looked at accessibility to services in terms of the opening and working hours at the facility, kinds of services offered, staff characteristics, competencies, perceptions and attitudes towards the services and service provision

1.3: Study area and respondents Population

The survey was conducted at 6 health care centers located in three Divisions (Rubaga, Makindye and Nakawa) that signed standard Memorandums of Understanding (MOUs) with Uganda Youth Development Link (UYDEL). As shown in table 1, a total of 15 health care service providers were interviewed by 6 social workers and 2 social workers. Among the respondents included; 2 youth counselors, 4 clinic officers, 1 Direct of Programs, 2 hospital in-charge personnel, 1 coordinator of the youth corner, 4 peer educators and 1 Liaison officer.

Table 1: Study areas and respondents

Division	Name of the Health center	No. of respondents interviewed	Gender	Job titles of the health care worker service (respondents
Makindye	Kisugu Health center III	2	Male	Hospital in-charge
			Male	Coordinator of the youth corner
	Kisenyi Health center IV	2	Male	Director of programmes
			Female	Youth counselor
Rubaga	Kitebi Health Center III	2	Female	Liaison officer
			Male	Hospital in-charge
Nakawa	Kiswa Health center III	3	Female	Clinic officer
			Female	Youth counselor
			Female	Peer educator
	Naguru teenage center	3	Male	Clinic officer
			Female	Clinic officer
			Female	Peer educator
	China-Uganda Friendship Hospital	3	Female	Peer educator
			Female	Clinic officer
			Female	Peer educator
		Total = 15		

1.6: Data collection methods

This study employed a mixed method design to collect data on the friendliness of adolescent and youth services provided at the health facilities**.** Data was collected using a semi-structured questionnaire which was uploaded in the KOBO Toolbox on-line data collection app. The questionnaire comprised of questions adapted from World Health Organization (WHO)'s expectations on the provision of Youth Friendly Health Services (YFHS).

The questionnaire had sections where respondents needed to respond "Yes" (1) and "No" (2). Each response from this quantitative section, had a follow up qualitative question to explain why the respondent answered in that manner. Data was collected by 4 social workers and 2 Peer educators working with youths from UYDEL under the supervision of the Lead Consultant. Interviews typically lasted for 30 minutes or an hour.

Data was also collected using the activity reports that social workers and peer educators compiled upon accomplishing data collection.

1.7: Data quality assurance

Data collectors were carefully trained and orientated on the data collection tool and the question content. Close supervision was made on a daily basis to ensure completeness and consistency of each questionnaire and checklist. Data entry and cleaning was made carefully to avoid potential errors during analysis stages to assure data quality. In addition, the study also collected and analyzed secondary data.

1.8: Data analysis

Quantitative data was analyzed using SPSS, sorting, using the KOBO Tool box app. Results of quantitative data were presented using text, tables, and charts.

1.9: Ethical considerations of the study

The research respondent's verbal consent was sought before they were engaged in the survey. In this case, they were briefed about the objectives of the study and how they were to benefit from the study.

Discussions were held private settings such as in order to ensure the privacy and confidentiality of the respondents.

All data were rendered anonymous. The participants were assured that their anonymity would be protected.

2.0: Limitations of the study

Importantly, the findings should be interpreted with caution as the study had limited geographical coverage. Thus, the findings may not be generalized to the entire Kampala city since it was conducted in only 7 health facilities and only among 15 health workers.

Furthermore, the study results could have been biased by the absence of interviewing the adolescents who directly benefit from the services.

