Youth-Friendly Services: Botswana
End of Program Evaluation Report

African Youth Alliance (AYA)

December 2005

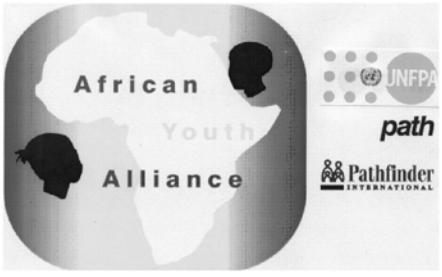


Table of Contents

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
AYA	African Youth Alliance
BCC	Behavior Change Communication
BOFWA	Botswana Family Welfare Association
DHT	District Health Team
FHD	Family Health Division
HIV	Human Immunodeficiency Virus
MOH	Ministry of Health
PATH	Program for Appropriate Technologies in Health
PNC	Postnatal Care
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TOT	Trainer of Trainers
UNFPA	United Nations Fund for Population Activities
VCT	Voluntary Counseling and Testing
YFS	Youth-Friendly Services

EXECUTIVE SUMMARY

The African Youth Alliance program (AYA) was launched in 2000 by Pathfinder International, the Program for Appropriate Technology in Health (PATH), and the United Nations Population Fund (UNFPA) in the fall of 2000 with funding from the Bill and Melinda Gates Foundation. AYA sought to improve overall Adolescent Sexual and Reproductive Health (ASRH) and reduce the spread of HIV/AIDS and other Sexually Transmitted Infections (STIs) in four African countries – Botswana, Ghana, Tanzania, and Uganda. Pathfinder International was responsible for the implementation of two of the six component areas of AYA, namely Youth-Friendly Services (YFS) and institutional capacity building in each of these countries.

This report highlights the results of the YFS work that was implemented by 18 of 20 clinics in Botswana. The AYA/Pathfinder approach to YFS focused on the following:

- Building on existing resources, using available facilities and service providers
- Reaching young people through a variety of channels such as: static clinics and outreach including peer education
- Establishing linkages with effective referral sites
- Creating partnerships with other institutions for future scaling-up
- Instituting a minimum package of youth-friendly Sexual and Reproductive Health (SRH) services, including:
    - Information and counseling on sexuality, safe sex and reproductive health
    - Contraceptive method provision (with an emphasis on dual protection)
    - STI diagnosis and management
    - HIV counseling (and referral for testing and care)
    - Pregnancy testing and antenatal and postnatal care
    - Counseling on sexual violence and abuse (and referral for needed services)
    - Postabortion care counseling and contraception (with referral for treatment of complications when necessary)

Specifically, the AYA/Pathfinder strategy for implementing youth-friendly SRH services included the following:

- Facility assessments
- Development and implementation of action plans for quality improvements based on the results of the facility assessments
- Provision of essential technical assistance and monitoring to the institutions, management and clinics as per identified needs
- Training of service providers in ASRH/YFS
- Training of supervisors in supportive supervision of YFS
- Orientation of program managers and site supervisors and other non-clinical staff on basic SRH issues and how to interact with youth clients
- Training and assistance on data collection and analysis of service statistics
- Implementation of youth input and feedback mechanisms
- Creation and/or expansion of peer education programs
- Community sensitization in SRH and involvement in peer selection for outreach work

- Institutionalization of YFS through development of YFS tools and curricula for in-service training

This report highlights the following results of the YFS work implemented in Botswana:

Facility Reassessment: Twelve clinics improved from baseline to endline assessment, three stayed the same, and three declined.

Analysis of Client Satisfaction Data: Mystery clients were used as the primary means of determining client satisfaction in the clinics. The mystery client data shows that out of 22 visits, 16 (73%) of the mystery clients would recommend the facility to their colleagues.

Trend Analysis: Analysis of service statistics show that there was an upward trend in the number of youth visiting the facilities from 2003 to 2004. More females than males visited clinics, particularly those between the ages of 20 and 24. More condoms were distributed than pills or other methods of contraception.

Based on the program evaluation activities and the data collected throughout the project lifecycle, recommendations are made for the future of the clinics and future programs such as AYA. The recommendations include: expand YFS to additional districts and facilities, devise strategies to attract more males and younger clients to clinics for services, continue training of service providers and supervisors beyond the project, sustain and scale-up facility assessment and strengthening efforts, and use mystery clients and client exit interviews to routinely monitor the quality of services at clinics.

INTRODUCTION

The African Youth Alliance program (AYA) was launched in 2000 by Pathfinder International, the Program for Appropriate Technology in Health (PATH), and the United Nations Population Fund (UNFPA) with funding from the Bill and Melinda Gates Foundation. AYA sought to improve overall Adolescent Sexual and Reproductive Health (ASRH) and reduce the spread of HIV/AIDS and other Sexually Transmitted Infections (STIs) in four African countries: Botswana, Ghana, Tanzania, and Uganda.

The main beneficiaries for the project were young people between the ages of 10 and 24, with a focus on the 10 – 19 year olds. The secondary targets included teachers, health workers, social workers and parents. In addition, the tertiary target group included religious leaders, the media, politicians and policy makers. The latter group was crucial for creating a supportive environment for the project. The project was developed with a focus on six broad areas, including:

1) Advocacy and policy – The creation of supportive community and political environments through advocacy and policy efforts at both the national and community levels, and efforts to improve communication between young people and the adults in their lives.
2) Behavior Change Communication (BCC) – The development and expansion of behavior change communication through interpersonal communication; folk and mass media, including drama; life planning skills programs for youth; peer education and counseling; and social marketing campaigns.
3) Youth-Friendly Services (YFS): The improvement of young people's access to – and the quality of – reproductive health services by developing, expanding and institutionalizing YFS in a variety of settings.
4) Institutional capacity building – Strengthening the institutional capacity of the country-level partners so they can better plan, implement, manage, and sustain programs and services.
5) Life and livelihood skills development – The integration of sexual and reproductive health into existing livelihood skills development and training programs for youth.
6) Coordination and dissemination – Coordination and information sharing of program activities, lessons learned, and best practices.

Pathfinder International was responsible for the YFS and institutional capacity building components implemented in each country. Through the YFS component, AYA/Pathfinder sought to address the factors that hinder young people from seeking SRH services and to improve the overall quality of services. YFS are services that attract youth, meet a variety of young people's needs comfortably and responsively, and succeed in retaining them for continuous care.

Pathfinder had, through previous work worldwide, developed a list of the key elements of youth friendly services. Under AYA, these have been categorized into essential and supportive elements as presented in table 1.

Table 1: Characteristics of Youth Friendly Services

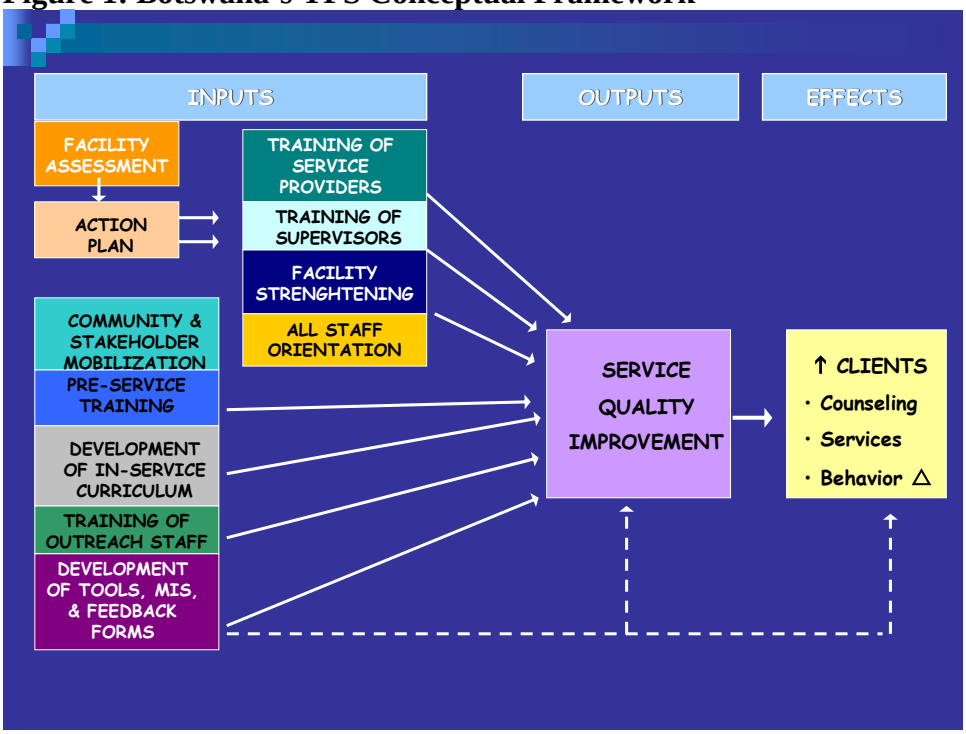
Essential	*Supportive*
• Convenient open hours • Privacy ensured • Competent staff • Respect for youth • Minimum package of services available • Sufficient supply of commodities and drugs • Range of family planning methods offered • Emphasis on dual protection/ condoms • Referrals available • Young adolescents (12-15) are served • Confidentiality ensured • Waiting time not excessive • Affordable fees • Separate space and/or hours for youth	• Youth input/feedback to operations • Accessible location • Publicity for YFS • Comfortable setting • Peer providers/counselors available • Educational materials available • Delay of blood test and pelvic exam, if possible • Partners welcomed and served • Non-medical staff oriented • Provision of additional educational opportunities • Outreach services available

The AYA Pathfinder approach to YFS focused on the following:

- Building on existing resources by using available facilities and service providers;
- Reaching young people through a variety of channels such as: static clinics and outreach including peer education;
- Establishing linkages with effective referral sites;
- Creating partnerships with other institutions for future scaling-up; and
- Instituting a minimum package of youth-friendly SRH services, including:
    - Information and counseling on sexuality, safe sex, and reproductive health;
    - Contraception and protective method provision (with an emphasis on dual protection)
    - STI diagnosis and management
    - HIV counseling (and referral for testing and care)
    - Pregnancy testing and antenatal and postnatal care
    - Counseling on sexual violence and abuse (and referral for needed services)
    - Postabortion care counseling and contraception (with referral for treatment of complications when necessary).

