World Health Organization

ANALYTIC CASE STUDIES
INITIATIVES TO INCREASE THE USE OF HEALTH SERVICES BY ADOLESCENTS

Evolution of the national Adolescent-Friendly Clinic Initiative in South Africa

South Africa

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Foreword

Though many individuals and institutions have important contributions to make to the health and development of adolescents, health workers play a particularly important role. As health service providers, they need to help adolescents maintain good health as they develop into adults, through the provision of information, advice and preventive health services. They also need to help ill adolescents get back to good health, by diagnosing health problems, detecting problem behaviours and managing these when they arise.

Unfortunately, for a variety of reasons, adolescents are often unable to obtain the health services they need. In many places, health services, such as emergency contraception, are not available to anyone, either adolescents or adults. In other places, where these health services are available, adolescents may be unable to use them because of restrictive laws and policies (e.g. laws that forbid the provision of contraceptives to unmarried adolescents) or because of the way in which they are delivered (e.g. the cost of health services is beyond their reach). Even where adolescents are able to obtain the health services they need, they may be discouraged from doing so because of the way they are delivered. Common reasons for this include fear that health workers will ask them difficult questions, put them through unpleasant procedures, or scold them; or that health workers will not maintain confidentiality. Finally, health services may be 'friendly' to some adolescents, such as those from wealthy families, but may be decidedly 'unfriendly' to others, such as those living and working on the streets. Not surprisingly, in many parts of the world, adolescents are reluctant to seek help from health facilities. If they do seek help, they often leave discontented and unhappy with the way they were dealt with; determined not to go back, if they can help it.

There is widespread recognition of the need to overcome these barriers and make it easier for adolescents to obtain the health services they need. Initiatives are being undertaken in many countries to help ensure that:

- health service providers are non-judgemental and considerate in their dealings with adolescents, and that they have the competencies needed to deliver the right health services in the right ways;
- health facilities are equipped to provide adolescents with the health services they need, and are appealing and 'friendly' to adolescents;
- adolescents are aware of where they can obtain the health services they need, and are both able and willing to do so;
- community members are aware of the health service needs of different groups of adolescents, and support their provision.

Nongovernmental organizations are in the forefront of these efforts in most places, although in a growing number of countries, government-run health facilities are also reorienting themselves in order to reach out to adolescents.

There is growing evidence of the effectiveness of some of these initiatives in improving the way health services are provided and increasing their utilization by adolescents. In the past, most of these initiatives were small in scale and of limited duration, however there are a growing number of initiatives that have moved beyond the pilot stage to scale up their operations across an entire district, province or country.

In 2006, the World Health Organization (WHO) department of Child and Adolescent Health and Development (CAH) published a systematic review of the effectiveness of interventions to improve the use of health services by adolescents in developing countries[1]. This review identified 12 initiatives that demonstrated clear evidence of the increase in the use of health services by adolescents. When presenting the findings of the review to policy-makers and programme managers in countries, WHO was pressed for information that went beyond the brief descriptions of interventions provided in the review, to more detailed information about what was being done in these different settings to scale up the provision of health services while maintaining and improving their quality.

In response, CAH has supported the documentation of three outstanding initiatives in different developing country settings. These are intended to provide analytic case studies of what has been achieved, to assist: i) governmental and nongovernmental organizations in developing countries that are involved in scaling up adolescent-friendly health services; and ii) staff members in international organizations that provide technical and financial support for these services.

WHO is pleased to share these three case studies from Estonia, Mozambique and South Africa. The key message emanating from each is that scaling up the provision of health services to adolescents in developing countries in a sustainable way is clearly doable, but it requires deliberate and concerted efforts.

[1] Review of the evidence for interventions to increase young people's use of health services in developing countries. Geneva, World Health Organization, 2006 (Technical Report Series, No. 938:151–204).

ACRONYMS AND ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
BFHI	Baby-friendly Hospital Initiative
COHSASA	Council for Health Service Accreditation of Southern Africa
DfID	Department for International Development
HIV	human immunodeficiency virus
ICPD–POA	United Nations International Conference on Population and Development–Programme of Action
IPPF	International Planned Parenthood Federation
ISDS	Initiative for Sub-District Support
NAFCI	National Adolescent-Friendly Clinic Initiative
PPASA	Planned Parenthood Association of South Africa
QAP	Quality Assurance Project
RHRU	Reproductive Health Research Unit
SRH	sexual and reproductive health
STI	sexually transmitted infection
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

Purpose of this document

This document describes an initiative for quality improvement in adolescent-friendly services implemented in public-sector primary health care clinics in South Africa. The programme was coordinated by the Reproductive Health Research Unit (RHRU), University of Witwatersrand, Chris Hani Baragwaneth Hospital, Johannesburg, South Africa.

