GENDER LINKS
FOR EQUALITY AND JUSTICE

RAPID ASSESSMENT OF

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (ASRHR)

IN EIGHT SADC COUNTRIES



January 2022

AMPLIFYCHANGE

Hivos
people unlimited

Table 1: Key indicators

Country/Indicator	Regional	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe
Total sample	13395	1862	743	585	1993	1119	2282	1813	2998
% female	52%	50%	57%	48%	54%	50%	52%	51%	52%
% gender non-conforming	0,3%	0%	0%	0%	0%	2%	0%	0%	0%
% male	48%	50%	43%	52%	46%	48%	48%	49%	48%
Logistic information on health facilities									
Health facility within 10km from your home %	71%	78%	30%	68%	65%	95%	76%	89%	68%
The facility opens after school? %	57%	22%	30%	44%	78%		86%	76%	63%
The facility opens on weekends? %	62%	59%	47%	41%	74%	59%	44%	94%	77%
The facility has a comfortable waiting and consultation area? %	82%	71%	93%	80%	83%	90%	79%	80%	78%
Does the facility charge a fee? %	29%	0%	87%	43%	33%	0%	0%	0%	65%
Average fee in USD	$2	$0	$2	$1	$2	$0	$0	$0	$3
Quality of care									
Did you have access to a peer counsellor? %	53%	61%	16%	57%	78%	13%	65%	63%	72%
Young people treated with respect %	89%	97%	96%	69%	92%	90%	88%	94%	82%
Young people are treated without parent present %	58%	71%	87%	38%	68%	43%	53%	49%	54%
Young people have privacy %	85%	85%	98%	67%	75%	92%	87%	98%	74%
Young people have confidentiality %	89%	96%	98%	62%	89%	93%	89%	98%	84%
Health workers spend sufficient time with young people %	75%	54%	96%	42%	82%	84%	81%	94%	68%
Young people receive appropriate information %	74%	48%	93%	86%	82%	54%	84%	75%	73%
Sexual and reproductive health services (%)									
Maternal health									
% Young people who requested contraceptives	31%	36%	17%	50%	46%	3%	42%	28%	27%
% Young people who requested contraceptives that received contraceptives	79%	94%	99%	79%	85%	21%	90%	84%	80%
% Young women who requested a pregnancy test	29%	38%	24%	35%	42%	2%	36%	28%	27%
% Young women who received a pregnancy test	70%	77%	86%	66%	85%	33%	88%	73%	52%
% Young women who were pregnant	9%	3%	22%	15%	5%	3%	16%	1%	9%
% pregnant YW who requested ante-natal check-up	65%	31%	63%	73%	73%	22%	95%	91%	73%
% pregnant YW who received ante-natal check-up	82%	73%	83%	83%	93%	50%	98%	78%	97%

Country/Indicator	Regional	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe
% pregnant women who requested prevention of mother-to-child transmission (PMTCT)	40%	11%	34%	44%	62%	17%	78%	50%	24%
% pregnant women who who requested PMTCT that received PMTCT	75%	75%	59%	72%	79%	33%	91%	100%	91%
% YW who requested post-natal care	10%	0%	10%	16%	23%	1%	21%	5%	5%
% YW who requested post natal care who received post-natal care	75%	67%	86%		88%	25%	92%	100%	66%
% YW who requested help with breast feeding	10%	0%	6%	22%	19%	1%	19%	4%	7%
% YW who requested that received help with breast feeding	77%	50%	100%	65%	78%	40%	96%	100%	84%
Menstrual health									
% YW who requested pads	14%	1%	10%	24%	13%	2%	30%	7%	29%
% of those who requested pads that received pads	64%	20%	92%	21%	76%	67%	87%	81%	65%
HIV and AIDS and STI									
% YM who requested male circumcision	40%	37%	25%	80%	33%	0%	41%	56%	50%
% of those who requested male circimcision received an appointment	87%	79%	75%	83%	83%	100%	93%	96%	90%
% youth who requested PREP	8%	0%	2%	9%	23%	0%	20%	2%	6%
% youth who received PREP	47%	0%	38%	38%	81%	0%	92%	55%	71%
% who requested post-exposure prophylaxis (PEP)	7%	0%	3%	9%	17%	0%	18%	1%	5%
% of those who requested who received PEP	53%	0%	100%	31%	83%	0%	94%	47%	70%
% who requested HIV test	45%	30%	82%	70%	30%	2%	46%	59%	38%
% of those who requested who received HIV test	83%	90%	99%	95%	92%	15%	92%	99%	87%
% who requested STI test	17%	21%	4%	24%	24%	0%	31%	15%	14%
% who requested who received STI test	83%	99%	94%	87%	88%	33%	89%	93%	78%
% who requested anti-retrovirals (ARVs)	6%	2%	2%	8%	12%	0%	14%	3%	8%
% who requested who received ARVs	64%	97%	26%	63%	72%	0%	80%	91%	85%
% who said Health worker asked about mental health	37%	13%	29%	31%	59%	8%	53%	45%	55%
Follow up and referral									
% who said the HW set up a follow up appointment	55%	6%	80%	80%	83%	29%	68%	37%	60%
% referred to a relevant facility	61%	9%	76%	68%	89%	56%	64%	62%	63%

EXECUTIVE SUMMARY



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

These are among the findings of the Adolescent Sexual and Reproductive Health and Rights (ASRHR) Rapid assessment undertaken in Botswana, Eswatini, Lesotho, Madagascar, Mauritius, South Africa, Zambia and Zimbabwe from November 2019 to December 2020.

The purpose of this research is to strengthen youth-led and focused efforts to promote ASRHR through gender and youth responsive local governance. The research included 13,395 adolescents between ages 10 and 19 in eight countries, 6,916 (52%) females and 6,445 (48%) males. HIVOS and Amplify Change supported Gender Links to carry out the survey with the Centres of Excellence for Gender in Local Government. Other key preliminary findings include:

- 71% of the sample had a health facility within 10 km of their homes.
- 53% of the respondents reported meeting peer counsellors in the health facilities they visited.
- 31% of the sample requested contraception and 79% of these received contraception.
- 29% of the female respondents requested a pregnancy test and 10% requested post-natal care.
- 45%, of respondents requested an HIV test and 17% requested a sexually transmitted infection (STI) test. Most received these tests.
- 72% of the sample received materials tailor made for their needs. About a quarter of the sample did not receive youth friendly information that is relevant and responds to their needs.
- 55% of the sample received follow up appointments and 61% received a referral to another facility.

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

At a policy and legislative level, it is important that young people be able to access SRH services without third party authorisation. Health workers insisting on a parent or family member being present may result in young people not availing themselves of these vital health facilities. Only Madagascar and South Africa provide for adolescent access to SRHR services without parental consent.