AYA/Pathfinder's YFS work is reflected in the conceptual framework presented below (figure 1).

Figure 1: Botswana's YFS Conceptual Framework



The AYA/Pathfinder strategy for implementing youth-friendly SRH services included the following activities:

1) Facility assessments;
2) Development and implementation of action plans for quality improvements based on the results of the facility assessments;
3) Provision of essential technical assistance and monitoring to the institutions, management and clinics as per identified needs;
4) Training of service providers in ASRH/YFS;
5) Training of supervisors in supportive supervision of YFS;
6) Orientation of program managers, site supervisors and other non clinical staff on basic SRH issues and how to interact with youth clients;
7) Training and assistance on data collection and analysis of service statistics;
8) Implementation of youth input and feedback mechanisms;
9) Creation and/or expansion of peer education programs;
10) Community sensitization in SRH and involvement in peer selection for outreach work; and
11) Institutionalization of YFS through the development of YFS tools and curricula for pre-service training.

This report highlights the results of the YFS work implemented in Botswana from early 2002 to end of 2004 that improved both Ministry of Health and International Planned Parenthood Federation-affiliated clinics (which are part of the Botswana Family Welfare Association (BOFWA)) throughout the country. It describes the work implemented by AYA/Pathfinder staff in the country, the process used to evaluate the interventions, and the findings of the evaluation. It also offers recommendations on implementing and evaluating further YFS efforts for the future.

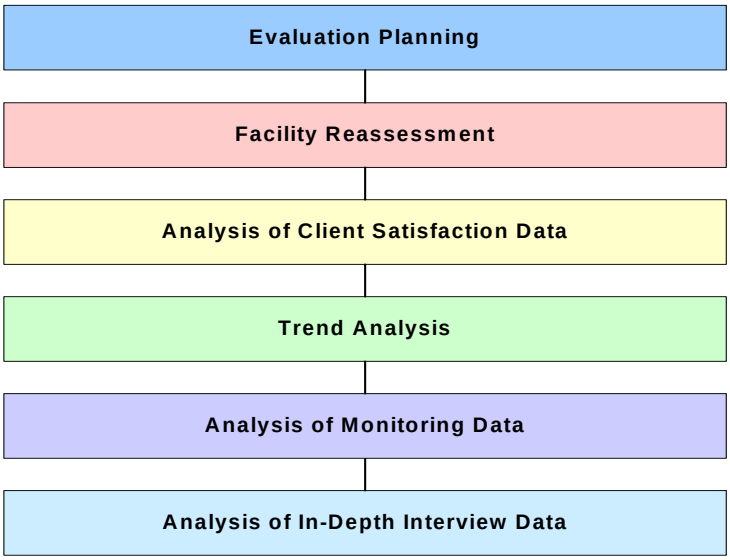
OVERALL METHODOLOGY

The YFS evaluation consisted of a number of activities designed to assess the extent that the interventions met their objectives, and to capture successes, challenges, and lessons learned of both facility and outreach efforts. The evaluation process was designed by both Pathfinder International headquarters and field staff and implementation was carried out by the field staff, with assistance from Pathfinder headquarters. Key evaluation activities included:

1) Evaluation planning,
2) Facility reassessments,
3) Analysis of client satisfaction data,
4) Trend analysis,
5) Analysis of monitoring data, and
6) Analysis of in-depth interview data.

The diagram below shows the evaluation activities, forming the outline for this report. Each of the activities is described generally in this section and then more specifically as it relates to the sections later in the report.

Figure 2: Botswana Evaluation Framework



Evaluation Planning: AYA/Pathfinder and Pathfinder headquarters staff designed the evaluation strategy jointly. Staff selected the following key activities to evaluate based on available resources for evaluation: facility strengthening and client satisfaction.

Facility reassessments: AYA/Pathfinder field staff reassessed all facilities using the facility assessment tool,[1] and applied the certification tool[2] to establish endline results in November 2004. These results were compared against the baseline scores obtained at the outset of the project. It should be noted that the original baseline information obtained through the facility assessment tool was qualitative in nature and was intended primarily for planning purposes. In order to quantify the baseline, a retroactive scoring process was used whereby a quantitative scoring tool (i.e., the certification tool) was applied to the facility assessment results to obtain a numerical score.

Essential and supportive elements were scored as follows:
Score 2: If the element meets the criterion fully
Score 1: If the element meets the criterion partially or if actions are underway to comply
Score 0: If the element does not meet the criterion

Analysis of client satisfaction data: Youth served as mystery clients in order to gauge client satisfaction of service provision at the clinics. Interview results of 22 mystery client visits conducted in 17 clinics in the 8 districts were analyzed in November 2004.

Trend analysis: Each facility collected and reported service statistics on a quarterly basis. A trend analysis of those data was conducted in November 2004 to reveal changes in the service statistics following the YFS intervention.

Analysis of monitoring data: Analysis of monitoring data, including facility strengthening data, was done to provide additional information for this report.

Analysis of in-depth interview data: In-depth interviews were conducted with at least two program staff and service providers per clinic to determine the strengths and limitations of the YFS interventions, including training and facility assessments. Data from a total of 32 staff interviews were analyzed in November 2004.

Overall Data Limitations

There were a number of limitations to the data and the evaluation itself, including:

Service statistics: AYA/Pathfinder was unable to get service statistics data from all of its facilities. Attempts were made to address the facility-based issues at the ASRH service provider trainings and also during monitoring visits. AYA/Pathfinder staff helped service providers complete the tool, understand how to interpret the data, and how to use the data to improve the delivery of services at the facility. AYA/Pathfinder also tried to address the national data entry issue by hiring a management information system specialist in December 2003 (under the institutional capacity building component) to work with the research, monitoring, and evaluation officer at the MOH on developing a system for entering and analyzing ASRH and YFS data received from the

[1] The Facility Assessment Tool, *Clinic Assessment of Youth-Friendly Services: A Tool for Improving Reproductive Health Services for Youth,* can be downloaded from Pathfinder International's website at http://www.pathfind.org/site/PageServer?pagename=Publications_Guides_and_Tools_Assessment_Tools.
[2] The *Certification Tool for Youth Friendly Services* can be downloaded from Pathfinder International's website at http://www.pathfind.org/site/PageServer?pagename=Publications_RH_Resources_ASRH.

facilities. A data clerk was then hired in June 2004 to enter the service statistic data. Despite these efforts, much of the facility data was still not available.

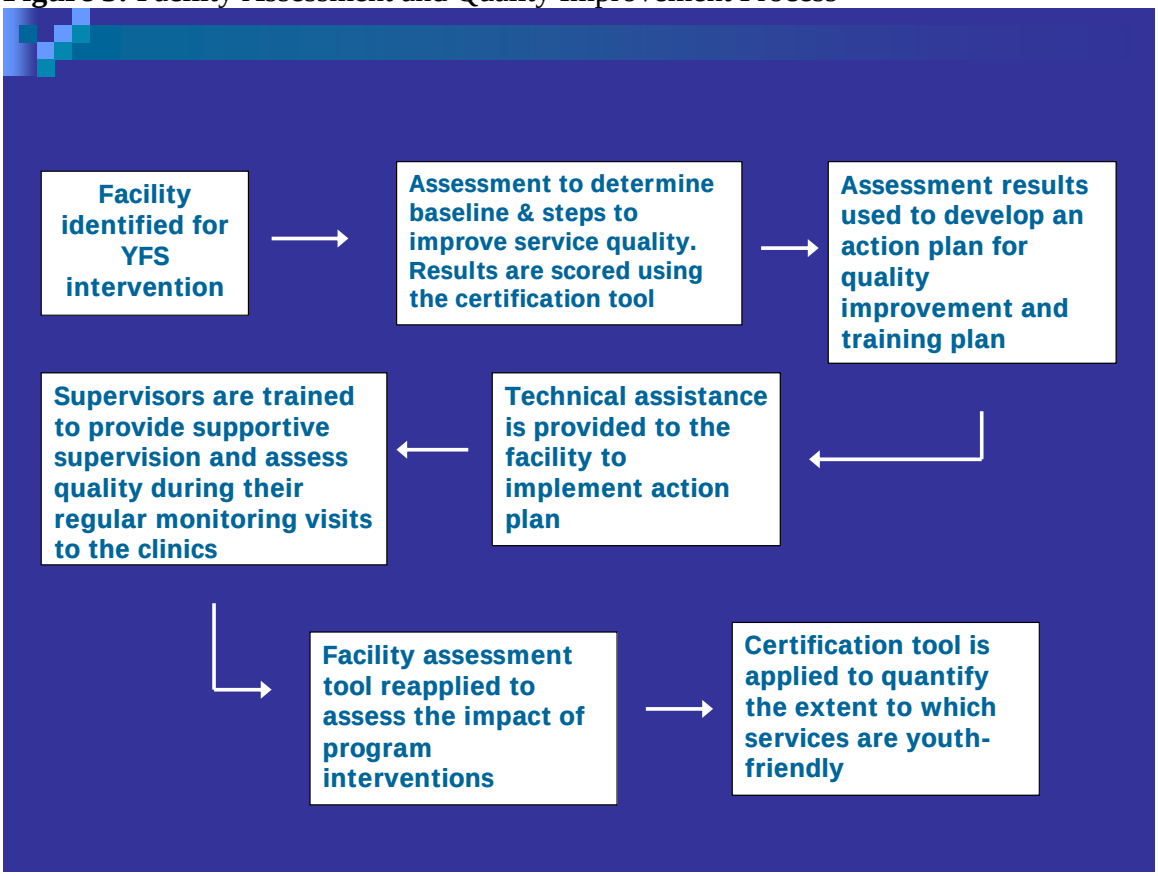
Baseline data: As mentioned earlier, the original baseline was qualitative and in order to assign a numerical value, it was necessary to retroactively score the original data. The retroactive scoring process was a limitation to the reassessment data because many baseline assessments were scored after the initial assessment, which was done without the certification tool. This meant that in some cases, related information required to score was missing and could not always be collected retroactively. Because the endline assessments were done after the development and application of the certification tool, endline assessment information was found to be more complete.