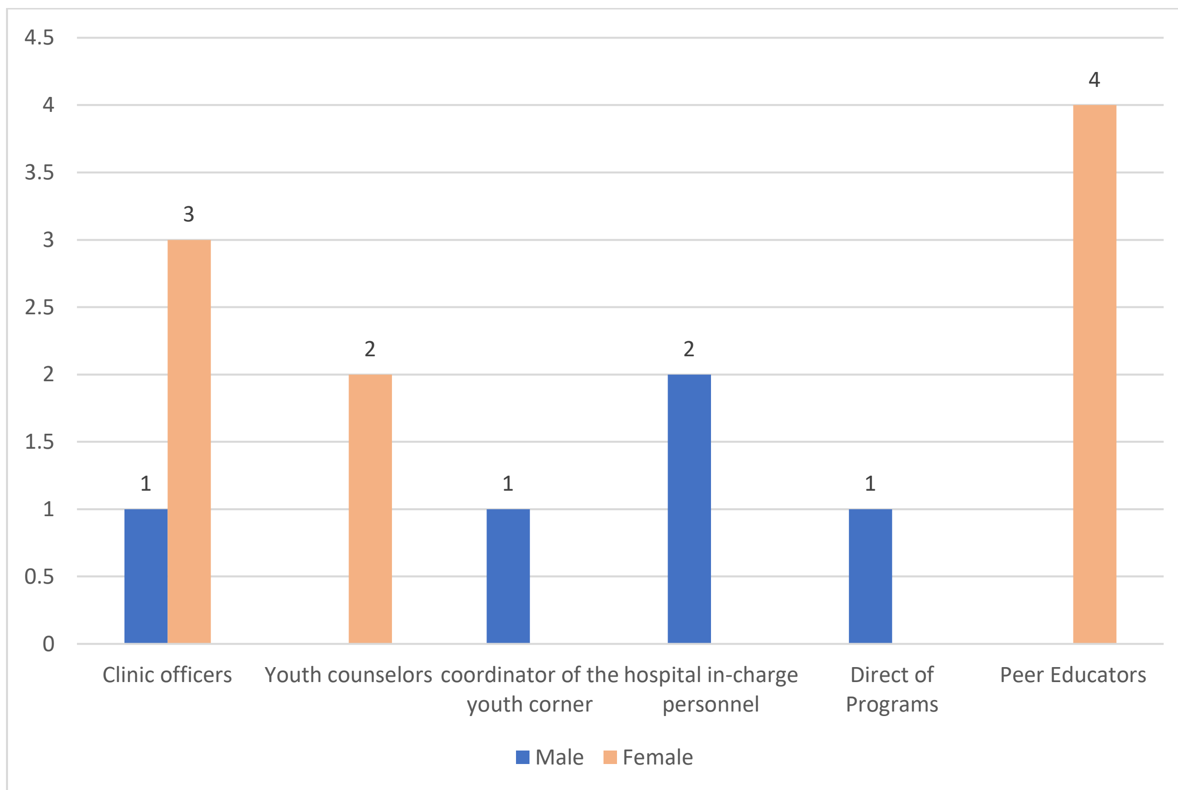
SECTION 2: RESULTS AND DISCUSSION

This section presents the findings and discussions of the survey as per the themes that emerged based on the questionnaire and the standard measures. The section is organised as follows; We start off by presenting the socio-demographic characteristics of the survey participants, this is followed by the structural quality of health care facilities, then accessibility of youth friendly services and equity of the services. The four major objectives of the study as discussed in section one are presented as the major themes of this section. These themes are further sub-divided into sub-themes to make chapter organised and easier to read.

2.1: Socio-demographic characteristics of the study respondents

As shown in table 1, the study participants included; 5 males and 10 females. Respondents held 7 distinct job positions. Among them, were 2 youth counselors, 4 clinic officers, 1 Direct of Programs, 2 hospital in-charge personnel, 1 coordinator of the youth corner, 4 peer educators and 1 Liaison officer.

Figure 1: Distribution of job titles among male and female respondents



2.2: Structural quality of the health facilities

Structural quality of health facilities was measured in terms of availability of adequate space, capacity in terms of number of young people served on a daily basis, sufficient privacy, confidentiality and comfortability

2.2.1: Availability of space at the health facilities

Regarding this indicator, researchers sought to find out if the health facilities had adequate space within which SRH services were provided. Findings from the survey indicated that majority 10 (67%) of the health care service providers that were interviewed had adequate within which SRH services were provided. These were particularly at Kisugu, Kiswa, and Kisenyi Health Center IV.

Lack of adequate space at YFCs not only compromises privacy and confidentiality but also discourages youth from seeking for SRHs. These results are in congruency with findings of another study conducted by Atuyambe, Kibira. Bukenya et al, (2015) which examined the sexual reproductive health needs of adolescents in Wakiso District. In this study, it was reported that the facilities lacked of privacy which discouraged so many adolescents from seeking reproductive health services.

In this survey, 5 (33%) respondents from two health facilities; China-Uganda Friendship Hospital, Naguru Teenage center and Kitebi Health Center III reported that they did not have adequate space. At Kitebi Health Center, it was reported that the facility no longer had a youth corner since Naguru Teenage center which was supporting the facility had withdrawn funding. As a result, youth were served together with the general. A female health worker reported;

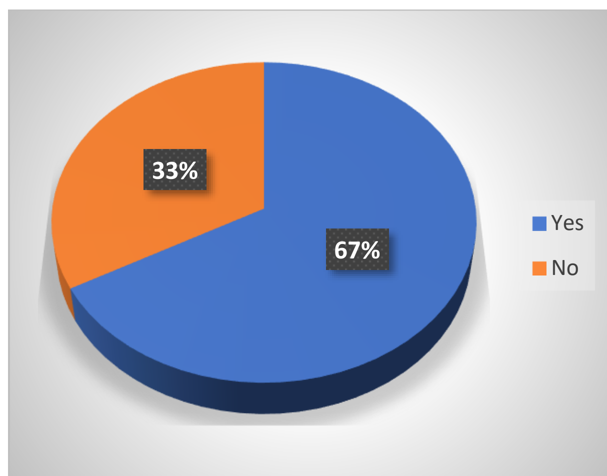
> *Here at Kitebi Health Center, we do not have a specific place in which youth are worked on. This is because Naguru Teenage center which used to sponsor the youth corner withdrew funding from the facility. We therefore combine both adult and youth clients (Female health worker, Kitebi Health Center III)*

Combination of youth with general clients during provision of SRH services greatly discourages them from seeking for services as it brings feelings of mistrust and or suspicion that their sensitive and intimate sexual and reproductive health concerns are being overhead by other persons which negatively affected access and provision of SRH services in a youth friendly way at the facilities.

However, a health worker at Kiswa health Center III reported that there were plans by the facility management to more space for provision of ASRH upon completion a new building which was still under construction at the facility.

At Naguru teenage center, it was reported that the facility was in the process replacing all old staff with new recruits right from the Executive Director. Health workers at this facility mentioned such changes had negatively affected effective provision of SRH services.