BACKGROUND AND CONTEXT

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

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

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

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

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

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

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

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

Source: African Health Observatory

[1] UNFPA ESARO | Young people, https://esaro.unfpa.org/en/topics/young-people, accessed: 3 September 2021
[2] WHO Africa Region, https://aho.afro.who.int/profiles_information/index.php/, accessed 3 September 2021

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

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

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

Source: UNAIDS

Table 3 shows that in this eight country survey, only two countries (Madagascar and South Africa) do not require parental consent for adolescents to access SRHR services. In Lesotho parental consent is required if you are under the age 14. This applies to Botswana, Zambia and Zimbabwe if you under age 16. In Eswatini and Mauritius adolescents under the age of 18 cannot access SRHR without parental consent.

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

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

What are youth friendly ASRHR services

The International Planned Parenthood Federation (IPPF)[4] provides guidelines on youth friendly services and the key elements that should be included for effective service delivery. Youth-friendly service delivery is about providing health services based on a comprehensive understanding of what young people in any given society or community want and need. It is also based on an understanding of, and respect for, the realities of young people's diversity and sexual rights. A youth-friendly approach requires offering young people a wide range of sexual and reproductive health services, including:

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

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

- Where possible, these services should be provided in an integrated manner at the same delivery point to allow for ease of access for young people.

[3] UNAIDS 2018, http://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf, accessed 3 September 2021

[4] IPPF, http://www.ippf.org/our-work/what-we-do/adolescents/services, accessed 3 September 2021

- The financial barriers that young people can face should also be recognised and services should be provided free of charge or at a discounted rate to young clients.
- Services are only truly youth-friendly if young people themselves are involved in determining the content, scope, and monitoring and evaluation of such services.

METHODOLOGY

A research questionnaire was designed to assess the extent to which ASRHR services are youth friendly in eight Southern African countries. The questionnaire is self-administered by ado-lescents after they have been to a health facility seeking services that they need. The question-naire is available online through Survey Gizmo, an online data gathering tool. Internet access is facilitated through local councils or by providing resources for Internet access in the local councils. None of the young people received any payment to participate in the survey.

The questionnaire gathered demographic data on country; council; health facility; name and surname; sex; age and date. Questions covered:

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

Research sites and sample

The ASRHR Rapid Assessment employed purposive sampling to focus on particular characteristics of a population that are of interest, which will enable the researcher to answer the research questions.

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

Junior councils and youth organisations that GL and the local councils have worked with on the SRHR campaigns identified the youth in the sample.

Table 4: Research sample to date

Country	No. of COEs	No. of clinics	Female	Male	GNC	Total
Botswana	10	59	925	937		1862
Eswatini	11	22	423	320		743
Lesotho	11	16	281	304		585
Madagascar	10	27	1080	913		1993
Mauritius	7	38	557	536	26	1119
South Africa	20	168	1185	1094	3	2282
Zambia	4	58	920	893		1813
Zimbabwe	13	152	1545	1448	5	2998
Total	**86**	**540**	**6916**	**6445**	**34**	**13395**
Overall %			**52%**	**48%**		

As reflected in Table 4, the total number of respondents from the eight countries is 13 395: 6 916 (52%) young women and 6 445 (48%) young men with 34 people identifying as gender non-confirming (GNC). Due to the low number of GNC persons, GL could not draw any findings pertaining to their ASRHR needs.

South Africa conducted the research in the highest number of clinics (168). Zimbabwe had the highest number of respondents (2998). Lesotho with only nine clinics had the lowest number of respondents at 585.

For the overall report the sample included all clinics where data was gathered. The country reports included only those clinics where there were 20 or more female or male respondents. The country samples will therefore differ from the overall sample.

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

Table 5: Sample characteristics by age and gender

Age	Female	Male	GNC	Total	%
10	229	204	1	433	3%
11	226	228		454	3%
12	343	291		634	5%
13	453	367	3	820	6%
14	600	499	1	1099	8%
15	806	718	1	1524	11%
16	1046	916	2	1962	15%
17	1000	1014	2	2014	15%
18	1139	1098	7	2238	17%
19	1073	1110	17	2200	16%
Total	**6915**	**6445**	**34**	**13395**	**100%**

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

Ethical considerations

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

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

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

FINDINGS

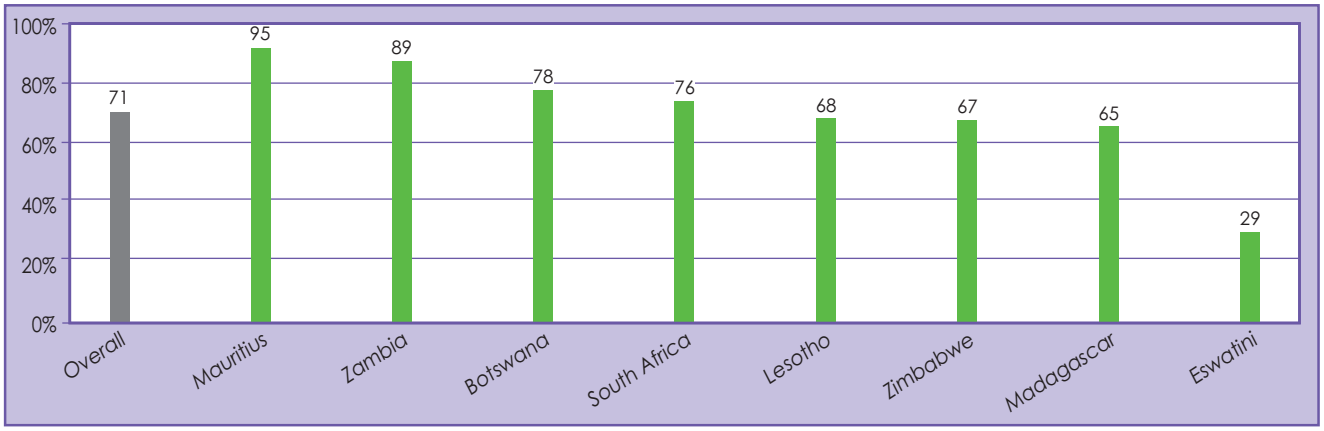
All the data in the study is disaggregated by sex. The results are presented for the whole sample because the responses by female and male respondents did not have any substantial variations. In the final report that will include ten countries further analyses will be done by sex and age.