This document has been written for programme and project managers at national, district and local levels who are interested in the implementation of youth-friendly services. The document outlines the process used to develop, set up and implement the National Adolescent-Friendly Clinic Initiative (NAFCI) in South Africa. The main steps of the programme are described, as are the key lessons learned—including the facilitating and constraining factors that influenced the implementation of the programme. This case study is intended to provide an example of how to set up a large-scale national quality improvement programme for adolescent-friendly clinics.

The authors acknowledge that this document describes the process and steps undertaken in just one country and that other countries have different political, social and cultural environments. It is, however, hoped that the insights and experiences of the NAFCI programme will provide valuable guidance in setting up similar programmes in other countries.

The context of adolescent health

The international context

The sexual and reproductive health of adolescents is a major concern in all countries, but most specifically in developing countries. More than 13 million adolescent girls have unintended births each year in the developing world [1]. In addition, more than 100 million sexually transmitted infections (STIs) occur each year in young people aged 15 to 24 [2]. STIs are treatable but when left unchecked they can cause serious illness and even death. In particular, the presence of untreated STIs increases the risk of both acquiring and transmitting the human immunodeficiency virus (HIV) [3].

An estimated 40 million people were living with HIV at the end of 2005 and a projected 7000 young people become infected with HIV every day [4]. About half of the people who acquire HIV become infected before they turn 25 and typically die of acquired immunodeficiency syndrome (AIDS) before they reach 35 years of age [5]. The overwhelming majority of people with HIV, approximately 95% of the global total, live in developing countries. In particular, young women (less than 25 years of age) in these countries make up about half of all people currently infected with HIV [6]. Sub-Saharan Africa has suffered the greatest impact of this disease; the region has 10% of the world's population, but is home to over 60% of all people living with HIV [7].

Governments and international organizations have signed up to commitments to reduce the rates of adolescent pregnancy, STIs and HIV.

- The United Nations General Assembly Special Session on HIV/AIDS (UNGASS) (2001) defined five goals and targets that have particular implications for young people. These relate to increasing young people's access to core interventions necessary for the prevention of HIV infection: information, skills and services; decreasing young people's vulnerability to HIV; and decreasing the prevalence of HIV among young people.

- The United Nations International Conference on Population and Development–Programme of Action (ICPD–POA) [8] urges governments and health systems to remove barriers (laws, regulations and social customs) between adolescents and reproductive health information, education and services. The POA emphasizes the need for governments to establish, expand or adjust programmes to ensure that adolescents have access to services and information and that their reproductive and sexual health needs are met.

Even though a multisectoral response that includes health, education, sports and other sectors of government and civil society is required to combat AIDS, it is imperative that the health system takes a leading and strategic role in preventing HIV. In addition to providing health-care services, the health sector can provide young people with information and counselling that could help reduce their vulnerability and risk. Although health care providers may not be the main source of health information for young people, they do play a critical role. The health system presents unique opportunities for providing young people with information and counselling and these opportunities need to be exploited more systematically. All countries have clinics and a network of health care workers who could intervene more effectively with young people if they knew what to do and how to do it.

Public health clinics are an important resource in providing preventive and curative services to deal with this epidemic. However, surveys have shown that young people encounter many barriers when seeking public health services. Some of the concerns expressed by the young are the lack of privacy and confidentiality as well as poor-quality clinical services and the rudeness of health care providers [9,10]. In response to these reports, WHO developed a document entitled *Adolescent-friendly health services: an agenda for change* [11], which outlined several strategies for designing adolescent-friendly services. Further, at the 57th World Health Assembly (2004), a call to action was made to design and test strategies to expand interventions of proven effectiveness. Young people need information and skills, health and counselling services, and a safe and supportive environment to grow and develop in good health. Many approaches [12] have been employed to meet these needs; making health services youth-friendly is one such approach.

The South African context

Africa is experiencing a youth health crisis. WHO reported that the highest rate of new cases of STIs (per 1000 cases) in 1999 occurred in sub-Saharan Africa [13]. In many cases, the prelude to developing HIV is the development of a sexually transmitted infection. In South Africa, nearly half a million young people under the age of 20 are infected with HIV. The prevalence of HIV has increased from 14.8% in 2002 to 16.1% in 2004 in young people under the age of 20 [14]. The results of a large national population-based HIV-1 prevalence survey conducted among young people showed that young women were significantly more likely to be infected with HIV in comparison with young men (15.5% versus 4.8%) [15].

For the majority of young South Africans, sexual activity starts in the mid-teens, with an estimated national average age of first intercourse at 15 years for girls and 14 for boys [16]. A recent study in South Africa revealed that nearly one-third of 15–19-year-olds and almost two-thirds of 20–24-year-olds reported having been pregnant, with the overall rate for 15–19-year-olds being 15.5% [17]. Just as important is the finding that 66% of these young women reported that the pregnancy was unwanted. In addition, adolescents' knowledge of sexuality and reproductive health is generally poor [18], and a substantial number have indicated a need for more information on such issues as pregnancy, relationships and sexually transmitted infections (STIs) [19].