Lack of funding: As often happens as multi-year projects near an end, funding limitations affected the end of project activities. Because of resource limitations, both human and financial, the evaluation design had to be modified to provide the best information possible.

Facility Assessment and Strengthening Activities

AYA/Pathfinder worked to improve the youth friendliness of the partner facilities through the static facility component. The process of integrating YFS into the facilities included the selection of facilities, assessment of those facilities using a facility assessment tool, development of action plans to address gaps in youth friendliness, implementation and monitoring of the action plan, and then reassessment and certification of those facilities. The process is shown in figure 3.

Figure 3: Facility Assessment and Quality Improvement Process



As part of this process, the following activities were conducted in Botswana:

- Selection of districts and clinics,
- Facility assessments,
- Development and implementation of quality improvement action plans, and
- Monitoring and supervision.

Selection of Districts and Clinics

AYA/Pathfinder staff met with Ministry of Health (MOH) staff to decide how to introduce YFS into government health clinics. AYA/Pathfinder and the MOH decided to work with two government clinics per district and to use a phased approach. In the first year, YFS would be introduced in four districts (total of eight clinics). In the second year, YFS would be introduced into an additional 4 districts (8 clinics), for a total of 16 government clinics.

The AYA team, in consultation with the MOH and other stakeholders (such as the Ministry of Local Government and district health teams), first chose the eight districts in which to work. Districts were chosen based on the size of their youth populations, HIV prevalence rates among youth, and the extent to which the districts were underserved. The first districts selected were Ngamiland, Gantsi, Kgatleng, and Francistown. In late 2002, the four additional districts brought on board were Serowe/Palapye, Selibi-Phikwe, Southern, and Kgalagadi.

The group developed the following selection criteria for the clinics in which they would work:[3]

- HIV prevalence rates in the catchment areas;
- Proximity to places where young people congregate (i.e., schools, youth centers, play grounds, etc.);
- Easily accessible (i.e., where there is regular public transport); and
- Commitment and interest of staff in working with young people.

Consultative meetings were conducted in each district with the District Health Teams (DHTs) to introduce AYA to the teams, sensitize them to the concept of YFS, discuss implementation modalities, and select the two facilities in each district that would participate. Pathfinder also subcontracted with BOFWA in May 2001 to work in four of its clinics.

A total of 16 government and 4 BOFWA facilities were part of the YFS component. The clinics included (by district):

- Kgatleng – Boseja, Mochudi Clinic II, and Mochudi Clinic (BOFWA);
- Francistown – Area W and Gerald Estate;
- Ngamiland – Maun Main Clinic, Boseja, and Maun (BOFWA);
- Gantsi – Gantsi Clinic and Gantsi Primary Clinic;
- Selibe-Phikwe – Lesole Clinic and South East;
- Serowe/Palapye – Kadimo and Extension 3;
- Southern – Dada, Mmamokhasi, and Kanye (BOFWA);
- Kgalagadi – Werda and Omaweneno; and
- Gabarone – Gabarone (BOFWA).

Facility Assessments

Facility assessment team members were selected based on their familiarity with YFS (several had participated in the curriculum review and development process described earlier) and included staff from the Family Health Division (FHD) of the MOH, local government, and the AYA program technical officer for YFS in Botswana. The Pathfinder headquarters ASRH Associate gave a one-day orientation on the facility assessment tool to the team members. Pathfinder staff also served as team members for the first round of assessments (eight clinics in March 2002),

[3] It should be noted that in selecting clinics, priority was given to those clinics with high HIV prevalence rates in their catchment areas, although other selection criteria (such as staff commitment to working with young people) may not have been as strongly demonstrated.

providing hands-on coaching as necessary. The second set of assessments was conducted by staff from the FHD and the program technical officer for YFS in Botswana.

Sixteen public sector and two BOFWA facilities[4] were assessed using the facility assessment tool. Due to the phased implementation approach, eight clinics were assessed in March 2002, and the remaining clinics were assessed in August 2003.

Development and Implementation of Quality Improvement Action Plans

The assessment findings were then used to develop quality improvement plans for each facility by clinic staff, including managers, representatives from the district health teams, and representatives from the MOH national office. Facility staff then implemented the quality improvement action plans with technical assistance from FHD. Facility strengthening primarily focused on training service providers and other staff on YFS, SRH, and management information systems and making improvements to the clinics to make them more youth friendly. For example, clinics were painted, youth-specific posters were hung on walls, partitions were built to increase privacy, extra spaces were created for youth-specific services, and signs were posted outside the clinics to notify youth of available services. Clinics also worked to improve procurement of supplies and equipment, organize suitable youth hours, and add or improve peer outreach services.

A sign publicizes YFS at the government's Gaborone clinic.

[4] It should be noted that although AYA funded and collected data from four BOFWA clinics, only two of the clinics were a part of the facility assessment and strengthening intervention.

The training of service providers for the provision of SRH and YFS services was done at two levels, in-service and pre-service.

In-service

Curricula Review and Development: A Botswana ASRH training manual for service providers was developed through a participatory process that involved a range of stakeholders from the MOH, local government, pre-service training institutions, BOFWA, and the Botswana National Youth Council. A one-week workshop was held where participants reviewed module 16 (*"Reproductive Health Services for Adolescents"*) of Pathfinder's "*Comprehensive Reproductive Health and Family Planning Training Curriculum"* and other resources on YFS, and developed an outline for the curriculum. Additional technical assistance was provided by Pathfinder to FHD to finalize the curriculum and ensure that exercises were participatory and the manual was user friendly. It fully integrated international covenants, national policies, standards of practice, and institutional procedures, and also addressed issues such as the lack of BCC (Behavior Change Communication) and other support materials by including activities that could be implemented at the clinic level. Opportunities to talk with young people about SRH issues were also incorporated into the curriculum. The training manual was then adapted as the national curriculum by FHD and used to train service providers in YFS.

Training of Trainers: Fifty-five trainers were trained for 10 days using Pathfinder's *"Adolescent Sexual and Reproductive Health: A Training of Trainers Manual.*" This manual was developed to assist trainers in understanding ASRH and includes training methodologies for ASRH and YFS. The trainers were identified by the district matrons based on their previous experience with training and interest in working with young people. The trainers were trained by a team consisting of MOH staff, the program technical officer for YFS, and a training consultant hired by AYA.

Service Providers: One-hundred nineteen service providers were trained using the "*Botswana ASRH Training Manual for Service Providers*." The service providers were trained for 10 days by a team of MOH staff, the program technical officer for YFS, and local trainers who participated in the training of trainers. The service providers were selected primarily from the districts in which YFS was being implemented. Other selection criteria included interest in working with young people and experience with providing reproductive health services.

Supervisors: Training courses were also held for 33 clinic supervisors. The impetus behind initiating a course for supervisors came from the results of the post-training surveys of previously trained providers. Providers reported that supervisors were the main barrier to implementing YFS strategies, thus it was necessary to sensitize supervisors to the need for YFS and what it included.

Supervisors were trained using Pathfinder's "*Supportive Supervision for YFS Training Manual."* The course was designed to increase supervisors' knowledge of ASRH, develop skills that would enhance service delivery, and provide tools that supervisors could use in their work. The training included information on YFS, the process of quality improvement (including how to apply the assessment tool), and supervisory skills (including how to use the supervision checklist for YFS).

Pre-Service

The need for specialized provider training in ASRH/YFS was identified because youth often cited provider attitudes and lack of ASRH skills as being at least partially responsible for their low patronage of existing health facilities. As in-service training can be costly and is often not sustainable due to staff attrition and transfer, AYA collaborated with the Institute of Health Sciences (affiliated with the University of Botswana) to conduct a course on ASRH for 17 tutors. In addition to providing a review and orientation to ASRH issues, the training of tutors familiarized them with the training manual contents and methodology, thus laying the foundation for tutors to incorporate ASRH into their courses at the Institute.

Monitoring and Supervision

Monitoring and supervision was carried out in order to identify weak areas and make improvements to the facilities and in project implementation. Monitoring and supervision included collection and analysis of facility service statistics and regular supervision by MOH and AYA/Pathfinder staff, as described in more detail below.

Collection and analysis of service statistics: A new tool for collection of facility service statistics was introduced into the clinics in late 2002, which had been developed by MOH staff in collaboration with monitoring and evaluation staff from AYA. Although the tool was not pre-tested, it was revised based on feedback from the service providers. Orientation to the tool was provided during service provider training on ASRH/YFS. Facility service statistics were collected and monitored throughout the project period, disaggregated by sex, age (10-14, 15-19, 20-24), type of visit (new or revisit[5]), and services provided to each client. The data was compiled and submitted to AYA/Pathfinder on a quarterly basis by the partners. AYA staff reviewed the statistics for purposes of strengthening data collection and implementation.