Logistic information on health facilities

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

[5] Adolescents Guidance on HIV SRH Research, https://icop.or.ke/wp-content/uploads/2016/10/Adolescents-Guidance-on-HIV-SRH-Research.pdf, accessed August 2021

Figure 1: Health facility within 10 km of adolescents' homes

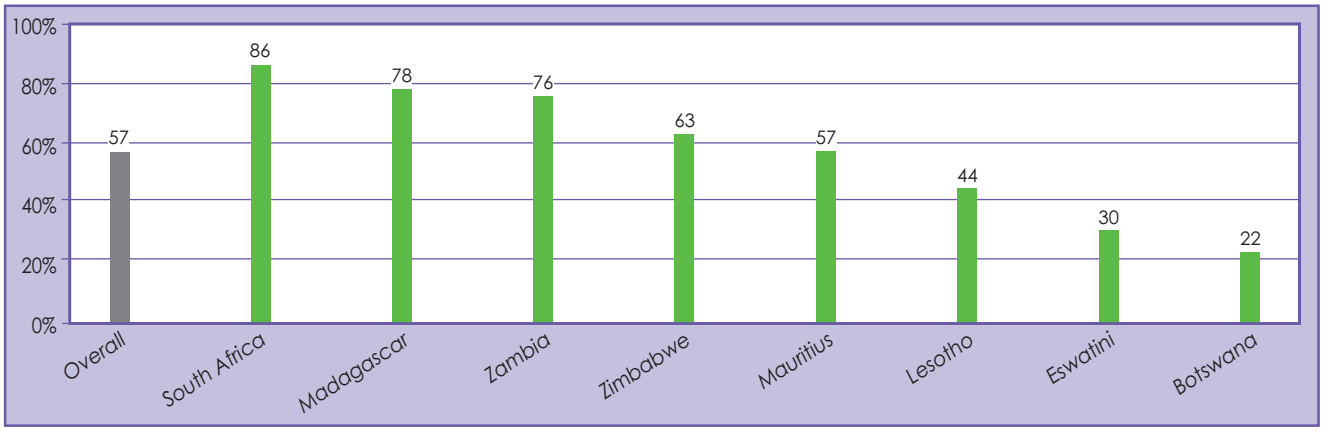


Of the total sample, 71% of young people had a health facility within 10 km from their homes. Almost one third of the young people sampled have to travel further than 10 km to access health care.

Young people in Mauritius (95%) and Zambia (89%) had the greatest access to a health facility within 10 km of their homes. Botswana and South Africa follow at 78% and 76% respectively. In Lesotho, Madagascar and Zimbabwe between 65% and 68% of the adolescents had access to health facilities within 10 km of home. Only 29% of young people in Eswatini had access to a health facility within 10 km of their homes. Young people generally do not have the resources to travel long distances to access health care.

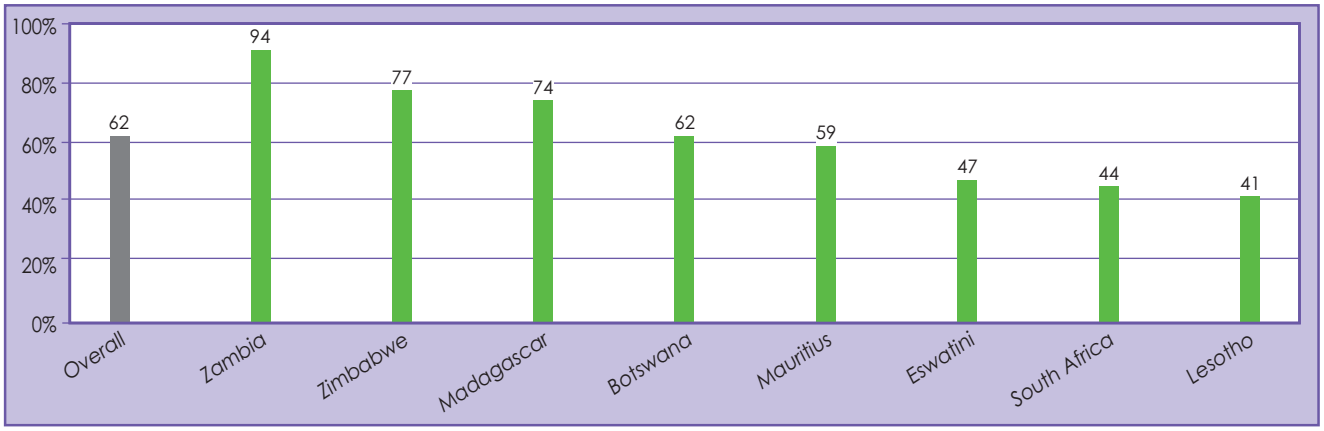
> Young people generally do not have the resources to travel long distances to access health care

Figure 2: Does the health facility open after school



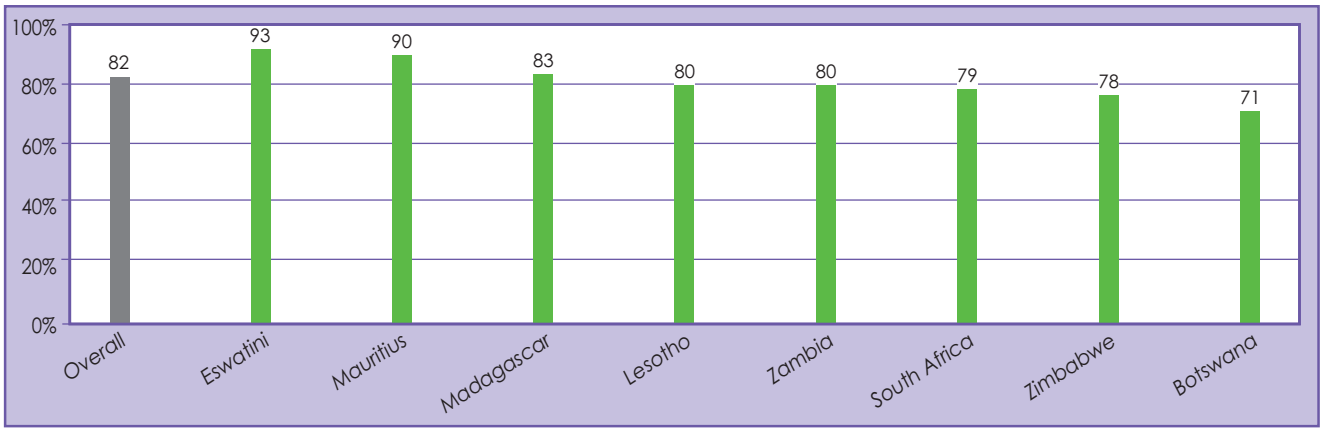
Fifty seven percent of respondents reported that health facilities open after school. At 86%, South Africa has the most health facilities that open after school. In Botswana, Madagascar and Zambia between 76% and 78% of the respondents reported that health facilities open after school. The figure for Zimbabwe is 63% and Mauritius, 57%. Less than half of the respondents in Lesotho (44%), Eswatini (30%) and Botswana (22%) reported being able to access health facilities after school.