In addition to a need for more information, there is clearly a need for youth-friendly services. In spite of the high prevalence of HIV, STIs and teen pregnancy, many young people do not use public health services in South Africa, and have reported barriers when they have attended clinics [20,21]. As in other countries, the barriers reported by young people relate to access and quality, including the attitude of staff, the time of the service, confidentiality, embarrassment at being seen in the clinic waiting room with adults from their community, and not understanding their diagnosis or treatment.

Development of the National Adolescent-Friendly Clinic Initiative in South Africa

Within this context, loveLife, a sexual health campaign for young people, was established in 1999. (Annex 1 describes the programme as it initially existed; the programme has since evolved.) The National Adolescent-Friendly Clinic Initiative (NAFCI) is at the heart of loveLife. The cornerstone of loveLife is the prevention of HIV, STIs and teen pregnancy. loveLife advocates a new lifestyle for young people based on informed choice and shared responsibility. loveLife is a multidimensional initiative focusing on improving the sexual and reproductive health of South African adolescents. loveLife uses a range of strategies, including media, sports, branding, youth culture, clinical services, community mobilization, healthy lifestyle educational packages and outreach as vehicles for awareness-raising and behaviour change. For the first five years, loveLife was implemented by a consortium of leading nongovernmental organizations, including the Planned Parenthood Association of South Africa (PPASA), an International Planned Parenthood Federation (IPPF) affiliate; the Reproductive Health Research Unit (RHRU), an academic research and training unit of the University of Witwatersrand; and the Health Systems Trust (HST), an organization actively involved with primary health care transformation in South Africa.

NAFCI was formed out of the recognition that a successful sexual health campaign must be supported by health services that accommodate the needs of young people. NAFCI also recognized that the public health sector is the most sustainable way of providing health services that can reach out to most adolescents. The NAFCI programme was conceptualized and implemented by the RHRU between 1999 and 2005*.

The process coincided with the government's development of a health policy document for youth and adolescents. The government's "Youth and Adolescent Health Guidelines"22 provided a policy framework for NAFCI and also stimulated interest in the programme.

Seeking national consensus

To begin the process of consensus, a draft of the first NAFCI programme guidelines was developed and distributed to stakeholders. In November 1999, a national meeting was convened to discuss the concept and guidelines[23] with national and provincial programme managers and policy-makers, representatives of youth and youth-serving organizations and other key nongovernmental organizations. The intent of this meeting was to gain national consensus on the basic principles and tenets prior to consulting with international experts. The key concepts, aims, objectives and guiding principles of NAFCI were set out at this meeting.

* Thereafter, the consortium was dissolved and NAFCI has since been implemented directly by the loveLife Trust.

The aims and objectives of NAFCI were outlined as follows:

- NAFCI aims to improve the quality of adolescent health services at the primary care level and to strengthen the public sector's ability to respond appropriately to adolescent health needs.

Three key objectives of the NAFCI programme are:

- to make health services accessible and acceptable to adolescents;
- to establish national standards and criteria for adolescent health care in clinics throughout the country;
- to build the capacity of health-care workers to provide high-quality adolescent health services.

Subsequently, in January 2000, an international consultation was convened with international experts, including some from WHO (Department of Child and Adolescent Health and Development), IPPF, the Quality Assurance Project (QAP) and other international youth-serving organizations, to assist with the development of the systems and tools. At this meeting, various quality and accreditation models were reviewed, including Brazil's Proquali Clinic Initiative*, Egypt's Gold Star Hospital Programme†, the Baby-friendly Hospital Initiative (BFHI)‡ and the Council for Health Service Accreditation of Southern Africa (COHSASA)§. The first draft of the NAFCI standards and criteria was produced at this meeting.

NAFCI management structure

NAFCI developed a project management structure under RHRU directorship. The programme was started with a director, two project coordinators and a programme assistant. The director was responsible for the overall coordination, leadership, strategic direction, technical support, coaching and mentoring of the coordinators. The project coordinators provided direct technical support and coaching of the clinic staff and teams. The programme assistant was a young person who helped to define young people's roles in the clinic and worked to ensure meaningful adolescent involvement and participation in the programme. From the outset and for at least four years thereafter technical support was provided by the QAP, a project with expertise in quality improvement funded by the United States Agency for International Development (USAID).

By January 2001, as the programme expanded to all nine provinces of South Africa and the number of participating clinics increased, additional staff were needed. More coordinators were employed and an additional tier of management was introduced. Deputy directors were positioned to mentor, support and manage the coordinators. With continued expansion, by the end of 2003, two additional directors were appointed for

* An accreditation model for primary health care reproductive health services, USAID-JHPIEGO, Johns Hopkins University/Center for Communication Programmes and Management Sciences for Health/Family Planning Management Development (http://www.jhuccp.org/la/brazil/proquali.shtml).