Supervision by MOH and AYA/Pathfinder: Quarterly monitoring visits of clinics were conducted by national MOH and AYA staff. During these monitoring visits, the team discussed in detail the implementation of the quality improvement plan, the challenges, and how to address these challenges in practical and cost effective ways with the facility managers. The team also worked with the service providers on completing the data collection forms.

[5] If the client was new to the facility, the visit was marked as new. If the client had been served at the facility previously, regardless of what they were served for, the visit was marked as revisit.

Facility Reassessment

Evaluation Methodology

The primary means of evaluating the facility strengthening activities was through a reassessment of facilities using the facility assessment tool and certification tool to receive an endline score. Interviews were also held with service providers and facility managers to gather additional information. All 16 government and 2 BOFWA clinics were reassessed in November 2004. Data from baseline and endline were compared to determine if, and in what ways, clinics improved their youth friendliness following the intervention. In addition, interviews were conducted with assessment team members and staff to gather information on their experiences with the assessment and strengthening process. Action plans and monitoring data were also reviewed and analyzed.

In conducting the reassessments with the facility assessment and certification tools, the methods below were applied.

Review of clinic records: This involved looking critically at the daily, monthly, and quarterly statistic forms to see how many youth were served, with what services, and what age groups and sex were served to uncover issues like younger youth not being served or youth being counseled but not really given FP. In addition, the team would note if data was collected by age groupings and if there were problems with data recording.

Observations/ examination: This involved observing the general layout of the clinic and client flow as well as availability of equipment, commodities, and educational materials. Client-provider interaction was also observed to determine provider attitudes toward serving youth clients and technical competency in ASRH.

Interviews with clinic managers, staff and clients: Questions were posed to managers, clients and providers to elicit their opinions on the youth-friendliness of the clinic and to determine their attitudes and practices in serving youth. During the reassessment, questions were asked to find out more detail about clinic improvements.

Review of policy and procedures: At each facility, managers were asked if they had any policy documents that were in support of ASRH, YFS, or both. If they did, these documents were reviewed, but in absence of the documents, providers or mangers were only asked whether such documents existed and whether they were aware of the policies mentioned in the documents. Different scenarios were presented to the managers and staff related to the appropriate age group for ASRH services, especially on eligibility of contraceptives to explore barriers such as minimum age or parental consent.

Data Limitations

Quantitative analysis of facility assessment data was difficult in some cases due to the qualitative nature of the tool, particularly where there were close-ended questions and when young clients were not available to be interviewed during the assessments. If an element could not be verified by client interview or observation, it was given a particle score of "1". Therefore, some scores are not necessarily fully representative of the levels of YFS in the facilities.

Results

Twelve clinics improved from baseline to endline assessment, three stayed the same and three declined from baseline to endline assessments. The results are shown in the chart below.

Table 2: Facility Assessment Baseline and Endline Scores

Facility	**Baseline Score**			**Endline Score**		
	Essential	**Supportive**	**Total**	**Essential**	**Supportive**	**Total**
Gaborone YF Center (BOFWA)	20	12	**32**	21	17	**38**
Mochudi YF Center (BOFWA)	22	17	**39**	23	20	**43**
Mochudi II (FHD)	13	6	**19**	21	15	**36**
Boseja (FHD)	15	6	**21**	19	13	**32**
Gantsi Primary Hospital (FHD)	17	5	**22**	15	7	**22**
Gantsi Clinic (FHD)	14	10	**24**	21	9	**30**
Ithekeng Clinic, Area W (FHD)	21	6	**27**	16	6	**22**
Gerald Estate (FHD)	17	5	**22**	20	11	**31**
Maun Main Clinic (FHD)	15	9	**24**	15	8	**23**
Boseja Clinic (FHD)	16	8	**24**	16	8	**24**
Lesole Clinic (FHD)	14	10	**24**	19	10	**29**
South East Clinic (FHD)	15	11	**26**	20	12	**32**
Omaweneno Clinic (FHD)	19	11	**30**	17	7	**24**
Werda Clinic (FHD)	18	12	**30**	23	11	**34**
Extension 3 Clinic (FHD)	10	10	**20**	12	11	**23**
Kadimo Clinic (FHD)	14	8	**22**	17	6	**23**
Mma-Mokhasi Clinic (FHD)	15	7	**22**	18	6	**24**
Dada Clinic (FHD)	18	11	**29**	16	13	**29**

As seen in the table below, in looking at the individual elements (essential and supportive) across facilities, a majority (15) improved. Four elements maintained their score (competent staff, affordable fees, accessible location, and outreach services available), while six decreased (sufficient supply of commodities and drugs, confidentiality ensured, waiting time not excessive, publicity for YFS, educational materials available, and provision of additional educational opportunities). Each element and its total baseline and endline score is shown below. The total possible score was 36 for each.

Table 3: Total Element Scores across Facilities

	Element	Baseline	Endline	Change
Essential	Convenient open hours	33	34	+1
	Privacy ensured	25	34	+9
	Competent staff	18	18	0
	Respect for youth	13	20	+7
	Minimum package of services	34	35	+1
	Sufficient supplies of commodities	19	9	-10
	Range of methods offered	34	35	+1
	Emphasis on dual protection	9	20	+11
	Referrals available	16	21	+5
	Young adolescents served	10	17	+7
	Confidentiality ensured	20	14	-6
	Waiting time not excessive	17	16	-1
	Affordable fees	34	34	0
	Separate space and/or hours	7	12	+5
Supportive	Youth input feedback mechanism	2	4	+2
	Accessible location	34	34	0
	Publicity for YFS	8	7	-1
	Comfortable setting	12	16	+4
	Peer educators/counselors available	6	10	+4
	Educational materials available	17	16	-1
	Delay of tests	13	26	+13
	Partners welcomed	26	32	+6
	Non medical staff oriented	1	8	+7
	Provision of additional educational opportunities	16	7	-11
	Outreach services available	18	18	0

A number of improvements were observed with respect to the essential and supportive elements, including:

- Privacy ensured,
- Respect for youth,
- Emphasis on dual protection/condoms,
- Referrals available,
- Young adolescents served,
- Separate space and/or hours,
- Comfortable setting,
- Peer providers/counselors available,
- Delay of blood test and pelvic exam,
- Partners welcome and served, and
- Nonmedical staff oriented.

These improvements reflect AYA/Pathfinder's focus in Botswana on training providers and nonmedical staff on YFS and ASRH and on the physical improvements made to the clinics to improve services for youth.

Clinics were found to be strong in a few areas at both baseline and endline, including the following:

- Convenient open hours – Most facilities were open enough hours during the week and weekends to best serve youth.
- Accessible location – Most of the facilities are located within walking distance of or within easy reach of public transportation from schools, social spots or workplaces of youth.
- Affordable fees – Although the facilities charged two pula for a registration card, young people said that they found the fees affordable. In most cases where a young person was unable to pay the fee, it was waived and services were provided without any charge.
- Availability of the minimum YFS package of services – This includes referrals for services not available at the clinic.
- Range of methods offered – Almost all facilities offered the full range of contraceptive methods, including condoms, oral contraceptives, Injectables, Norplant, and emergency contraceptive pills.
- Publicity for YFS (BOFWA) - BOFWA extensively publicized and marketed YFS through the use of media and community events.
- Separate space for youth (BOFWA) – BOFWA youth clinics were separate, stand alone facilities. In these clinics, youth did not have to mix with adult clients and providers guaranteed confidentiality and privacy.

A youth seeks services in a BOFWA clinic, which contained a separate space for youth clients.

Three of the elements declined in several clinics, including provision of additional educational opportunities (11 facilities), sufficient supply of commodities and drugs (8 facilities), and confidentiality ensured (6 facilities). Further investigation should be done about why educational opportunities and confidentiality decreased over the project period, and efforts must be made to ensure adequate supplies in the future.[6]

In addition to needed improvements in the three areas above, clinics identified several areas on where they would have liked to improve, but faced challenges in strengthening these areas. The elements and the reasons given by clinic staff for lack of improvement include:

- Separate space for youth (government facilities) – Although improvements were made in this, several government facilities were not able to offer separate spaces for youth, as this was an issue that required DHT approval.
- Publicity for YFS (government facilities) – Unlike BOFWA clinics, most clients interviewed did not know that government facilities were offering YFS. Again, DHT approval was needed.
- Peer providers/counselors and outreach services available (government facilities) – Though several clinics began or expanded peer and outreach programs, they faced a number of challenges in implementation. Issues such as stipends for peer providers and supervision by clinic staff could not be easily resolved. Facilities were encouraged to connect with the district youth officer to recruit and supervise young people to be volunteer peer providers. For outreach, facilities were encouraged to establish relationships with community-based

[6] It should be noted that commodity provision was not part of AYA's mandate.

health workers and community-based sites and organizations that were linked, and able to refer to the clinic.

- Educational materials available – There was a lack of synergy between the BCC and YFS components, leading to inadequate supplies of BCC materials in the clinics.

In addition to challenges noted above, facility staff also reported challenges in implementing plans where there was insufficient support by managers, competing priorities, and staff turnover. For example, given that the HIV epidemic is viewed as a higher priority than YFS programs, service providers reported that managers were often not available to assist with the implementation or monitoring of the plans as their attention was turned towards activities for prevention of mother-to-child transmission of HIV, antiretroviral therapy, tuberculosis, and child survival programs. Also, while training providers helped improve provider respect for youth in many clinics, trained providers were sometimes transferred, which reversed any gains made in this area, and left the clinic without sensitized staff. This might have been prevented if providers, their managers, and their supervisors were better informed about the program, why their clinic had been selected, and what they were expected to do.