Figure 3: Does the health facility open on weekends?



Sixty two percent of the respondents stated that health facilities open on weekends. This ranged from 94% in Zambia to 41% in Lesotho. Less than half the respondents in Eswatini, South Africa and Lesotho.

Figure 4: Health facility has a comfortable waiting and consultation area

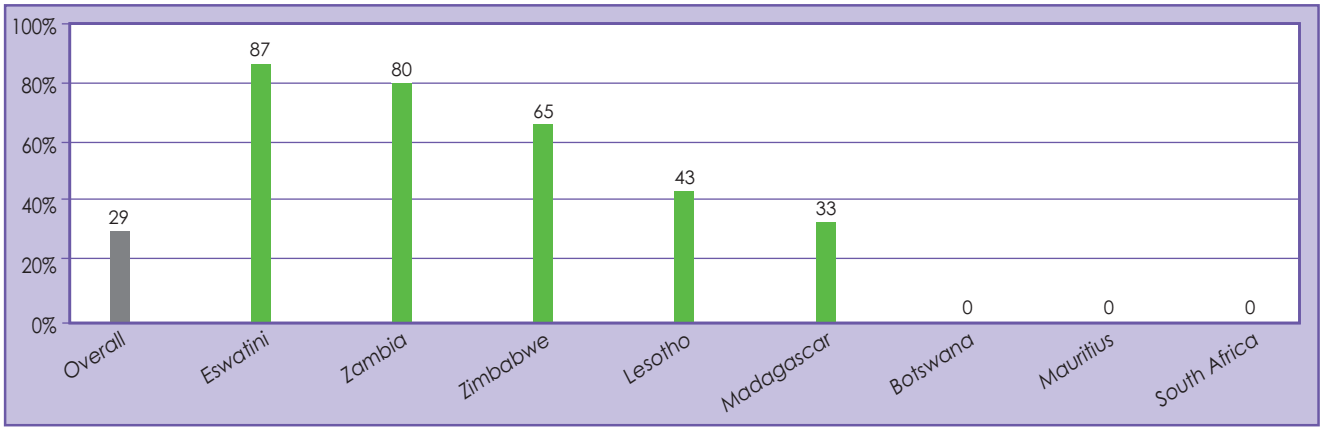


A high proportion of the respondents (82%) reported a comfortable waiting area in the health facilities. Eswatini (93%) followed closely by Mauritius (90%) had the highest proportions of adolescents reporting a comfortable waiting area. Botswana (71%) had the lowest proportion of respondents that found the waiting area in the health facilities to be comfortable.



Youth in Botswana take part in a campaign event at a mall in Gaborone in 2020 as part of the Botswana Family Welfare Association (BOFWA) Youth Action Movement.
Photo: Mboy Maswabi

Figure 5: Proportion of respondents who paid a fee for health services



Overall 29% of young people in the sample had to pay a fee for health services. This varied widely by country. In Botswana, Mauritius and South Africa, all services are free. In Eswatini (87%), Zambia (80%), Zimbabwe (65%) and Madagascar (33%) of respondents paid fees for health services.

Table 6: Fees, average daily income and fee % of daily income by country

Country	Fee in USD	Average daily income in USD[6]	Fee % of daily income
Zimbabwe	$3	$20	15%
Eswatini	$2	$9	22%
Madagascar	$2	$11	18%
Lesotho	$1	$22	5%

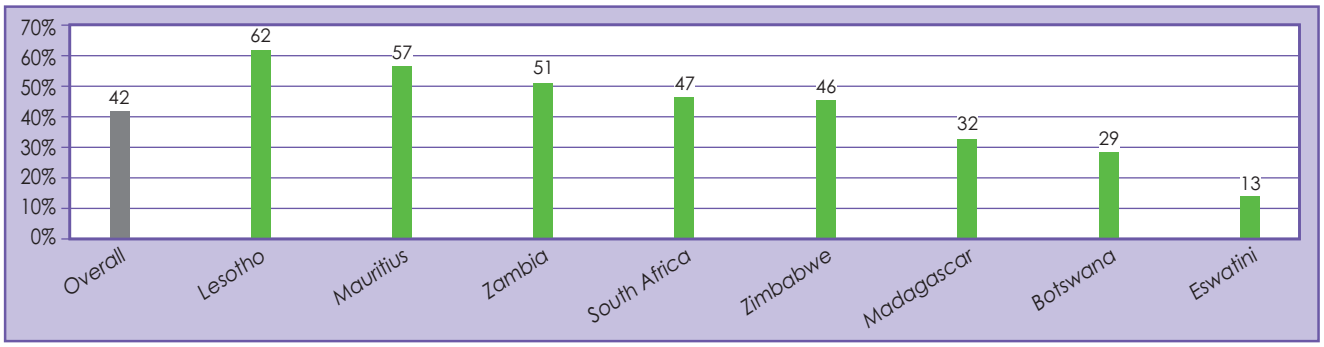
Fees for health services range from $1 in Lesotho $3 in Zimbabwe, with an average of $2 across the four countries where respondents pay fees. In Eswatini, the $2 fee constitutes 22% of the average daily income of $9 a day. The $2 fee in Madagascar constitutes 18% of the daily income. In Zimbabwe, where respondents paid the highest fees ($3) this constitutes 15% of the average daily income and 5% of the average daily income in Lesotho.

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

Presence of adults

Adolescents are generally not comfortable discussing their SRHR needs in the presence of their parents or other adults. One of the main lobbying and advocacy points on adolescent SRHR is for access to such services free of parental consent.

Figure 6: Proportion of respondents who did not receive a service without third party authorisation



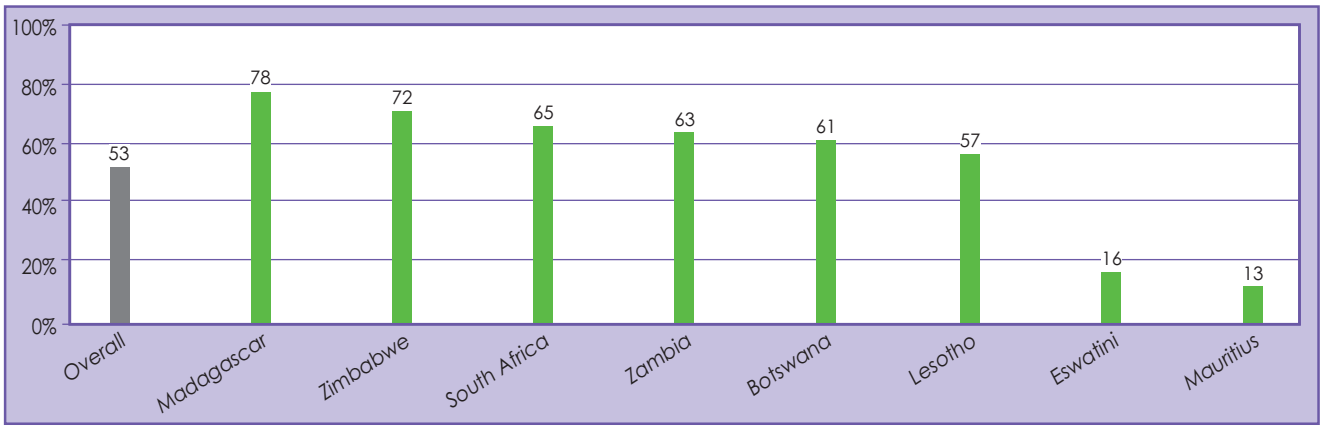
[6] Salary Explorer | Salary and Cost of Living Comparison, http://www.salaryexplorer.com/?loc=208&loctype=1#browsesalaries, accessed 3 September 2021.