† A public sector family planning quality improvement programme, USAID Population/Family-planning Project (http://www.jhuccp.org/neareast/egypt/goldstar.shtml).

‡ A joint WHO/UNICEF initiative adapted and launched in South Africa in 1993 (http://www.unicef.org/programme/breastfeeding/baby.htm).

§ COHSASA accredits health care facilities in South Africa (http://www.cohsasa.co.za/).

training and quality improvement. Each coordinator supported an average of six clinics, and the deputy directors provided oversight to two provinces. The heart of the process was the quality improvement teams within the clinics, which were supported by the NAFCI coordinators. When clinics became ready for external assessments in 2003, a senior quality assessor was brought on board to develop this phase of the programme.

Adopting a quality improvement approach

The NAFCI programme was designed around four main elements of quality improvement: focus on the client, effective systems/processes, use of data, and a team approach. The quality triangle [24] is the framework for the programme. The triangle (Figure 1) depicts a relationship between defining quality (e.g. setting standards), measuring quality (determining how well the standards are being achieved) and improving quality (implementing a process to achieve the standards). As a result, standards were developed to define "adolescent-friendly" services, tools were designed to measure the quality of the services, and quality improvement methods were introduced to assist in overcoming barriers to providing quality services.

Figure 1. ***The quality triangle***

Development of the NAFCI standards

A participatory approach was set in motion to design the programme and develop the standards. In addition to the national and international consultations, focus groups were held with young people regarding their needs and expectations of clinic services. From these consultations, key functions were identified. These functions formed the basis for the development of the 10 NAFCI standards (Box 1).

Box 1. NAFCI standards

1. **Management systems are in place to support the effective provision of adolescent-friendly services.**
2. **The clinic has policies and processes that support the rights of adolescents.**
3. **Clinic services appropriate to the needs of adolescents are available and accessible.**
4. **The clinic has a physical environment conducive to the provision of adolescent-friendly health services.**
5. **The clinic has drugs, supplies and equipment to provide the essential service package for adolescent-friendly services.**
6. **Information, education and communication consistent with the essential service package are provided.**
7. **Systems are in place to train staff to provide adolescent-friendly services.**
8. **Adolescents receive an accurate psychosocial and physical assessment.**
9. **Adolescents receive individualized care based on standard service delivery guidelines.**
10. **The clinic provides continuity of care for adolescents.**

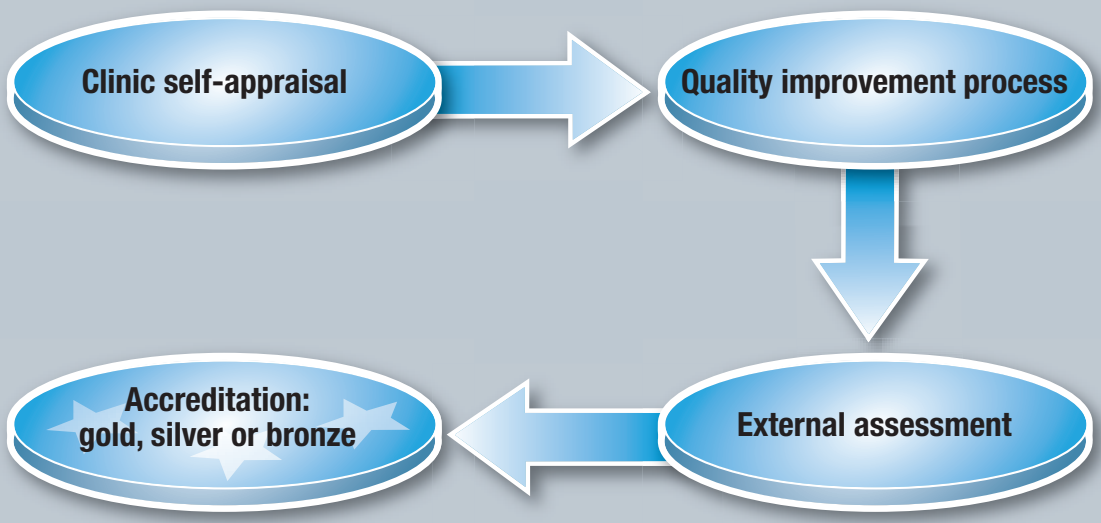
Building consensus on the standards among various stakeholders involved a year of discussion, revision and field-testing. Workshops were held with district level and clinic staff to validate the standards. Ultimately, 10 standards were agreed upon with 41 corresponding criteria. For each of the 10 standards, criteria were outlined to describe how the standard would be met. For example, criteria for the standard on management included identifying the needs of adolescents within the community and developing plans to meet those needs. To further explain the standards and criteria, 101 questions were also outlined. The challenge in developing the standards and criteria was to ensure that the standards were clear, reliable, valid and, most important, realistic [25].