Analysis of Client Satisfaction Data

Evaluation Methodology

Mystery client visits were used as a means of determining client satisfaction in the clinics, and were conducted in September 2004 in 17 clinics in 8 districts. The mystery clients visited all 16 government facilities and 1 BOFWA facility. The facilities visited comprised 15 clinics, 1 health post and 1 district hospital, in 10 rural, 4 peri-urban, and 3 urban areas. A total of 22 mystery client visits were conducted.

The mystery client assessment involved the following steps:

- Recruitment of youth,
- Training of youth,
- Mystery client visits, and
- Reporting back from youth.

Recruitment of youth

Assistance was sought from the Botswana National Youth Council to recruit young people to act as mystery clients. They sought youth with some background in ASRH and the personality (e.g. assertiveness and self-confidence) to conduct this type of activity.

Twelve young people (a combination of out of school youth and peer educators) were recruited from six districts. Though Kgatleng and Kgalagadi were not represented, two young people recruited from Gaborone were assigned to these two districts. The young person from Francistown expressed concern that the providers at the facilities knew him well since he had been a peer educator stationed at the two facilities and could therefore not act as a mystery client. Therefore, a switch was made and the young person from Serowe went to Francistown and the young person from Francistown went to Serowe. This arrangement worked well since these districts are close to each other. The following table shows the breakdown of the mystery clients by age and sex.

Table 4: Age and Sex of Mystery Clients

Age	***Males***	***Females***
19	0	2
20	2	1
21	1	0
22	1	3
23	1	1

Training of youth

The young people underwent a one-day training that included information and exercises to assist participants in understanding the concept of YFS, enable them to understand the purpose of the mystery client strategy, demonstrate the skills of being a mystery client, and equip participants with skills in report writing. Specifically, the training focused on the following topics**:**

- An overview of mystery client visits,
- The concept of youth-friendly health care,
- Standards or indicators of health facilities' youth friendliness,
- Adolescent reproductive health rights,
- Essential service package,
- Techniques in conducting mystery client study,
- How to compile a mystery client report, and
- Some role-plays on typical youth SRH visits.

Mystery Client Visits

The mystery clients were assigned their scenarios and sent to the districts with instructions on how to complete the data collection forms and when to report back. The data collection form that was used for this particular assessment was developed by the Christian Health Association of Ghana and used as part of cross-fertilization among AYA countries (see Appendix A). The mystery clients were encouraged to complete the data collection form as soon as they had visited the facility.

Reporting back from youth

The mystery clients were asked to return to Gaborone for a session in which they reported on their mystery visit. The youth prepared presentations about their experiences at the facilities and what they thought could have been done differently to improve the assessment. A presentation template was provided to the mystery clients to assist them. Members of MOH and AYA were invited to this presentation session.

At the end of the session the mystery clients were asked to turn in their presentations and the completed data collection forms. The presentations and the data collection forms were used to compile a summary report. Feedback from the mystery client assessment was shared with the clinics that were assessed.

Data Limitations

There are some significant limitations in the mystery client study. Most importantly, only one mystery client visit was conducted at the majority of clinics – only four clinics were visited twice. With more visits, more information to substantiate any arguments regarding facilities' youth friendliness could be collected. In addition, it is difficult to know whether the observations were consistent among the mystery clients. More questions that focused on condoms and peer education would have been helpful. For example, adding questions regarding the availability of condoms in the clinic and their location and provider's demonstration of condom use would have been useful for this evaluation, as well as for future mystery client assessments.

Results

The table below shows the mystery client recommendations and comments by clinic.

Table 5: Mystery Client Recommendations and Comments by Facility

Name of clinic and district	*Mystery client recommendation*	***Mystery Client Comments***
Boseja – Kgatleng	Recommend Not to recommend	Very youth friendly No confidentiality and provider didn't have time to listen
Mochudi II- Kgatleng	Not to recommend Not to recommend	Provider was not youth friendly and neither were other staff. Long waiting times Nurses need to be trained more to be youth friendly.
Werda Clinic – Kgalagadi	Recommend Not to recommend	Provider was friendly and willing to help. Encouraged me to come with more youth to the clinic Provider was not willing to help unless I paid the two pula, which can be expensive for some young people.
Omaweneno Clinic – Kgalagadi	Recommend Recommend	The provider is very youth friendly. The provider is very youth friendly and also young.
Gantsi Primary Hospital- Gantsi	Recommend	Provider was very friendly and willing to help. Gave me time to express myself.
Gantsi Clinic – Gantsi	Recommend	Provider was willing to assist and asked me to come back with my girlfriend
Area W- Francistown	Not to recommend	Was not assisted because I didn't have the money
Gerald Estate – Francistown	Not to recommend	No privacy and the counseling wasn't good
Lesole Clinic- Selibe/Phikwe	Recommend	Counseling is done by a young person and it is very good
South East Clinic – Selibe/Phikwe	Recommend	Need to work on the privacy
Mma Mokhasi Clinic – Southern	Recommend	The place is welcoming, treated me nicely, and the providers know how to do their jobs
BOFWA – Southern	Recommend Recommend	It is clean, welcoming, and good for youth. N/A - No comment from mystery client given
Dada – Southern	Not to recommend	Service was very poor and don't want other young people to suffer
Boseja Clinic – Maun	Recommend	Provider was very good and willing to listen
Maun Main Clinic - Maun	Recommend	Provider helpful
Kadimo Clinic – Serowe/Palapye	Recommend	It is absolutely youth friendly. Provider is outstanding.
Extension 3 – Serowe/Palapye	Recommend	It is absolutely youth friendly. Provider is very good.

Table 6 shows a comparison of variables across all the sites. The data shows that out of 22 mystery client visits, 16 (73%) of them would recommend the facility to their peers. Reasons for not recommending the facility ranged from lack of privacy and confidentiality to affordability.

From the data, it appears that the facilities seemed to be performing well on issues such as providing information on safer sex practices and condoms. However, it is important to note that most of the mystery clients presented conditions relating to SRH (unwanted pregnancy, information on contraceptives, and STIs). As noted in the limitations, it would have been interesting to have mystery clients report if they were shown how to use a condom, were given a condom, or both, as opposed to only being given information about this method. It would also have been interesting to note if information on safer sex and condoms was given to mystery clients presenting with a minor ailment. For instance, clinic reassessment reports show that counseling on sexuality, safer sex, pregnancy prevention, and STI and HIV prevention (including dual protection) is only provided when clients are seeking family planning services or have an STI.

Table 6: Mystery Client Visit Results

Variable	***#(%) of facilities or visits***
Were there any signs outside the facility?	8 of 17 facilities (47%)
Was there a separate waiting room for adolescents?	4 of 17 facilities[7] (24%)
Are there posters on STIs and other SRH issues in the facility?	11 of 17 facilities (65%)
Was your medical history taken?	9 of 22 visits (41%)
Was your social record taken?	12 of 22 visits (55%)
Was your sexual history taken?	15 of 22 visits (68%)
Were you given information on safer sex practices?	15 of 22 visits (68%)
Were you given information on condoms?	16 of 22 visits (73%)
Were you assured of confidentiality?	13 of 22 visits (59%)
Were you counseled in a place where visual privacy was guaranteed?	13 of 22 visits (59%)
Will you recommend this facility to any of your colleagues?	16 of 22 visits (73%)

[7] The BOFWA facility is an adolescent clinic and thus this question did not apply.

Although this clinic has a signboard advertising YFS, not all clinics that mystery clients went to had signs.

Overall, the mystery client reports indicate that there is room for improvement in the areas of assuring confidentiality and guaranteeing privacy, providing adequate quantities of BCC materials (especially materials for clients to take with them) and erecting sign boards outside clinics. These were all noted in the clinic reassessment reports as well.

Trend Analysis

Evaluation Methodology

The service statistic data were analyzed at the end of project to examine if any trends existed and to explore reasons for those trends.

Data Limitations

As noted above, one limitation was the lack of data from government facilities; trends are only shown for April to December 2003 and data from all facilities are not included. The number of clinics reporting for each quarter is indicated in table 6. Another limitation is that both government and BOFWA facilities, did not record numbers of family planning visits but rather numbers of family planning commodities distributed during visits. Therefore, it is not possible to calculate the number of family planning visits, nor compare them to other types of visits (counseling, pregnancy testing, STI treatment, etc.). Government and BOFWA facilities also had different implementation periods – government facilities implemented the program from January 2003 to September 2004 and BOFWA facilities implemented from June 2001 to April 2004 – making direct comparisons difficult. Finally, because data collection forms were not finalized and put in use until 2002, BOFWA's 2001 and 2002 data is not disaggregated by age group, and is thus not comparable to BOFWA's 2003 and 2004 data.