Of the total sample, 42% did not receive services they requested at the health facility without an adult present. There are, however, variations between countries. In Lesotho 62% of respondents did not receive services because there was no adult third party present. Between 46% and 57% of respondents did not receive services in Zimbabwe, South Africa, Zambia and Zimbabwe respectively. Lower proportions of respondents in Madagascar and Botswana did not receive services without third party authorisation. In Eswatini, only 13% reported not receiving services without third party authorisation. Accessing health services without third party authorisation is a critical lobbying and advocacy priority to promote universal health care and access to ASRHR.

Quality of care

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

Figure 7: Access to peer counsellors when seeking SRHR services



Fifty three percent of the respondents indicated having peer counsellors in the health facilities visited. The presence of peer counsellors is an important component of youth friendly services. Young people often face challenges in communicating with older health workers.

In Madagascar and Zimbabwe, over 70% of respondents indicated that there were peer counsellors in the health facilities visited. In Lesotho, Botswana, Zambia and South Africa between 57% and 65% of respondents reported that there were peer counsellors at the health facilities visited. At 16%, Eswatini and 13%, Mauritius had the lowest number of respondents that reported there were peer counsellors at the health facility visited. This is an area that needs urgent attention in Eswatini and Mauritius.

Figure 8: Health worker treats young person with respect



The vast majority (89%) of respondents said that they had been treated with respect. Only 11% of adolescents felt disrespected. The highest proportion of respondents (between 90% and 97%) who felt respected came from Botswana, Eswatini, Zambia, Madagascar and Mauritius. A lower proportion of respondents from South Africa (88%) and Zimbabwe (82%) felt that they had been treated with respect. At 69%, Lesotho registered the lowest proportion of respondents who felt respected during their visit at the health facility.



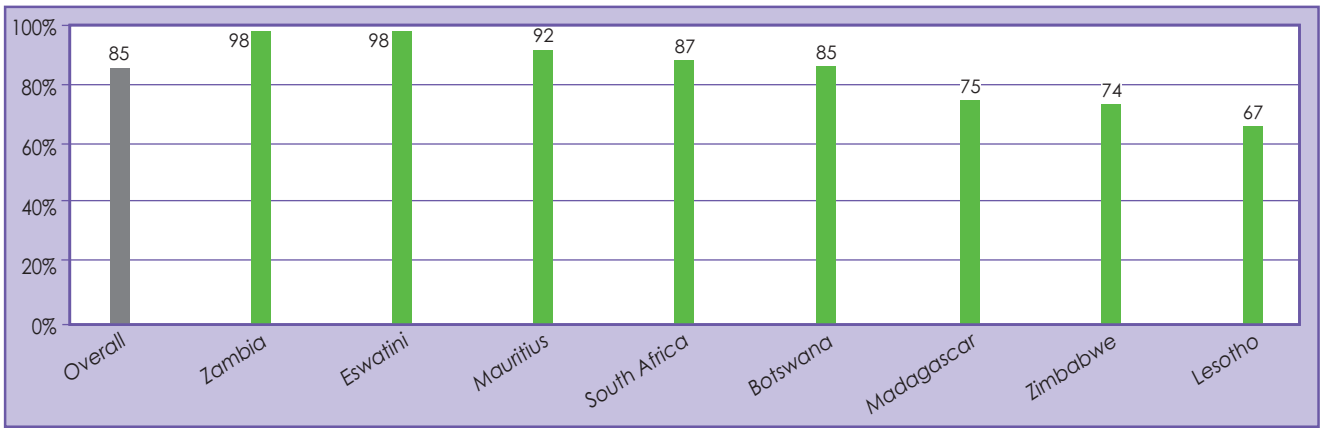
Learners at the Mphangala Primary School in Kasungu district in Central Malawi in May 2019. Photo: Thokozani-Matewe

Table 7: Reasons why participants felt disrespected

Why respondents felt disrespected	%
My session was interrupted several times	32%
Told I was too young	21%
Did not trust the person I spoke to	18%
The staff did not want to answer my questions	17%
Told I needed to be accompanied by an adult	10%
Told I was a drug user	10%
Told I was naughty	9%
They could not answer my questions	9%
I felt like they lied to me	7%
Not given services because I was a boy	4%
Not given services because I was a girl	2%
Based on religion	1%
Other	1%

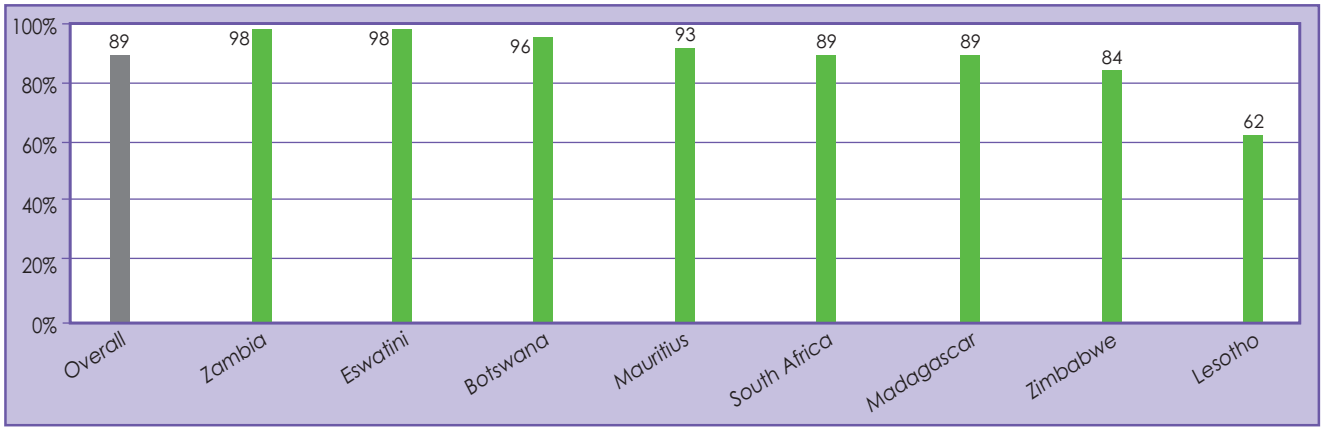
The reasons provided for why 11% of the sample felt disrespected range from being constantly interrupted (32%) to religious concerns (1%). In addition to constant interruptions, being told they were too young (21%), health personnel did not want to answer questions (17%), and equal proportions (10%) of respondents were told they needed to be accompanied by an adult and that they were drug users. It is concerning to note that 9% of the sample felt the health care workers could not answer questions.