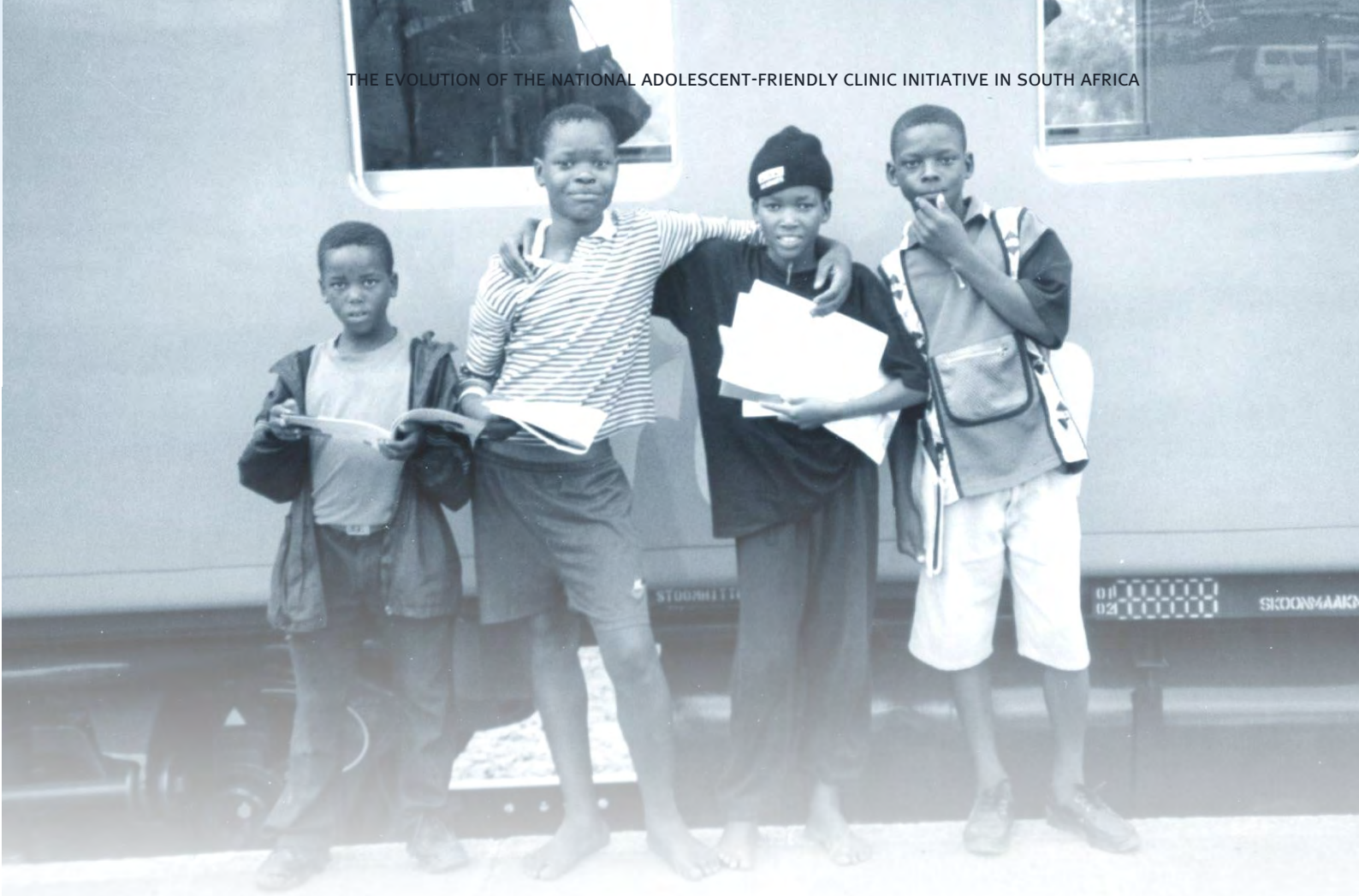
NAFCI accreditation model

After the standards were agreed on, the discussions turned to the accreditation model. An accreditation approach was chosen as it was felt that health workers and district managers would find this method motivating by seeing the opportunity of working together as a team towards a common goal. The BFHI was identified as a successful programme to emulate. The group decided to award three levels of accreditation—bronze, silver and gold—so that health workers could easily achieve some level of success whilst striving to obtain the gold. Another factor taken into consideration was that health workers in South Africa are keen on receiving certificates of achievement, and therefore developing a system that gave an award would encourage health workers to participate. In addition, it was felt that by giving a clinic award the clinic staff would be encouraged to work together as a team.