Results

Government facilities

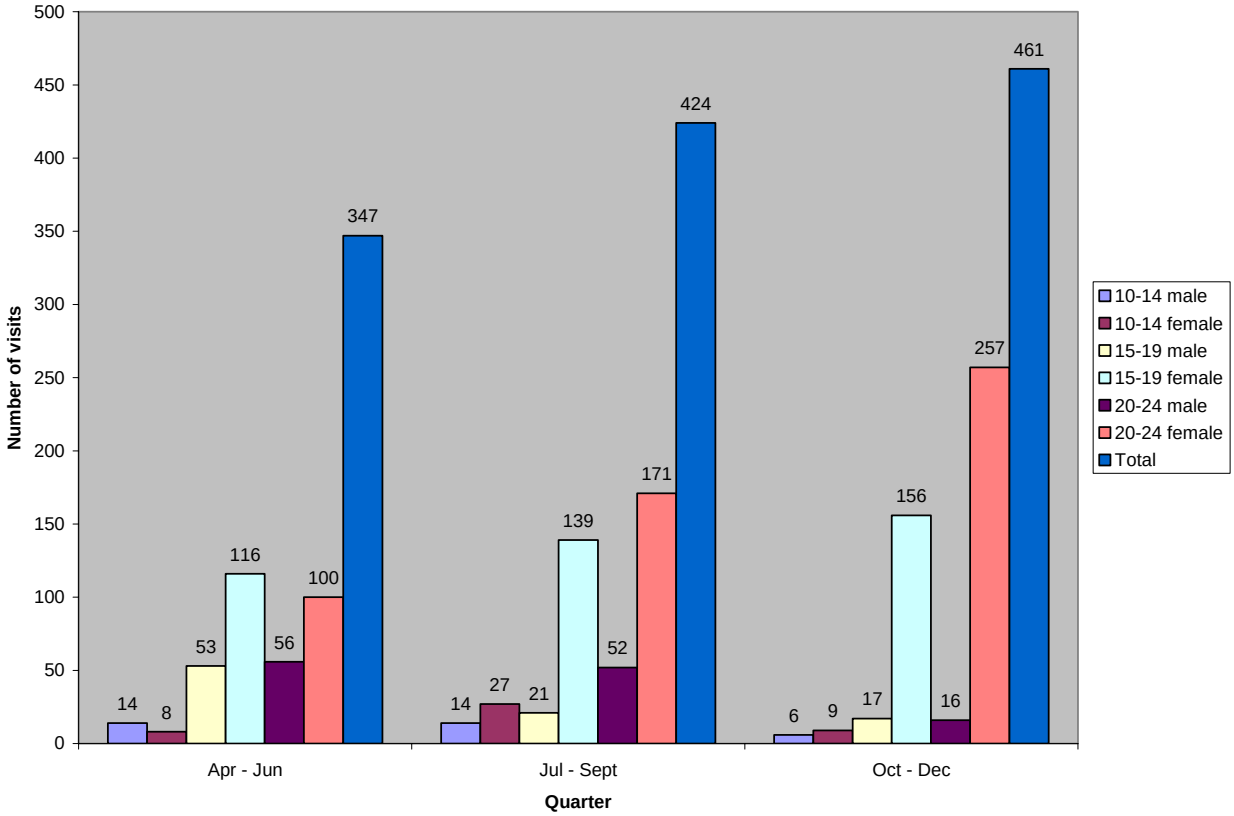
Below are the service statistics reported by the government facilities from January 2003 to September 2004. Youth aged 20-24 made the most (51%) visits to the clinics and 77% of the visits were made by females. Females aged 20-24 visited the clinics the most, followed by females 15-19. More females than males visited the facilities most likely because traditionally these services have been housed with maternal and child health services so the perception is that these services are for women. Additionally, young women, not young men, need Antenatal Care (ANC), Postnatal Care (PNC), and Postabortion Care (PAC) services. Youth aged 10-14 made the least number of visits, particularly males. Utilization was low for 10-14 year olds of both sexes as would be expected since many youth in this age group are not sexually active and may not need SRH services.

Table 7: Youth Visits to Government Facilities by Age and Sex (January 2003 to September 2004)

	2003				*2004*			
Age and Sex	***Jan – Mar (3[8])***	***Apr – Jun (6)***	***Jul – Sept (6)***	***Oct – Dec (6)***	***Jan – Mar (4)***	***Apr – Jun (3)***	***Jul – Sept (2)***	***Total***
10-14 male	1	14	14	6	11	7	18	71
10-14 female	6	8	27	9	10	10	35	105
15-19 male	7	53	21	17	32	80	53	263
15-19 female	32	116	139	156	113	127	120	803
20-24 male	14	56	52	16	36	40	33	247
20-24 female	70	100	171	257	173	87	190	1,048
Total	130	347	424	461	375	351	449	2,537

The figure below shows the number of visits by age and sex from April to December 2003. The number of visits increased steadily from quarter to quarter, as did the numbers of visits by females aged 20-24 and 15-19. The number of visits by females aged 10-14 increased and then decreased, while the number of visits by males decreased in each quarter. More investigation is needed to understand why the number of visits by males decreased consistently.

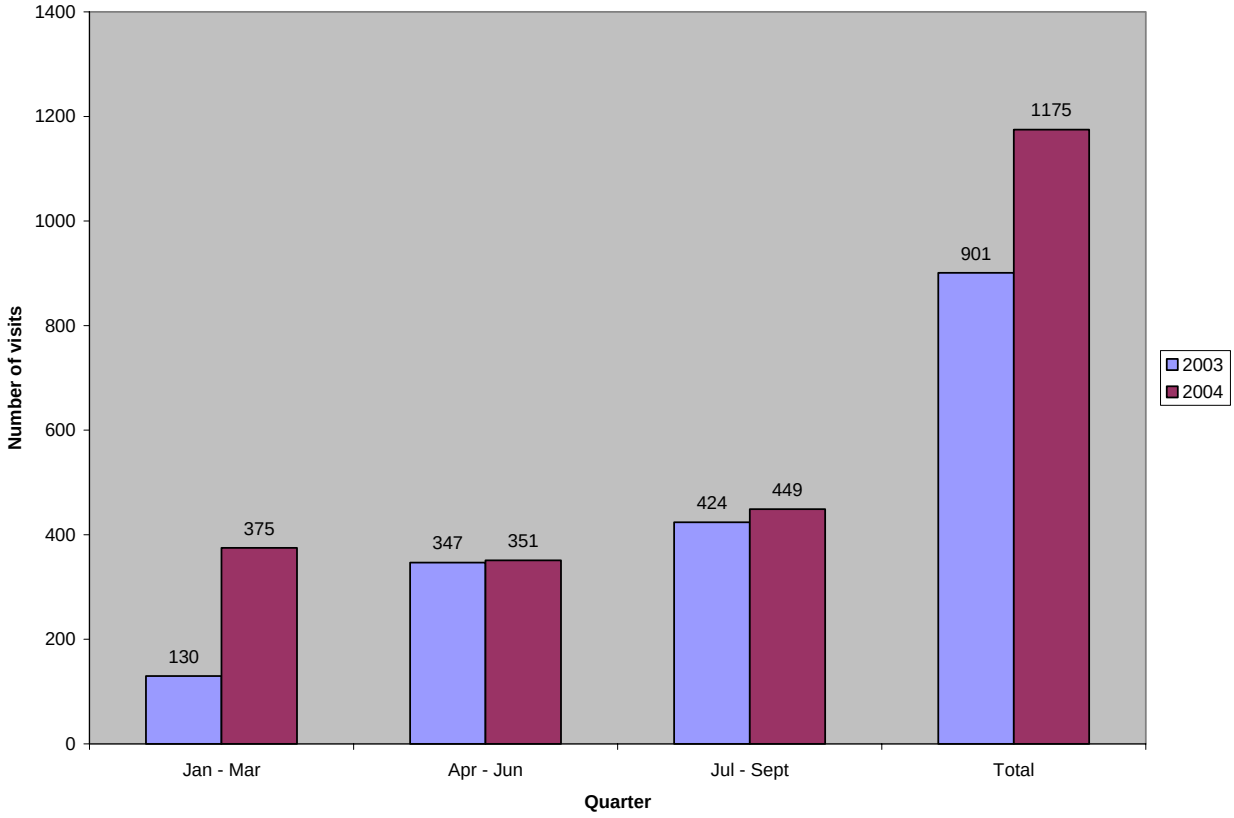
Figure 4: Youth Visits to Government Facilities by Age and Sex (April to December 2003)



[8] Number of facilities reporting.

Even though fewer facilities reported in 2004 than in 2003, the data show an upward trend in the number of youths visiting the facilities in 2004 compared to the same time period in 2003; the increase in visits would likely be even higher with equal facilities reporting. The number of youth visits to the clinics from January to September increased by 30% from 901 in 2003 to 1175 in 2004. The visits made by 15-19 year olds increased from 27% in 2003 to 45% in 2004.

Figure 5: 2003 vs. 2004 Youth Visits to Government Facilities



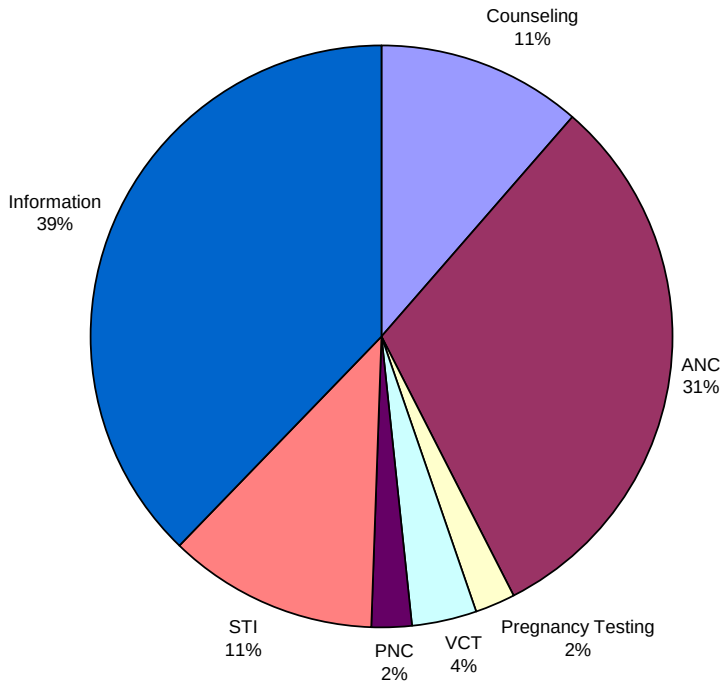
A number of services were provided to youth during these visits, including counseling, ANC, PNC, pregnancy testing, Voluntary Counseling and Testing (VCT), STI testing and treatment, and SRH information. The services provided to youth are shown below.