Figure 9: Health care worker ensures privacy



Eighty five percent of respondents said that the health care worker ensured they had privacy. It is important that young people feel they can trust the health care facility and personnel with their SRH concerns. Over 95% of respondents in Zambia, Eswatini and Mauritius felt that the health workers respected their privacy. Relatively high proportions of respondents in South Africa, Botswana, Madagascar and Zimbabwe enjoyed privacy during their visit to the health facility. Lesotho is of concern as only 67% of the respondents felt they had privacy during their appointments.

Figure 10: Health care worker ensures confidentiality



Overall, 89% of the respondents indicated that they had confidentiality during the consultation. Over eighty percent of respondents in Zambia, Eswatini, Botswana, Mauritius, South Africa, Madagascar and Zimbabwe reported confidential consultations. At 62%, Lesotho had the lowest level of confidentiality.

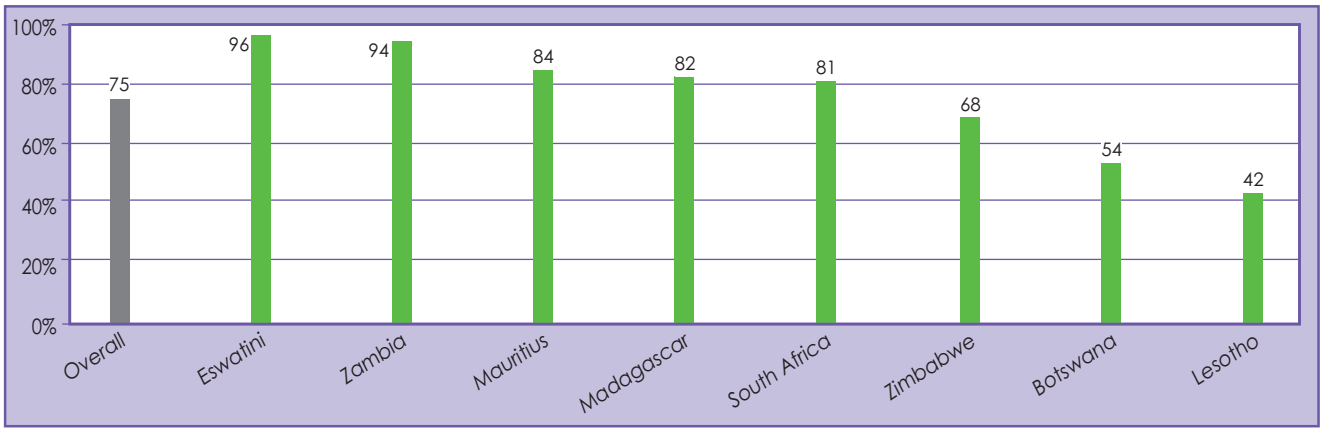
Table 8: Reasons cited for a lack of privacy and confidentiality

Reasons	%
No confidential/private space	34%
They verbally announced which services I came for in public areas	31%
My file was left open for others to see	29%
Told that they were going to tell my family that I was there	12%
They called my parents/family	12%

The three key concerns in relation to confidentiality and privacy were:
- Files open for others to see
- No private or confidential space for the consultation
- Health personnel telling family

A lower proportion of respondents (12%) reported that health personnel told them that they were going to tell family about the visit and that they had called the parents or family.

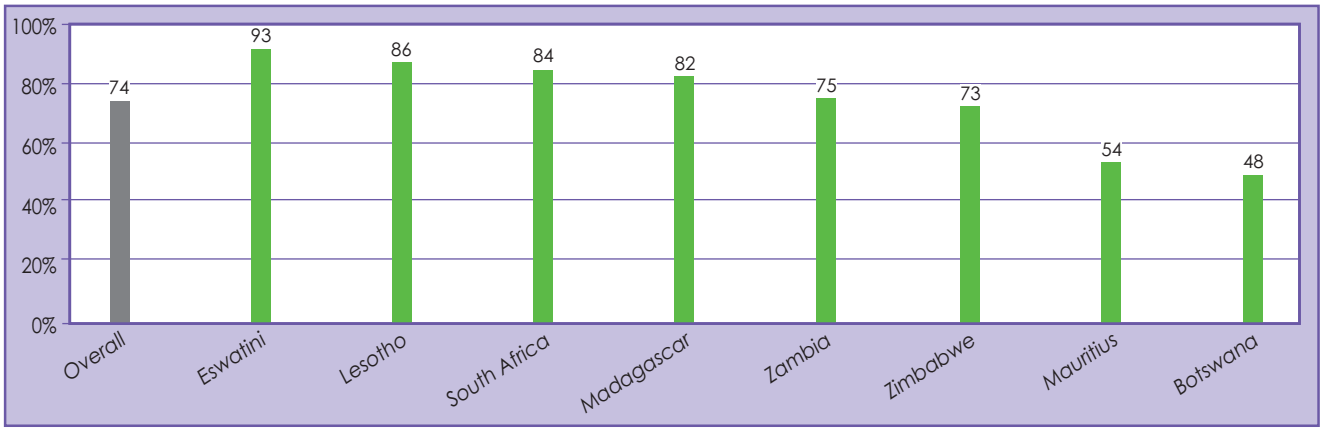
Figure 11: Health care worker spends sufficient time with young person



Three quarters of the respondents indicated that the health personnel spent sufficient time with them. Of the total sample, 25% of the respondents felt the health care workers did not spend sufficient time with them.

In Botswana, Eswatini, Mauritius, South Africa and Zambia between 81% and 96% of respondents reported that they felt that the health workers had spent sufficient time with them. About two thirds of the respondents in Zimbabwe reported that they had sufficient time with the health personnel. The lower proportions of respondents in Botswana (54%) and Lesotho (42%) indicated that the health personnel spent sufficient time with them.