Figure 2: Availability of adequate space and sufficient privacy



2.2.2: Capacity of the health facilities

In terms of capacity of the YFCs, it was revealed that each of the facilities received at least 60-100 young people on a daily basis. The highest number of young people was reported at Kisenyi Health Center IV and Kitebi Health Center III. At Kisenyi Health center IV, health workers reported that the high numbers were as a result of the fact that this is a higher-level facility compared to other health centers and hence many referrals were received from lower-level facilities.

Table 2: Capacity of the health facilities

Name of Health Facility	Approximate number of youths served on a daily basis
Kisugu Health center III	60-70
Kitebi Health Center III	100
Kisenyi Health center IV	80-100
Kiswa Health Center III	50
China-Uganda Friendship Hospital	50
Naguru Teenage Center	50

Health workers highlighted that they faced some challenges as a result of the overwhelming number of young people received. Among these included; the limited staff capacity to serve them; particulaly at Kisugu Health center III, Kiswa health center III. As a result, staff were not able to adequately attend to the young people. A challenge of inadequate drugs was cited at Naguru Teenage Center and Kisugu Health Center III. They however mentioned that they make use of the peer educators to support them conduct some activities such as conducting pre-counselling sessions to overcome the challenge of inadequate staff.

2.2.3: Data privacy, protection and confidentiality

In regards to privacy and confidentiality, health workers were asked to mention some of the privacy and confidentiality guidelines that they followed when providing youth with SRH services at the facilities. Qualitative data indicated that there were a number of guidelines that health workers at different facilities followed while providing SRH services to youth as shown in the narratives below;

> *We first ask for permission from the clients before doing medical examinations but also verbally assure them of confidentiality. All client details and information are entered into our computers which have personal passwords. We have a separate office where client records are kept and this is not accessible by everyone except counsellors in charge. One has to follow protocol before getting there (*Female health worker, Kitebi Health center)

> *The health facility has a spacious waiting room and each client is identified with a unique number, not their real names. Ccounseling rooms are labelled have key locks and one person is allowed at a time, even if it's a couple, they are not supposed to enter the rooms at once. We even ensure that the counselling rooms are locked before a session begins to prevent interruptions during the sessions.* (Female health worker at Kisenyi Health Center III).

Although the report further reported that facility rooms were labelled and had locks, a study by Senderowitz, Hainsworth and Solter (2018) reported that young people were afraid to be stigmatized, if they were seen entering a room that was labeled "family planning"

> *Here at Naguru Teenage center, we follow Ministry of Health (MOH) guidelines of client care, ASRH service provision guidelines, reproductive health policy of 2012 but also, we uphold the medical code of conduct. But also, here at Naguru Teenage center, we have teenage center guidelines that we follow* (Female health worker, Kiswa Health center III

Most of the confidentiality strategies highlighted by health workers are very similar with those of other researchers like Mulugeta, Girma, Kejela et al (2019); Senderowitz, Hainsworth and Solter 2018) who reported that health

workers promoted privacy and confidentiality at the facilities by simply erecting doors to examination rooms (so their interactions cannot be seen or heard), closing existing doors, minimizing interruptions during visits, and ensuring that records are stored in a confidential manner.

2.2.4: Comfortability of the health workers with spaces within which they provided reproductive health services to youth

When asked whether or not they were comfortable with the spaces in which SRH services were provided, 10 respondents revealed that they were comfortable whereas 5 were not. These findings may be as a result of the fact that 5 health workers reported lack of adequate space and sufficient privacy at their health facilities, particularly at China-Uganda Friendship Hospital and Naguru Teenage center.

The researchers further asked respondents whether or not consultation areas were away from public view. As indicated in table 2, 9 respondents reported that the consultation areas were far away from public view whereas 6 revealed that the areas were near public view.

This therefore implies the health workers found difficulties of ensuring confidentiality of the information shared by the youths as well as their privacy. Additionally, health workers also reported congestion at the consultation and waiting areas.

> *The consultation area is always congested because youth clients are combined with adults, we therefore need to separate rooms for youth in order to ensure confidentiality is observed (*Female health worker at Naguru Teenage center*)*

Narration of the above health worker is similar to a study conducted by Ndayishimiye et al (2020) in which most young people recommended that they would like their own space or clinic hours, so that they do not have to "mix" with the adult clients, since one of the biggest barriers was fear of being seen by adults from their community

When respondents were asked what needed to be improved to be in order to provide a comfortable environment. Only two respondents reacted to this question as follows;

> *Youth have to be separated from other clients because they need privacy and we now lack funding (Peer educator, Female, China-Uganda Friendship Hospital)*

> *There is a need Providing a specific wing especially as the youth clients have an almost similar waiting room as all other clients (Peer educator, Female, Naguru Teenage center)*

Similarly, our findings are in congruency with those of another study in Uganda by Atuyambe et al (2015) which reported that lack of privacy at health facilities is further compromised if the young people are required to seek services at the same time as adult clients. This is likely to deter them from utilizing health services.

Table 3: Comfortability with the available space.

Question	Frequency	Percentage
Are you comfortable with the spaces within which SRH services are provided?		
Yes	10	66.7
No	5	33.3
Are the consultation areas away from public view?		
Yes	9	60
No	6	40
Total	**15**	**100**

Other challenges related to privacy and space that were reported included; interruptions by other people while working on the youth and also being overhead while in the consultation room with clients.

2.3: Accessibility to sexual reproductive health services to youth at the health facilities

We looked at accessibility to services in terms of opening and working hours at the facilities, kinds of services offered, staff characteristics, competencies, perceptions and attitudes towards the services and service provision.