Table 8: Services Provided to Youth at Government Facilities (January 2003 to September 2004)

	2003				***2004***			
Service	***Jan - Mar***	***Apr - Jun***	***Jul - Sept***	***Oct - Dec***	***Jan - Mar***	***Apr - Jun***	***Jul - Sept***	***Total***
Counseling	2	30	64	20	42	69	44	271
Antenatal care	27	63	103	221	166	69	86	735
Pregnancy Testing	4	6	16	5	8	10	4	53
VCT	0	16	18	2	21	15	12	84
Postnatal care	9	6	8	3	12	14	3	55
STI	12	51	67	22	46	50	23	271
Information	42	96	87	57	117	213	285	897

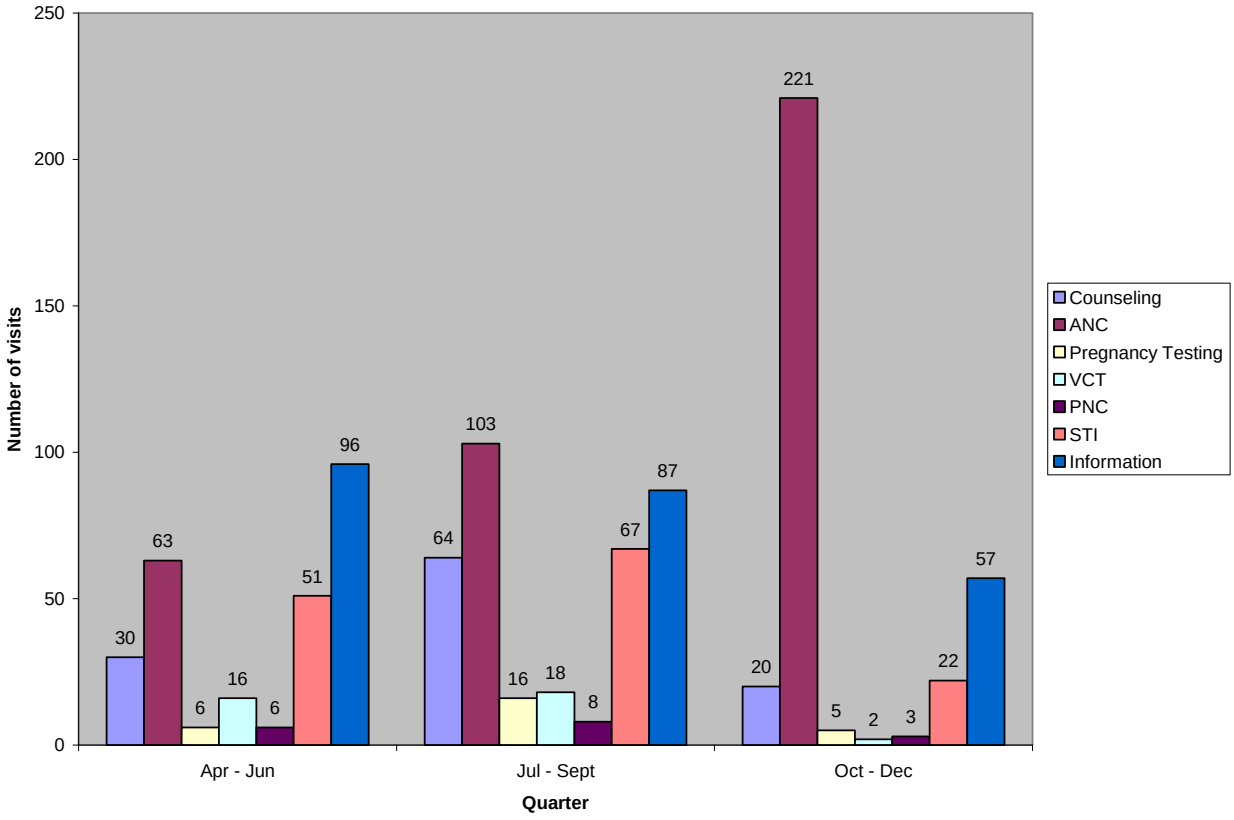
The figure below shows the percentages of each of the services provided. Most visits were made for antenatal care and for SRH information. The high numbers of antenatal care visits are consistent with national data that shows teenage pregnancy continues to be a problem in Botswana. Counseling and STI testing and treatment visits were also high.

Figure 6: Services Provided to Youth at Government Facilities (January 2003 to September 2004)



The number of services provided, disaggregated by type, from January to September 2003 are shown in the figure below. Although visits for all services increased from April to June and July to September, only ANC visits continued to increase into the next quarter. An explanation was not found for the decreases in other types of visits.

Figure 7: Youth Visits to Government Facilities by Type of Service (January to September 2003)



BOFWA Facilities (June 2001- April 2004)

Below are the service statistics for the four BOFWA facilities for the project duration from June 2001 to April 2004.

Table 9: Youth Visits to BOFWA Facilities (June 2001 – April 2004)

Type of Visit		***2001 June to December***	***2002 January to December***	***2003 January to December***	***2004 January to April***	***Total***
Clinic	Family Planning	665	2,228	3,764	754	7,411
	Other RH Services[9]	2,452	5,204	8,561	2,075	18,292
Center[10]	Monthly talks	0	1,102	2,198	196	3,496
	Male only hour	0	468	757	0	1,225
Outreach[11]	Household	351	6,221	10,903	408	408
	Institutional	0	23,804	10,459	10,221	10,221

The data show that there was a 65% increase in the total number of clinical visits from 2002 to 2003.[12] In addition, from 2002 to 2003, center visits for monthly talks and the male-only hour increased by 99% and 62% respectively and household visits increased by 75%. However, institutional visits by peer and outreach staff decreased during this period. This decrease is a result of a scaled back peer education program due to funding cuts within BOFWA in 2003.

[9] Other RH services include STI testing and treatment, ANC, PNC, VCT, pregnancy testing, counseling, and referrals.

[10] A *center visit* is defined as when a young person visits a BOFWA center for monthly BCC talks or male-only hours that occur at the centers.

[11] An *outreach visit* is defined as contact by a peer educator or a provider, such as a community health worker, with a young person outside the clinic and provides them with information, condoms, or refers them to the clinic for services. (This covers both household and institutional visits, such as schools and workplaces.)

[12] Data from 2002 and 2003 are used as comparable data, as data are available for full years. Since data were recorded for seven months in 2001 and four months in 2004, these data are not used for comparison, but for informational purposes only.

A number of services were provided at the BOFWA clinics for youth. The following tables show the services and commodities provided to youth during the project period. As was found with the government facility data, females visited the BOFWA clinics more than males. Eighty-five percent of the services were provided to females. Again, this is likely due to the perception that these services are for women.

Table 10a: Services Provided to Youth at BOFWA Facilities (June 2001 to December 2002)[13]

Type of Service	***Male***	***Female***	***Total***
ANC	0	341	341
Pregnancy Testing	0	118	118
PNC	0	159	159
STIs	282	464	746
Post abortion care	0	4	4
Other RH	0	233	233

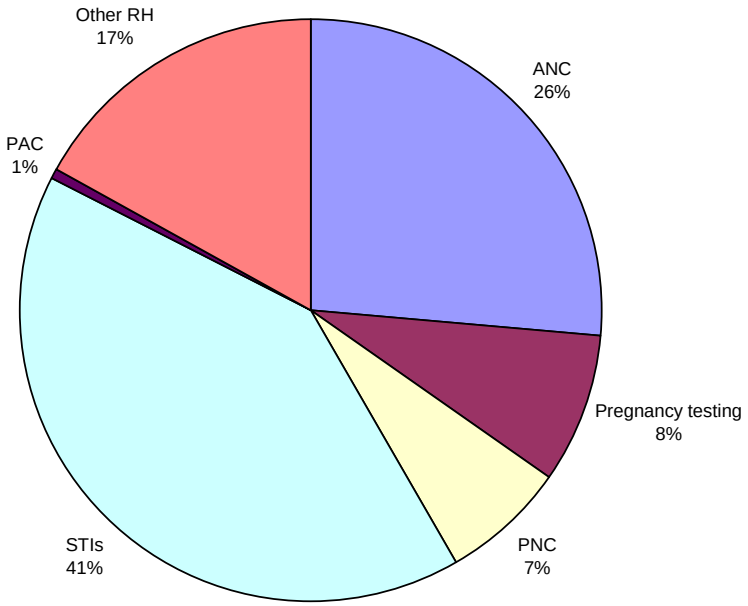
Table 10b: Services Provided to Youth at BOFWA Facilities (January 2003 – April 2004)

Type of Service	***10-14***		***15-19***		***20-24***		***Total***	
	M	***F***	***M***	***F***	***M***	***F***	***M***	***F***
ANC	0	1	0	100	0	250	0	351
Pregnancy Testing	0	6	0	49	0	48	0	103
PNC	0	0	0	9	0	13	0	22
STIs	0	0	28	67	77	147	105	214
Post abortion care	0	0	0	5	0	6	0	11
Other RH	0	8	0	87	0	117	0	212

[13] In 2001 and 2002, data collected were not segregated by age range.