Figure 12: Health care worker provides information tailored to YP needs



About three quarters (74%) of the sample indicated that they received relevant and appropriate information, while 26% of the sample felt they did not receive required information targeted to adolescents.

Between 82% and 93% of respondents in Eswatini, Lesotho, South Africa and Madagascar received relevant and appropriate information. Lower proportions of respondents in Zimbabwe (73%) and Zambia (75%) reported that the information they received was tailored to their needs. In Mauritius only 54% of respondents felt they had received appropriate and relevant information. Less than 50% of the respondents in Botswana felt that they had received information tailored to their needs.

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

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

Sexual and reproductive health services

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

[7] ASK Manual 2016, https://www.sexrightsafrica.net/wp-content/uploads/2016/10/ASK-manual-2016_web.pdf, accessed 24 August 2021

Maternal health

Table 9: Access to contraception

Country	Requested	Received
Overall	31%	70%
Lesotho	50%	79%
Madagascar	46%	85%
South Africa	42%	90%
Botswana	36%	94%
Zambia	28%	84%
Zimbabwe	27%	80%
Eswatini	17%	99%
Mauritius	3%	21%

Overall thirty one percent of respondents requested contraception and 70% received this service. This ranged from 50% in Lesotho to 3% in Mauritius. The low proportion of young people requesting contraception is a concern as this is key to preventing unwanted pregnancies, unsafe abortion, and the many other traumas that accompany such eventualities.

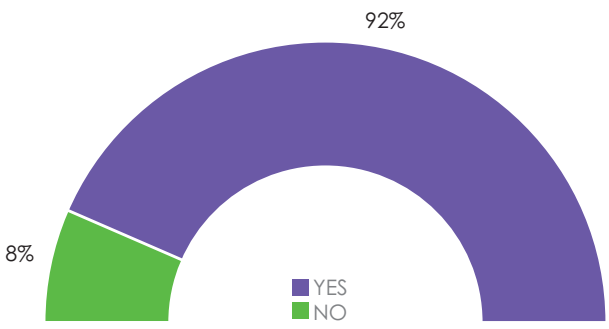
Teenage pregnancies

Table 10: Female respondents that requested and received a pregnancy test

Query	Overall	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe
% Young women requested a pregnancy test	29%	38%	24%	35%	42%	2%	36%	28%	27%
% Young women received a pregnancy test	70%	77%	86%	66%	85%	33%	88%	73%	52%

Madagascar (42%) has the highest proportion of those requesting pregnancy tests, followed by South Africa (36%) and Lesotho (35%). Mauritius (2%) has the lowest. Most of the young women who sought a pregnancy test received this; but these figures were low in Mauritius (33%); Lesotho (66%) and Mauritius (33%).

Figure 13: Proportion of female respondents who were pregnant



Of the total sample of female respondents 9% were pregnant at the time of conducting the survey.

Table 11: Pregnant female respondents by country

Country	Proportion of female respondents who are pregnant
Eswatini	22%
South Africa	16%
Lesotho	15%
Zimbabwe	9%
Botswana	3%
Madagascar	5%
Mauritius	3%
Zambia	1%

The highest proportion of female respondents who reported being pregnant came from Eswatini, South Africa and Lesotho (22%, 16% and 15%) respectively.

Table 12: Access to ante-natal care among survey respondents

Ante-natal care	Overall	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe
Asked for an ante-natal check-up - while pregnant	65%	31%	63%	73%	73%	22%	95%	91%	73%
Received an ante-natal check up	82%	73%	83%	83%	93%	50%	98%	78%	97%
Requested PMTCT	40%	11%	34%	44%	62%	17%	78%	50%	24%
Received PMTCT	75%	75%	59%	72%	79%	33%	91%	100%	91%

Of the total sample of female respondents who reported being pregnant 65% asked for and 82% received ante-natal care. South Africa (98%) had the highest proportion of pregnant young women who requested and received ante-natal care. Botswana (31%) and Mauritius (22%) had low levels of pregnant young women who requested ante-natal care.

Of the female respondents who were pregnant, 40% requested and 75% received Prevention of Mother to Child Transmission (PMTCT) treatment. Uptake of PMTCT is 50% and lower in all countries except for South Africa where 78% of the sample requested PMTCT. Only Zambia provided 100% of the female respondents with PMTCT. South Africa and Zimbabwe (91%) and Eswatini (89%) follow. Botswana with amongst the most effective HIV and AIDS strategies in the SADC region, only provided 75% of those who requested PMTCT with the service.

Table 13: Access to post-natal care among survey respondents

Post-natal care	Overall	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe
Asked for a post-natal - after giving birth	10%	0%	10%	16%	23%	1%	21%	5%	5%
Received a post-natal check up	75%	67%	86%		88%	25%	92%	100%	66%
Asked for help with breastfeeding from a health care worker	10%	0%	6%	22%	19%	1%	19%	4%	7%
Received help on breastfeeding from a health care worker	77%	50%	100%	65%	78%	40%	96%	100%	84%

Out of the total sample of young women, 10% requested post-natal care. Of those 75% received post-natal care while 10% requested help with breastfeeding and 77% received help with breastfeeding. A key concern is how new mothers still in the schooling system are supporting themselves and their babies.

Menstrual health

Table 14: Access to sanitary ware

Access to sanitary ware	Overall	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe
% Young Women (YW) who requested pads	14%	1%	10%	24%	13%	2%	30%	7%	29%
% of those who requested pads that received pads	64%	20%	92%	21%	76%	67%	87%	81%	65%

Only 14% of the female respondents requested sanitary pads from the health facility and 64% of those received pads. In Eswatini, South Africa and Zambia the health facilities provided pads to between 81% and 92% of the female respondents.The call for the removal of value added tax (VAT) and provision of free sanitary ware is central to effective menstrual health management. Schools and health facilities should be amongst the sites providing free sanitary ware.

HIV and AIDS

Table 15: Male circumcision

Male circumcision	Overall	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe
% Young Male (YM) who requested male circumcision	40%	37%	25%	80%	33%	0%	41%	56%	50%
% of those who requested male circumcision received an appointment	87%	79%	75%	83%	83%	0%	93%	96%	90%

Of the total sample of young men, 40% requested circumcision. Most (87%) got the circumcision. This number is generally high in all countries. There is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. Three randomised controlled trials have shown that male circumcision provided by well-trained health professionals in properly equipped settings is safe.[8]

Table 16: Pre- and Post-Exposure Prophylaxis

Query	Overall	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe
Pre-exposure prophylaxis									
% youth who requested PREP	8%	0%	2%	9%	23%	0%	20%	2%	6%
% youth who received PREP	47%	0%	38%	38%	81%	0%	92%	55%	71%
Post-exposure prophylaxis									
% who requested post-exposure prophylaxis (PEP)	7%	0%	3%	9%	17%	0%	18%	1%	5%
% of those who requested who received PEP	53%	0%	100%	31%	83%	0%	94%	47%	70%

Pre-exposure prophylaxis (PREP) is the use of anti-HIV medication, taken prior to any engagement that could potentially expose a person to HIV, that keeps HIV-negative people from contracting HIV. Overall, only 8% of the sample requested PREP with no requests at all in Botswana, Mauritius and Eswatini. This suggests

Post Exposure Prophylaxis (PEP) is the use of anti-retroviral medication, taken after any engagement that potentially exposes a person to HIV that keeps HIV-negative people from getting HIV. Only 7% of the sample requested PEP and 53% received the medication. There were no requests in Eswatini, Mauritius and Zambia and very low levels of requests in the other countries. This reflects low levels of awareness on the role of PREP and PEP in HIV prevention across all countries.