Regarding opening and working hours at the facilities, having YFCs open when youth can attend is critical to motivating them seek services. In this survey, respondents were asked whether there were specific hours during which they worked on youths. The responses that emerged from this question are summarized in table 3. Furthermore, they were asked the hours during which youths were worked on. Majority of the respondents (7) reported that they worked all day, 3 worked during afternoon hours, 3 also worked during morning hours and only 2 worked during evening hours.

Table 4: Hours during which youths are worked on

Question	Frequency	Percentage
Are there specific hours during which you work on youth?		
Yes	8	53.3
No	7	46.7
During which hours of the day do you work on youth?		
All day	7	46.7
Afternoon hours	3	20
Morning hours	3	20
Evening hours	2	13.3
Total	**15**	**100**

Existence of specific working hours at the YFCs helped to promote provision of SRHs to youth in a convenient way as another study by Senderowitz, Hainsworth and Solter (2018) reported that setting up convenient working hours at YFCs can help to utilize existing space and ensure privacy. However, some health workers, particularly at Kisenyi Health Center III reported that they worked on the youth based the time each arrived.

2.3.1: Mobilisation strategies of youth for SRH service provision

It was revealed that some health facilities, particularly Kiswa Health Center III, China-Uganda Friendship hospital and Naguru Teenage had peer educators who were responsible for mobilising youth to access reproductive services by conducting community outreaches. For instance, in the qualitative data a peer educator at Naguru teenage center reported that;

> *I am responsible for conducting and coordinating community outreaches through which youth are mobilized to seek for SRH services at the facilityy. Upon identifying the youth, I refer them to the health facility for services like counselling and guidance, some need treatment whereas others require counselling for behavioural change.* (Female Peer educator, Naguru Teenage center

These results differ from findings in Rwanda where Ndayishimiye, Uwase, Kubwimana et al (2020) reported that peer educators were not involved in provision of ASRH.

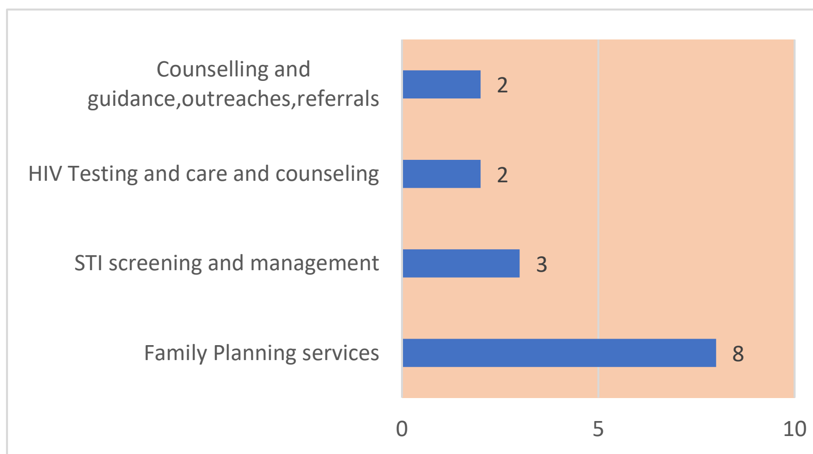
2.3.2: Kind of SRH health services provided at the facilities

In this survey, we also aimed at finding out kind of SRH services provided at the health facilities to youth and these are shown in figure 3. Majority of the health workers (8) (53.3%) mentioned that they provided family planning services. Three (3) (20%) health workers mentioned that they screened and tested Sexually Transmitted Infections (STIs), These were followed by those who conducted HIV testing and counseling and lastly general counseling and guidance (13.3%).

These results imply that the health facilities provide minimum health care packages as recommend by the (World Health Organization, 2012). However, there are other health care services which are critical for youth but were not reported by the health workers as reported by researchers such as Ndayishimiye, Uwase, Kubwimana, Niyonzima et al 2020). These included; post-abortion care, Sexual Gender Based Violence (SGBV) care services, Post and Pre-Exposal Prophylaxis (PEP) services.

Lack of minimum health care services as well recommended by WHO Health Care Guidelines at YFCs negatively affects accessibility of SRHs by youth as it discourages them from visiting them.

Figure 3: SRH services available at the surveyed health facilities



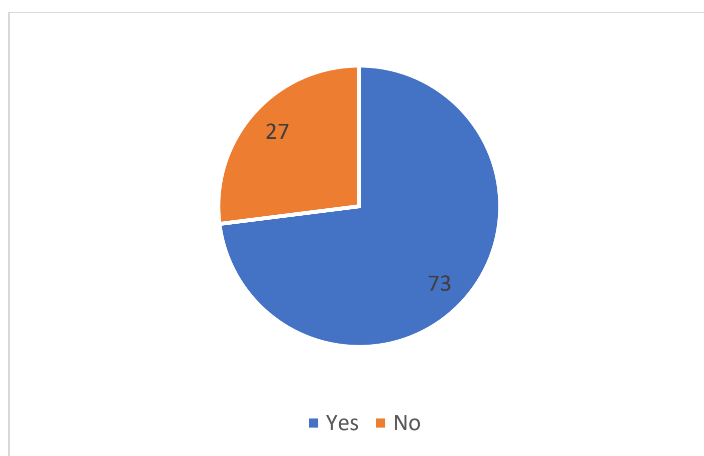
Regarding the kinds of reproductive health services available at the facilities, health workers were asked whether or not they provided contraceptives to youth in the past three months. As shown in figure 6, majority of the health workers (11) reported that they had provided contraceptives and only 4 reported having not provided reproductive health services.