The accreditation model depicted in Figure 2 represents the outcome of debate and discussion relating to this issue. The *clinic self-appraisal* was designed to involve clinic staff in the process at the outset. A self-appraisal process was selected because it was felt that staff would feel more comfortable and find it less critical to examine, appraise and grade their own practices. The self-appraisal was intended to help staff to determine which standards and criteria they met and which they did not meet. The unmet standards would then become the object for the *quality improvement process*. When the staff felt confident that they met the standards they would apply for an external assessment. Finally, *accreditation* would be awarded on the basis of the number of standards achieved.

Figure 2. ***NAFCI accreditation model***





Setting a national standard of care: the essential service package

All NAFCI clinics were expected to provide an essential package of basic clinical sexual and reproductive health services (Box 2). The essential service package was based on the primary-level care services that had been defined by the National Department of Health for clinics throughout the country. The department took into account that clinics at the primary-care level could provide only basic-level services but should also be able to provide information and education on common reproductive health conditions and have systems in place for appropriate referral.

Box 2. The essential service package

1. **Information and education on sexual and reproductive health**
2. **Information, counselling and referral for violence/abuse and mental health problems**
3. **Contraceptive information and counselling, and provision of methods including oral conceptive pills, emergency contraception, injectables and condoms**
4. **Pregnancy testing and counselling, antenatal and postnatal care**
5. **Pre- and post-termination of pregnancy counselling and referral**
6. **Sexually transmitted infections information, including information on the effective prevention of STIs and HIV, diagnosis and syndromic management of STIs**

Steps for implementing NAFCI

The steps for implementing NAFCI in a clinic are summarized in Box 3. Although there may be variation in sequencing, and other activities may be necessary, these steps are the core of NAFCI implementation common to all clinic sites.

Box 3. Steps for implementing NAFCI

Step 1. Get organized.

Steps for organizing the quality improvement team are outlined, as are the first meetings that need to be held to get the programme off the ground. Obtaining management and staff buy-in to the process is an important part of this step.

Step 2. Conduct a self-appraisal.

The self-appraisal is conducted by the clinic staff to determine how well the standards are met. The self-appraisal is a participatory process and is meant to foster team spirit within the facility. All staff members are informed about the exercise, and all categories of staff are represented on the quality improvement team.

Step 3. Initiate quality improvement.

Based on the findings of the assessment, an action plan is developed to improve adolescent services and to meet the standards. In some cases, problem-solving methods are used to study the problems and identify solutions.

Step 4. Apply for external assessment.

When the team has completed the quality improvement action plans, another self-appraisal is conducted to determine whether the standards are now being met. When the team, together with the NAFCI coordinator, feels ready, an external assessment is requested. An assessment team visits the clinic to carry out the external assessment. The process involves observations, interviews and a review of documents to assess compliance to standards.

Step 1. Get organized

Introducing NAFCI

The NAFCI coordinator initiated the activities by inviting key stakeholders—all clinic staff, the district manager, the clinic supervisor, representatives from key youth organizations, schools, local leaders and youth representatives—to a meeting. The objectives of this first meeting were to introduce NAFCI and to outline the purpose of the quality improvement team and the team's mandate. Some clinics had a clinic health committee or forum that provided guidance and support to the clinic, in which case members of the committee were invited to the introductory meeting.

Formation of a quality improvement team

A quality improvement team was selected by the staff and tasked with implementing NAFCI. It was important that all categories of staff were represented on the team (nurses, physicians, security guards, cleaners, receptionists, etc.), as each type of personnel contributed different knowledge and experience in providing adolescent services. Adolescent representation was critical to the team. If the clinic had links with a youth-serving organization, a young person from that organization was often asked to serve on the team. Otherwise, a young person active in the community was invited to participate. When a clinic committee existed, a committee member also participated in the team.

Selection of a team leader

A team leader was selected to guide the process, which included organizing and leading the meetings, initiating the self-appraisal, and overseeing the preparation of reports. The team leader therefore needed to be someone who fully understood the objectives of the adolescent-friendly programme and the process for accreditation. Guidance was given to assist in the selection of a team leader. Some clinics asked for volunteers and others nominated peers for the team leader position. All staff members were eligible for the team leader position. At times, team leaders were appointed by the clinic manager. In some cases, the appointed individual was not interested in the programme or was too busy to carry out the duties. In other clinics the nurse assistant was nominated as the team leader and proved to be successful in leading the team. The criteria for selecting a team leader that we found most important included having an interest in the programme, having the ability to organize and facilitate meetings, having time to dedicate to the process, and being respected by one's peers (Box 4). The NAFCI coordinators worked closely with the team leader to set the quality improvement meeting agendas and carry out the plans.

Box 4. Criteria for selecting a team leader

- **respected by his or her peers**
- **interested in achieving the goals of the programme**
- **able to organize and facilitate meetings**
- **able to dedicate time to the process.**

Seeking community buy-in

NAFCI was designed to involve both youth and the community, most particularly members of the clinic health committee and youth-serving organizations. Clinic health committees had been set up by many communities for liaison and to support the clinic's work. Therefore, these committees became natural vehicles for creating links with the community. Helping the community to understand the significance of the youth health crisis and the objectives of NAFCI in dealing with this crisis were primary goals. NAFCI was first introduced to the communities through a community stakeholders meeting initiated by the clinic managers.