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

Table 17: HIV testing & STIs

Query	Overall	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe
HIV testing									
% who requested HIV test	45%	30%	82%	70%	30%	2%	46%	59%	38%
% of those who requested who received HIV test	83%	90%	99%	95%	92%	15%	92%	99%	87%
Sexually transmitted infections (STIs)									
% who requested STI test	17%	21%	4%	24%	24%	0%	31%	15%	14%
% who requested who received STI test	83%	99%	94%	87%	88%	33%	89%	93%	78%

The highest proportion of HIV tests were requested in Eswatini (82%), Lesotho (70%) and Zambia (59%). Of the total sample 17% requested a Sexually Transmitted Infection (STI) test and 83% received a STI test. The highest proportion of requests for STI tests were South Africa (31%), Lesotho (24%), Madagascar (24%) and Botswana (21%).



HIV and AIDS testing in Kalimolefe, Lesotho. Photo: Gender Links

Table 18: Access to anti-retroviral drugs

Anti-retrovirals	Overall	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe
% who requested anti-retrovirals (ARVs)	6%	2%	2%	8%	12%	0%	14%	3%	8%
% who requested who received ARVs	64%	97%	26%	63%	72%	0%	80%	91%	85%

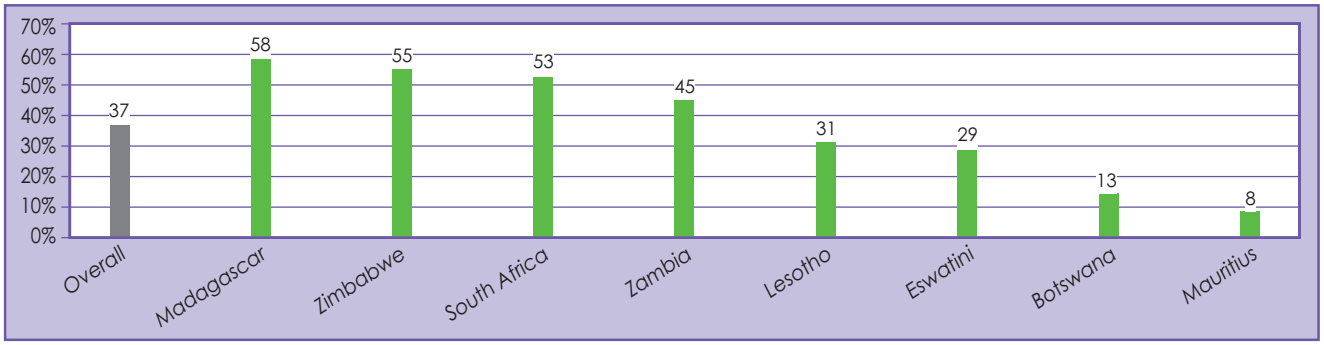
Of the total sample 6% of the sample requested ARVs and 64% received them. No ARVs were requested in Mauritius, where HIV and AIDS is low. Generally, the countries in the sample responded positively to requests for ARVs. However, at 26%, the provision of ARVs in Eswatini is low.

Mental health

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

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

Figure 14: Health care workers asking about mental health



As shown in Figure 14, of the total sample, only 37% of the respondents were asked about their mental health. In Madagascar, Zimbabwe and South Africa health workers engaged with more than 50% of the sample about their mental health. In Botswana (13%) and Mauritius (8%) very low proportions of the YP were asked about their mental health. Mental health is emerging as a significant concern amongst adolescents and must be part of integrated adolescent SRHR services.

Follow up and referrals

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

Table 19: Follow up and referral

Follow up	Overall	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe
% who said the HW set up a follow up appointment	55%	6%	80%	80%	83%	29%	68%	37%	60%
% referred to a relevant facility	61%	9%	76%	68%	89%	56%	64%	62%	63%

Overall 55% of the respondents said that health workers set up follow up appointments. Sixty one percent referred them to a relevant facility. Botswana is a serious concern as only 6% of respondents received a follow up appointment followed by Mauritius (29%) and Zambia (37%). In Botswana only 9% of respondents received a referral to another facility.

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

CONCLUSIONS AND RECOMMENDATIONS

- ***ASRHR Policies:*** Currently six countries (Botswana, Lesotho, Madagascar, South Africa, Zambia and Zimbabwe) have ASRHR policies in place. Eswatini and Mauritius do not have ASRHR policies. Botswana's policy ended in 2016 and all the other countries' ASRHR policies expire in 2020. There is need to lobby for ASRHR policies that are youth friendly in all eight countries.

- ***At a policy and legislative level, it must be clear that young people can access SRH services without third party authorisation:*** Health workers insisting on a parent or family member being present will mitigate against young people going to health facilities. Only Madagascar and South Africa provides for adolescent access to SRHR services without parental consent. In Botswana, Zambia and Zimbabwe parental consent is required for those under 16 and those under 18 in Eswatini, Lesotho and Mauritius.

- ***There is need for a set of standards that define what a youth friendly health facility should have in place:*** All health facilities should subscribe to these standards. The standards must include accessibility, respect, privacy, provision of peer counsellors, quality SRH services; health worker conduct and follow up care.

- ***Youth friendly communication and awareness campaigns*** moving from judgemental messaging to messaging that recognises that young people are sexually active and assist them with making informed choices.

- ***Campaigning and awareness on safe sex*** must be integral to all adolescent sexuality campaigns.

- ***Menstrual health*** must be central to services offered at health facilities.

- ***There is need for education on the role of PREP and PEP in HIV prevention:*** From low levels of uptake amongst young people there appears to limited knowledge on the availability and purpose of PREP and PEP.

- ***Teenage pregnancy is a crisis that needs a multi-faceted response:*** In Eswatini, Lesotho and South Africa the proportion of female respondents who are pregnant is much higher than the official figures for the proportion of adolescent live births per 1000 women.

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