Other services that were reported about included; rreferral services, peer to peer support, psychosocial support and community outreaches. In regards to referral to services, it was reported that these were conducted by peer educators who mobilised youth through community outreaches. Upon identifying the youth, they referred them to their health facilities for SRH services such as counselling, youth empowerment programmes, medical treatment among others as a peer educator at Kiswa health center III reported;

> *We usually conduct referrals of our youth for counseling on the dangers of engaging in risky sexual behavior, referral to partner organizations dealing with youth empowerment (Female Liaison officer, Kitebi* Health center III

Overall, the study revealed that three health care facilities; Naguru teenage center, China-Uganda Friendship Hospital, Kiswa and Kitebi Health Center III engaged in reinforcing positive prevention interventions such as communication for bevioural change, referral for other services, particularly counselling and guidance and economic empowerment programmes. These are conducted by selected peer educators and Liaison officer.

Figure 4: Have you provided contraceptives to youth in the past three months



We further asked the health workers to mention some of the contraceptive methods that they had provided to youth in the past three months. Contraceptives were available at the facilities in the following proportions as shown in table 4. Condoms were the most prominent contraceptives that health workers provided to youth in the past three months. These were followed by emergency pills, Intra Uterine Devices (IUDs). Other methods included; inject plans, implants, vasectomy and tub ligation.

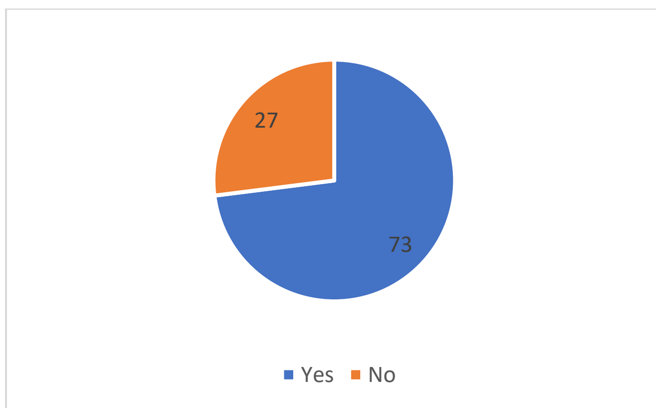
Table 5: Kinds of contraceptive methods provided to youth in the past three months

Contraceptive method	Frequency	Percentage
Condoms	5	33.3

Emergency pills	3	20
Intra Uterine Devices (IUDs)	2	13.3
Inject plan	2	13.3
Implants	1	6.7
Tub ligation	1	6.7
Vasectomy	1	6.7
	Total = 15	**100**

Health workers were asked to give their opinion regarding provision of contraceptives to youth. In this case, they were asked a close-ended question "Is there a minimum age for prescribing a particular contraceptive to a youth?" Figure 5 shows that majority of the health workers reported that there was a minimum age for prescribing a particular contraceptive.

Figure 5: Is there a minimum age for prescribing a particular contraceptive?



We further asked them to mention the methods and minimum age at which youth should be provided with contraceptives. The responses that emerged from the respondents are summarized in Table 5. Over 50% (8) of the health workers reported that youth should be provided with contraceptives at the age of the 12 and above. These findings are somehow different from those Motuma, Syre, Egata et al (2016) in which health workers reported that nearly 70 % of the participants reported that the youth should get contraceptives at the age of 15 years or older. Respondents who reported that youth should be provided with contraceptives at the age of 18 and above were 7 (46.7%).

Table 6: At that minimum age do you provide contraceptives to youth

Years	Contraceptive methods	Frequency	Percentage
12 and above	Condoms	8	53.3
Above 18	Emergency pills, IUDs, inject plan	7	46.7
		Total =15	

One of the major reasons that youth give for not using the SRH services at the health institutions was feeling discomfort by the conditions of the centers or the attitude of the service providers (Motuma, Syre, Egata et al 2016). In this study therefore, we asked health workers to give their opinions about contraceptive use among young people. The responses that emerged from them are summarized in table 6.

Table 7: Health workers opinions about provision of contraceptives to youth

Question	Frequency	Percentage (%)	
Are there contraceptive methods you would not provide to unmarried boy or girl			
Yes	8	53	
No	7	47	
Total	**15**	**100**	
If yes, what are the methods you would not provide to unmarried boy or girl (n=8)			
Vasectomy/tub ligation	3	37.5	
IUDs	3	37.5	
Injectables	1	12.5	
Emergency pills	1	12.5	
Total	**8**	**100**	
If a 14-year-old client admits to being sexually active and comes to you for contraception, what advice would you give him or her			

Give him/her information regarding the danger of engaging in early sex	**13**	**87**	
Advise him or her to use temporary contraceptives particularly condoms	**2**	**13**	
Total	**15**	**100**	

2.3.3: Staff attitudes towards service provision

Regarding this indicator, the researcher asked health workers to give their opinions give their opinions about different risky behaviors that youth engage in and the kinds of services they would provide them. Table 7 shows their responses.