In several communities, NAFCI was also introduced through a special community event which was organized in collaboration with the loveLife programme activities, e.g. loveTours and loveTrain (see Annex 1). Often this coincided with a special event like World AIDS Day. The approach was an excellent means of involving community and clinic leadership from the beginning. The quality improvement team, community leaders and young people worked together to organize and carry off the event. The event was packed with music, dancing, drama and parades that introduced NAFCI, as well as sending out important messages about sexual health and healthy lifestyles.

Building capacity

Orientation and capacity-building were vital components of the programme. One of the first steps was to engage in a process with health care providers to reveal and tackle the barriers that prevent young people from using clinic services. An important component was the attitude of health care providers to young people. The orientation therefore included a process of values clarification whereby health care providers were given the opportunity to explore how their attitudes, values and beliefs could hinder effective service delivery. The values clarification process was particularly useful in regard to the delivery of sexual and reproductive health care, where personal values and morals need to be weighed against the rights of the client and the quality of health care delivery. Values clarification has been used for developing termination of pregnancy services, working with high HIV transmission groups (e.g. sex workers), and where there is discomfort about issues such as sexual orientation.

The NAFCI publication *Grounds for respect: Facilitating change towards adolescent-friendly services* was developed to provide guidance for running a values clarification workshop. After field-testing and an evaluation process, this document became part of the core support package to clinics. A workshop was conducted for all categories of staff because the attitude or behaviour of a clerical worker, security guard or nurse could equally deter a young person from seeking a service. The workshop fostered teamwork among the staff as they shared their thoughts and feelings about these intimate matters. The workshop was often conducted in one of the local languages as well as in English because most staff felt more comfortable speaking the local language.

Workshops were also conducted to orient clinic staff to the adolescent-friendly standards and to show how the standards could be implemented. During these sessions, staff members were taught how to conduct a self-appraisal. In addition, clinic staff were trained in basic quality improvement skills, such as working as a team, identifying gaps in meeting the standards, action planning, and problem-solving. The coordinators coached the clinic staff at least once a month to apply the quality improvement methods and to implement the standards. When needed, educational sessions were provided on clinical topics such as emergency contraception.

Step 2. Conduct a self-appraisal

The first activity of the clinic quality improvement team was to conduct a self-appraisal. A self-appraisal tool was developed so that clinic staff could determine their own status in relation to meeting the standards. The tool included questions that could be answered by either "yes" or "no". Each criterion has a series of corresponding questions. "Partially met" is not a choice on the self-appraisal, as a "no" response highlights the need for improvement and an action plan. The coordinators assisted the clinics to conduct the first appraisal in order to establish a baseline and identify gaps in meeting the standards. Some of the gaps identified were "quick fixes" and could be easily remedied. Other issues were more difficult to deal with. In these cases, the clinic teams used a problem-solving approach to study the issue, develop solutions and evaluate whether their solutions were effective. The teams conducted self-appraisals at intervals to evaluate their progress towards meeting the standards.

Step 3. Initiate quality improvement

In addition to the self-appraisal and problem-solving method, other quality improvement tools were used to assist the team to improve the quality of services. For instance, a client flow analysis [26] would be carried out to determine the amount of time clients had to wait to be seen and the way staff were being used. The findings were used to decrease the waiting time and to use staff more efficiently. In order to understand better the needs and expectations of the clients, focus group discussions and client satisfaction surveys were conducted.

Monitoring tools were developed to evaluate clinical practice. Staff members were encouraged to use these tools to assess adherence to reproductive health protocols (e.g. counselling, syndromic management of STIs). Staff members were asked to observe the practice of their peers rather than having the supervisor or NAFCI coordinator evaluate practice. Peer evaluation was a new process for most staff and some felt it was threatening at first. Therefore, the NAFCI coordinators worked with staff to learn how to give and receive feedback effectively. These skills helped in the implementation of the clinical practice monitoring and in improving general communication between staff members.

Another important aspect of quality improvement is to use data for decision-making. Therefore, the clinic staff were assisted to use the clinic data (e.g. registration information) to analyse client needs and clinic use in order to improve service planning. Clinic staff needed assistance in developing graphs and charts to display the data better and to promote discussion.

Step 4. Apply for external assessment

When team members felt that they had achieved the standards, they applied for accreditation. One of the first considerations in designing accreditation was to determine the type of structure needed to manage the accreditation process. Questions outlined by QAP were used to assist the NAFCI partners in designing the accreditation process [27]. For instance, who would be responsible for overseeing the programme—the Ministry of Health or a nongovernmental organization? Who would be the accrediting body? Would this be a one-time accreditation or would there be a maintenance programme? Discussions were held regarding who would carry out the external assessments. It was decided that, in the long term, the process would be integrated into provincial and district Department of Health structures. In the interim, NAFCI would develop a specialist external assessment team that would carry out the assessments and build capacity in Department of Health structures.