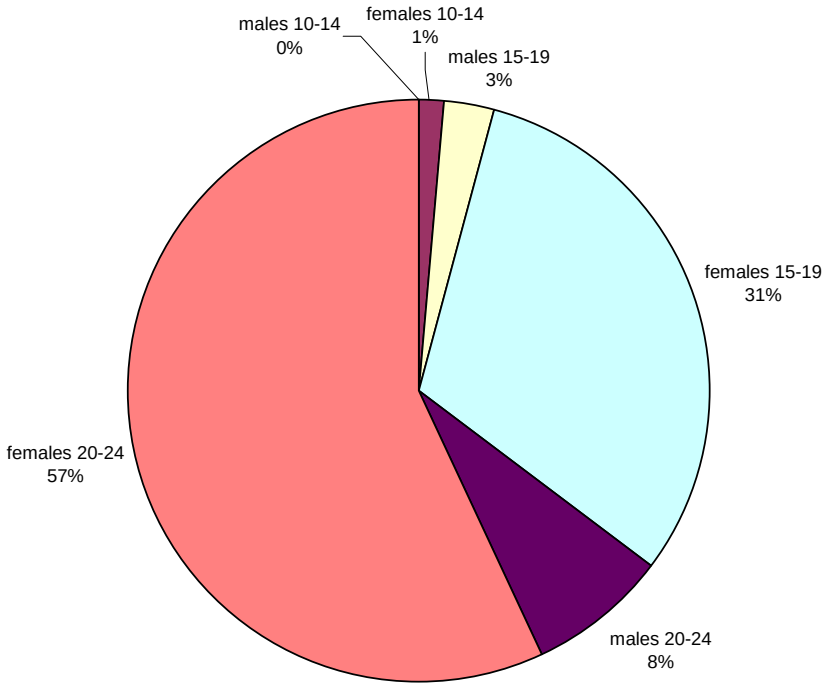
As can be seen by the figure below, the service provided most to youth by BOFWA during the project period was STI testing and treatment, followed by ANC and other reproductive health services. Due to the limitations in collecting data about family planning visits, we are unable to include that data in the graph. However, it is expected that the percentage of youth receiving family planning counseling would likely be relatively high given the mandate of BOFWA.

Figure 8: Services Provided to Youth at BOFWA Facilities (June 2001 to April 2004)



BOFWA data from January 2003 to April 2004 (broken down by age and sex) show that 90% of services were provided to females. Fifty-seven percent of visitors were females aged 20-24. The breakdown of the services provided by age and sex is shown in the figure below.

Figure 9: BOFWA Youth Served by Age and Sex (January 2003 to April 2004)



Overall, the data show increases in visits by females 20-24 and 15-19 years old. At government clinics, more visits were made for antenatal care, information, and counseling than for other services, and at BOFWA clinics, visits were made primarily for antenatal care and STI testing and treatment..

CONCLUSIONS AND RECOMMENDATIONS

Overall, most clinics improved many elements of their youth-friendliness and increased the number of visits by youth. Clinics improved in areas such as privacy, respect, and emphasis on dual protection and condom use. Many provided a comfortable setting, and separate spaces, hours, or both, for youth. Peer providers and counselors were made available, blood tests and pelvic exams were delayed, partners were welcomed and served, and nonmedical staff was oriented on YFS and ASRH issues. Elements that still need improvement include confidentiality, sufficient supply of commodities and drugs, publicity for YFS, availability of educational materials, provision of additional educational opportunities, and availability of outreach and peer providers or counselors.

The facilities were visited most often by females, particularly those 20-24 years of age. Many of the youth visited primarily for ANC services, counseling, and STI testing and treatment.

The majority of mystery clients were pleased with the services they found at the clinics. Results also showed that a majority were counseled in private and were given information on safer sex practices and condoms.

Despite the need to improve certain areas, AYA/Pathfinder did succeed in forging strong partnerships with the national government, which facilitated work in public sector facilities, increased coverage of YFS, and created a favorable environment for opportunities for future YFS work in the country. In addition, AYA/Pathfinder created sustainable tools for use beyond the project. In particular, the Botswana ASRH Training Manual for Service Providers has been adapted by the Ministry of Health as the national training curriculum and supervision and monitoring tools remain in use across the country.

Based on the program evaluation activities and the data collected throughout the project lifecycle, the following are recommendations both for the future of the AYA clinics and for future programs like AYA:

- Devise strategies to attract more males and younger clients to clinics for services.
- Training should continue beyond the project. Pre-service training should be strengthened so that serving adolescents is seen as standard procedure for service providers. Also, there should be ongoing in-service training to ensure that providers have support, maintain momentum, and are able to develop strategies to address challenges faced in their clinics and communities. Finally, supervisors' training should be scaled up so that the supervisors are provided with appropriate tools and resource materials needed to execute their jobs and in turn offer more support to service providers in implementing quality YFS.
- Sustain and scale-up the facility assessment and quality improvement process. Quality improvement teams could be formed at the facilities or districts, including the district health teams and clinic supervisors to increase their commitment. This would provide a means to maintain the quality improvement process. Setting up an accreditation system might motivate facilities to improve and maintain quality of services.
- Use mystery clients and client exit interviews routinely to monitor the quality of services rendered, and place continued emphasis on the importance of collecting service statistics to monitor the impact of the improvement efforts.

- Clinics should make the following improvements to increase access to and improve the quality of their youth services:
    - Make facility hours more convenient for young people by staying open beyond 4:30 p.m., possibly by staggering service providers' working hours.
    - Conduct outreach through community-based health workers or through community-based sites and organizations that are linked, and able to refer, to the clinic.
    - Set up alternative service delivery channels such as pharmacies and consider nontraditional condom distributors.
    - Initiate services that cater to the needs of young men.
    - Encourage younger adolescents (ages 12-15) to visit the clinics for information and services by improving provider attitudes and biases to serving this group of young people.
    - Place more emphasis on dual protection and condoms. Protection against pregnancy, STIs, and HIV needs to be discussed with each client regardless of presenting conditions, especially when young people come in for minor ailments, and condoms need to be made easily available.
    - Ensure that there are enough BCC materials available at the clinics for clients.
    - Include youth in designing, monitoring, and evaluating youth services (e.g. village health committee involvement in facility assessments, adding suggestion boxes to clinics, etc.)

Given the positive results that AYA/Pathfinder achieved in Botswana in increasing access of youth to SRH information and services, it is hoped that efforts will continue beyond the project. In particular it is hoped that support will continue for improvements in the Ministry of Health and BOFWA facilities facilities, in training service providers and supervisors in ASRH and YFS, and in monitoring client satisfaction of YFS facilities.

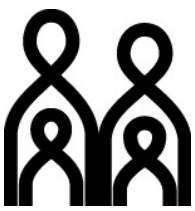
APPENDIX A: Mystery Client Interview Guide

QUESTIONS	RESPONSE	REMARKS
Scenario enacted:	**A** Unwanted Pregnancy **B** Information regarding contraceptives **C** Information regarding STIs **D** Counseling regarding premarital intercourse **E** Other	
A. LOCATION AND ENVIRONMENT		
District (name & number):		
Region (name & number):		
Date of interview:		
Level of facility where mystery client went:	Referral hospital, District Hospital, Primary Hospital, Health post, Clinic, Other	
Locality of facility:	Rural, Urban, Peri-Urban	
Age of mystery client:		
Sex of mystery client:	Male/Female	
Name of interviewer:		
Time client arrived at clinic:		
Did you find the facility easily?	Yes No	
Were there any directional signs outside the facility?	Yes No	
Were there any directional signs within the facility	Yes No	
How did you find the welcoming?	Friendly Not friendly	
Was the outside of the facility clean?	Very clean Somewhat clean Unclean	
Was the inside of the facility clean?	Very clean Somewhat clean Unclean	
Was there a separate waiting room for adolescents?	**Yes** **No**	
Are there posters on STIs and other SRH issues in the facility?	**Yes** **No**	
Did you find any poster stating the rights of the client?	Yes No	
How many adolescents did you find waiting to see the provider at the facility?	Number……..	
How long did you have to wait before being attended to?		
How did you feel about the waiting time?	Just OK Too long	
B. INSTRUCTION/EDUCATION		
How many providers attended to you during the service delivery process?	Number …	

QUESTIONS	RESPONSE	REMARKS
How would you judge the attitude of each provider?	Security	• Friendly • Not friendly
	Registration	• Friendly • Not friendly
	History	• Friendly • Not friendly
	Consultation/examination	• Friendly • Not friendly
	Laboratory	• Friendly • Not friendly
	Dispensary	• Friendly • Not friendly
Was your medical history taken?	Yes No	
Was your social record taken?	Yes No	
Was your sexual history taken?	Yes No	
Were you given information on safer sex practices?	Yes No	
Were you assured of confidentiality?	Yes No	
Were you counselled in a place where visual privacy was guaranteed?	Yes No	
Were you counselled in a place where auditory privacy was guaranteed?	Yes No	
Were you counselled on any contraceptive methods	Yes No	
Did the provider physically examine you?	Yes No	
Were you examined in a place where visual privacy was guaranteed?	Yes No	
Did the provider give you any treatment?	Yes No	
Did he/she give you instructions on how to use the treatment?	Yes No	
Did you feel the provider had adequate time for you during consultation?	Yes No	
Did the provider talk about STD/HIV/AIDS with you?	Yes No	
Were you given information on condoms?	Yes No	
If yes, what did he/she say?		
If you reported an STI case did the provider ask you to bring your partner for treatment?	Yes No	
Did the provider give you an opportunity to ask questions?	Yes No	
Were you given any educational materials to read?	Yes No	
Did you pay for the service you received?	Yes No	

QUESTIONS	RESPONSE	REMARKS
What did you think about the cost?	Expensive Affordable Cheap	
How much time did you spend With each provider?	Registration	
	History	
	1st Consultation	
	Laboratory	
	2nd Consultation	
	Injection	
	Dispensary	
In general, how did you find the counselling?	Satisfactory Not Satisfactory	
Did the provider ask you to return?	Yes No	
If yes, did he/she give you a specific date to return	Yes No	
Will you recommend this facility to any of your colleagues?	Yes No	
If no, what are your reasons?		

Other recommendations:



Pathfinder International
9 Galen Street, Suite 217
Watertown, MA 02472
U.S.A.
617-924-7200
http://www.pathfind.org