Table 8: Health worker's attitudes towards service provision

Question	Frequency	Percentage
What is your attitude towards youth who have sex before marriage?		
It is not good because they pre-dispose them to so many risks like HIV, early pregnancy	11	73.3
It is normal as long as they use protection	4	26.7
Total	**15**	**100**
What kind of services do you think who have sex before marriage need from a health facility?		
Sexuality education i.e. SRH knowledge and information	9	60
Counseling and guidance	6	40
Total	**15**	**100**
What is your attitude towards youth who have more than one sexual partner?		
It is not good because they pre-disposed them to so many risks like HIV	15	
What kind of services do they need from a health facility?		
Counseling and guidance	11	73.3
Reproductive health services i.e. contraceptives	4	26.7

Total	**15**	**100**

Respondents were further asked if there were some contraceptive methods that they would not recommend to youth. Their responses are highlighted in table 8

Table 9: Health worker's attitudes towards provision of contraceptives to youth

Question	Frequency	Percentage	
Are there any methods you would never recommend under any circumstances?			
Yes	**13**	**86.7**	
No	**2**	**13.3**	
Total			
If yes, mention them and explain why (n=13)			
I would not recommend some methods like vasectomy because it's irreversible	9	69.2	
I would not recommend IUDs for people with chronic STDs	4	30.8	
Total	**13**	**100**	
If you think that a youth client had a Sexually Transmitted Infection (STI), what do you do for him or her			
Refer her to a specialist	4	26.7	
Conduct a medical checkup /screening, provide treatment and provide Counseling and guidance	8	53.3	
Conduct proper diagnosis, treat the infection and also ask them to bring the partner and usually want the partner on board as well	3	20	
Total	**15**	**100**	
What do you do for a youth client who presents complaints the he or she may be HIV-positive			
Conduct HIV screening first	2	13.3	

Conduct pre-counselling to know why they think so and then a test is done to rule out the thought and there after post counseling is done	13	86.7	
Total	**15**	**100**	

2.3.4: Availability of SRH service information and educational materials

This survey also set out to establish existing SRH information delivering materials at the health facilities. Health workers were asked a close-ended question "Are there SRH educational materials at the health facilities". Table 9 summarizes their responses.

Table 10: Are there SRH educational materials at the facility?

Response	Frequency	Percentage
Yes	9	60
No	6	40
Total	15	
If yes, mention some of the materials available (n=9)		
Books	1	11.1
Leaflets	1	11.1
Posters	3	33.3
Stickers	4	44.4
Total	**9**	**100**

However, in one of the activity reports, a health worker at Kitebi Health Center reported lack of adequate SRH educational and information materials, particularly posters and stickers. Inadequate funding to print these materials was cited;

> *We have stickers Posters and stickers containing information messages on SRH. However, they are inadequate due to limited funding (*Female health worker, Kitebi Health center)

These findings are in congruency with those of another study in Wakiso District by (Bukenya et al, 2017) which found out that educational support facilities such as posters, brochures and other print materials were scarce at the health facilities which affected educational activities offered at the facilities.

2.4: Staff characteristics, attitudes and competence

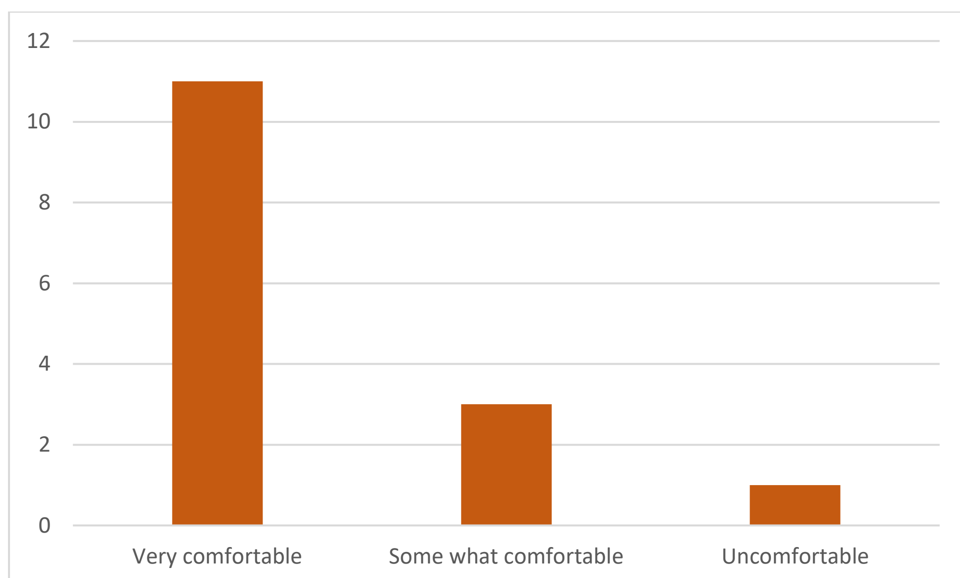
Regarding staff competence, we asked the health workers if they had received a refresher training to provide youth reproductive health services. As shown in table 10, majority of the health workers (10) reported that they had a special training on youth reproductive health issues such as patients and responsibilities, Sexual Gender Based Violence (SGBV) and peer education. However, they further expressed that they needed more SRH training in order to adequately serve youth particularly in aspects like family planning and reproductive health information, drugs and substance abuse.

Table 11: Staff characteristics and competence

Question	Frequency	Percentage
Have you had a special training on youth reproductive issues?		
Yes	10	66.7
No	5	33.3
Total	**15**	**100**
If yes, what did the refresher training topic cover (n=10)		
Patient rights, responsibilities and quality care	2	20
Sexual Gender Based Violence.	3	30
COVID-19 vaccination	3	30
Peer education	2	20
	Total =15	**100**
In order to adequately serve the youth, do you think you have enough training?		
Yes	9	60
No	6	40
Total	**15**	**100**
What would you like to have more training on		
Reproductive health information	7	46.7
Family planning issues	5	33.3
Obstetric operations	1	6.7
Drug abuse and BLOOD testing	1	6.7
Training on sign language because they receive youth who only use sign language yet they have no workers who are good at gesture language and they end up recording wrong information for those groups of youth	1	6.7
Total	**15**	**100**

Regarding this indicator, respondents were asked how comfortable they felt discussing sexual reproductive health issues with youth. As indicated in figure 5, majority of the respondents (11) reported that they were very comfortable, 3 were somewhat comfortable and only 1 felt uncomfortable.

Figure 6: How comfortable are you discussing sexual reproductive health issues with youth?



2.5: Equitability of the reproductive services

Regarding this indicator, researchers were asked a close-ended question "Are boys and girls welcomed at the facility. Survey results indicated all the 15 respondents welcomed both male and female youth clients. We further asked health workers if they sought consent parents or guardians' consent before they carried out any medical procedures on the youth. Majority of the health workers (66.7%) mentioned that they did not require parent's consent before providing youth with reproductive services compared to those who did (33.3%).

Furthermore, we asked health workers how they felt while providing reproductive health services to boys or young men. Table 11 shows that majority of the health workers (11) were very comfortable, followed by those who were somewhat comfortable (4). None of the health workers expressed being uncomfortable.

Table 12: How do you feel while providing reproductive services to boys or young men?

Response	Frequency	Percentage
Very Comfortable	11	73.3
Somewhat comfortable	4	26.7
Total	**15**	**100**

The researchers also asked health workers the protocols that they had followed while providing reproductive health services to boys and young men. The most prominent response to this question was the issue of non-discrimination. For example, in one of the activity reports. A health worker mentioned;

> *When a young man comes to seek reproductive health services, they are treated the same way as women. It is a general protocol for both genders. (Female health worker)*

When further asked to mention some of the things they would say to male client that might be different from a female, the following were some responses that emerged.

> *Issues around contraceptive use are different for both boys and girls. For instance, girls are told about contraceptive methods like IUDs, injectables whereas boys are told about vasectomy and male condoms (Female health worker)*

The survey also sought to find out kinds of services provided to male clients. Table 12 shows the health worker's responses.

Table 13: What kind of services do you provide to male clients

Response	Frequency	Percentage
Safe male circumcision	8	53.3
Provision of contraceptives	5	33.3
Prostate cancer screening	2	13.3

SECTION 3: EFFECTS OF SIGNING OF MOUS BETWEEN UYDEL AND THE HEALTH FACILITIES ON SRHS PROVISION TO YOUTH, GOOD PRACTICES/LESSONS LEARNED, RECOMMENDATIONS AND CONCLUSIONS

Information on this aspect was obtained from the activity reports that Research Assistants (Ras) compiled upon completing the data collection exercise. As a result of the signed MOUs, partners like UYDEL have supported health facilities to conduct SRH outreaches on aspects like family planning, HIV testing and counseling, COVID-19 awareness. This has helped to not only increase awareness about the services that the facilities provide but also improve uptake of SRH services by youth

Partners also conduct referrals of young people to the health facilities which improves uptake of SRH services such as HIV testing and counseling, Family Planning at the facilities.

In terms of challenges, health workers raised an issue of delayed of payment of funds by partners upon completion of an activity. This affects their morale to continue with their partnerships.

Health workers recommended that there was a need for partners to complement efforts of the health facilities in terms of providing essential equipments such as HIV testing kits, contraceptives, IEC materials so as to improve provision of SRH services to youth.

4.1: Good practices/lessons learned from the study

Privacy and confidentiality principles are greatly adhered to at the YFCs. Health workers reported a number of strategies that they used to observe not only the privacy of the client's records information but also during provision of SRHs youth. Among these included; asking for permission from the clients before doing medical examinations, assuring them of confidentiality, keeping client details and information in their computers which have personal passwords, having a separate office where client records are kept and this was not accessible by everyone except counsellors in charge, identifying clients with a unique number, not their real names, labeling counseling room and putting key locks, allowing one person to enter the rooms once at a time, follow Ministry of Health (MOH) guidelines of client care, ASRH service provision guidelines, reproductive health policy of 2012 but also, we uphold the medical code of conduct.

Health workers highlighted they use peer educators to mobilise fellow youth for SRHs. Mobilisation is conducted through community outreaches. Peer educators also helped to make referrals of youth for SRHs at the facilities. Scaling up the peer approach within the health facilities by having specially trained peer educators attend to youth helps win the trust of young people to seek health services.

To encourage youth, seek for SRHs at the facilities, health workers open the facilities whole day and serve youth at any time he or she arrives.

4.2: Good practices from other studies that can be replicated at the health care facilities

Other studies such as one conducted by Thomee, Malm, Christianson et al (2016) in Sweden highlighted a need to purposively locate the YFCs outside health-care facilities as it helps to make them more accessible for youth. Such a strategy would be good to be replicated by health facilities in this study as this will help to promote confidentiality and privacy at the YFCs but to also make youth feel more comfortable while sharing with the health care workers.

Although our study results reported that health care workers use peer educators to mobilize youth for SRH, other studies such as one conducted by Ndayishimiye, Uwase, Kubwimana et al (2020) in Rwanda reported that youth were involved engaged planning, managing and designing feedback mechanisms for services rendered to them or their peers. This would be a great strategy if also replicated at these facilities.

Regarding the working hours of YFCs, a study conducted by Senderowitz, Hainsworth and Solter (2018) recommended a need to offering special hours for youth as this can help utilize existing space and ensure privacy.

In other studies, such as one conducted by Motuma, Syre, Egata. et al, (2016), it was recommended that efforts should be made in the recruitment process to select professionals not only with the proper skills and education but also who were highly committed to working with youth.

Section 5: Recommendations

Based on the study findings, the following recommendations are made.

5.1: To Health Workers Who Provide YFS

Regarding privacy and confidentiality at the health facilities, there is a need for health workers to set specific working hours during which they work on youth as this will help to minimize interruptions from the adult clients but to also utilize the little space they have at the facilities.

5.2: To Health Care Managers at All Levels

Regarding adequate space, there is a need to make structural improvements such as building spacious waiting areas, expanding the consultation rooms and also establishing separate waiting rooms for both youth and adult clients, particularly at Kitebi Health Center III, Naguru Teenage center and China-Uganda Friendship hospital.

This will help to decongest the waiting areas but also promote privacy and confidentiality in the consultation rooms. In addition, there is a need to re-establish a youth corner at Kitebi Health Center III since one that existed is no more due to financial constraints.

There is a need to strengthen the capacity of the SRH health care service providers by conducting capacity building trainings in SRH aspects particularly, family planning and reproductive health information, drugs and substance abuse.

There is a need to create awareness should be given to clients regarding nature of services requested. This can be done by conducting community outreaches.

There is also a need to avail more SRH IEC materials, particularly posters and stickers so as to increase awareness about the available SRH services at the facilities.

5.3: Recommendations for further research

Since this study focused on only interviewing health workers, there is a need to also conduct a survey in which youth should be interviewed.

Conclusion

The friendliness of SRH services was found to be moderate in this study. Two facilities out of the 7 included in this study lacked adequate space and sufficient privacy to provide friendly services. Insufficient funding was reported at Naguru teenage center which SRH service provided. Information, Education and Communication (IEC) materials, most especially posters and stickers were inadequate. However, the facilities were open whole-day hence convenient for youth to seek services. Efforts should be made to make structural improvements such as building waiting areas, expanding the consultation rooms and also establishing separate waiting rooms for both youth and adult clients as Youth-friendly health services (YFHS) that address provider attitudes and enhance privacy and access have effects on service uptake among youth.

References

Atuyambe. L.M, Kibira. S.P.S, Bukenya. J, Muhumuza. C, Apolot. R.R, Mulogo. E. (2015). Understanding sexual and reproductive health needs of adolescents: evidence from a formative evaluation in Wakiso district, Uganda. *Reproductive Health*. Retrieved from https://doi.org/10.1186/s12978-015-0026-7

Bukenya. J.N, Mulogo. E, Kibira. S.P, Muhumuza. C, Atuyambe. L.N,. (2017, September). Health facilities' readiness to provide friendly reproductive health services to young people aged 10-24 years in Wakiso district, Uganda. *Journal of Reproductive Medicine*.

Motuma. A, Syre. T, Egata. G, Kenay. A. (2016). Utilization of youth friendly services and associated factors among youth in Harar town, east Ethiopia: a mixed method study. *BMC Health Serv Res, 16*(272).

Mulugeta. B, Girma. M, Kejela. G, Meskel. F.G, Andarge. E, Zerihun. E. (2019). *Assessment of Youth-Friendly Service Quality and Associated Factors at Public Health Facilities in Southern Ethiopia: A Facility-Based Cross-Sectional Study.*

Ndayishimiye.P, Uwase. R, Kubwimana. I, Niyonzima. J, Dzekem. R, Nyandwi. J.B, Kadima. J.N. (2020, 2020). Availability, accessibility, and quality of adolescent Sexual and Reproductive Health (SRH) services in urban health facilities of Rwanda: a survey among social and healthcare providers. *European Journal of Epidemiology, 20*.

Senderowitz. J, Hainsworth. G, Solter. C. (2018). *A Rapid Assessment of Youth Friendly Health Services.* Pathfinder International.

Thomee. S, Malm. D, Christianson. M, Hurtig. A.K, Wiklund. M, Waenerlund. A.K, Goicolea. I. (2016). Challenges and strategies for sustaining youth-friendly health services — a qualitative study from the perspective of professionals at youth clinics in northern Sweden. *Journal of Reproductive Health*.

USAID. (2011). *Navigating Challenges. Charting Hope: A Cross-Sector Situation Analysis of Youth in Uganda.* USAID.

World Health Organization. (2012). *Making Health Services Adolescent Friendly: Developing National Quality Standards for Adolescent Friendly Services.* Geneva: World Health Organization.

https://www.unfpa.org/sites/default/files/resource-pdf/One%20pager%20on%20youth%20demographics%20GF.pdf