The assessment team

The assessment team consisted of three or four members who included a clinician (nurse or a doctor) and a young person. The clinicians conducted the management interview, documents review, observations and clinical staff interviews. The young person interviewed key informants (defined as young people actively involved with the clinic programme) and conducted the client exit interviews.

Due to funding limitations, the first assessment teams were NAFCI coordinators. To avoid bias, the coordinators conducted assessments in clinics outside of their provincial responsibilities. To prepare the coordinators for this role, QAP held a two-day workshop in October 2001 to train them to conduct external assessments. At the end of the workshop, a training guide for preparing external reviewers was developed. The workshop was followed by trips to three clinics to mentor the coordinators in conducting the external assessments.

In October 2002, NAFCI designed a research study to investigate the effectiveness of the NAFCI programme towards meeting the standards. At this juncture, three individuals were hired and trained primarily to conduct the baseline and final assessments for the targeted research and control group clinics (total 22 clinics). With the rapid roll-out in 2004–05, this team was called upon to work in combination with the NAFCI coordinators to cover the growing number of clinics requesting external assessments. In June 2003, a specialist was hired to establish a system for collecting, entering and storing NAFCI data.

The assessment tools

Eight assessment tools were designed to capture data from various perspectives for the external assessment (Table 1). The new tools were field-tested and revised several times in order to ensure that the methods and questions were effectively measuring the achievement of the standards. The data processing of the baselines and external assessments was contracted out to Khulisa Management Services, an organization with particular expertise in this field.

Table 1. ***External assessment tools***

ASSESSMENT TOOL	METHOD OF DATA COLLECTION
1. Interview with clinic manager	A standardized questionnaire is administered to examine the management systems in place to support the provision of adolescent-friendly services.
2. Document review	Review of documents important to clinic function such as the community health profile, service plan, staff training plan, clinical guidelines and client records. A total of 19 documents and 10 clinic records are reviewed.
3. Inventory of the clinic and immediate surroundings	The clinic and immediate surroundings are assessed to determine cleanliness, infection control practices and the general state of the environment. Inventories are also done to determine the availability and storage of drugs, equipment and supplies.
4. Health-care provider interview	Questionnaires are administered to a random sample of health-care providers present on the day of the assessment to evaluate their knowledge on pertinent adolescent health issues and to assess whether the health-care providers have the necessary competencies to provide all services in the essential service package. In facilities with fewer than five health-care providers, all health-care providers are interviewed; where there are more than five health-care providers but fewer than 10, at least five are interviewed; where there are more than 10 health-care providers, 50% of them are interviewed.
5. Non-clinical support staff interview	Questionnaires are administered to a random sample of non-clinical support staff to assess their commitment to adolescent rights and any barriers that adolescents may experience. The same criteria are used for sample size as for the health-care provider interviews.
6. Client–provider interaction observations and simulations	Five client consultations are observed to determine whether adolescent clients received an accurate assessment and care based on standard case management guidelines. Simulations also are used as a means of assessing clinical practice where there are no actual cases to observe.
7. Adolescent client exit interviews	Exit interviews are conducted with five adolescents after they have received services to assess client satisfaction with the services.
8. Key informant interview	Interviews are held with five young people who have been involved with clinic activities. The key informants are expected to provide valuable insight into the clinic's activities towards providing adolescent-friendly services. Each clinic is asked to select its key informants.

The original intent for the client–provider observations was to make direct observations of interactions between health-care providers and adolescents seeking reproductive health-care services (e.g. contraceptives and treatment for STIs and HIV). Decisions also had to be made regarding how many observations were needed for a valid assessment. However, adolescent clients seeking reproductive health services were not always present during the assessment team visits. In addition, problems with confidentiality and client consent made the process more difficult. Consequently, NAFCI developed case studies and simulations to present during the external assessment. Finally, it was agreed that the assessors would make general observations of interactions between adolescents and health-care providers during any type of clinic visit and that simulations and case studies would be conducted. (Sexual and reproductive health topics were used for the simulations, such as contraceptive counselling and syndromic management of STIs.) In that way, the rapport with young people could be assessed as well as the technical knowledge. In addition, the interview with the health-care providers contained questions seeking their knowledge of reproductive health care as well as questions eliciting their attitudes about young people and the management of the services.

During the pilot phase of this process, interviews were conducted only with registered nurses. However, in some clinics the enrolled nurses were offended because they were not included. In addition, members of the health committee who came to the clinic on the assessment day were disappointed if they were not involved in the process. Thus, enrolled nurses were included in the interview process and informal discussions were held with the community members to invite their comments and accounts of their experiences.

The assessment process

Depending on the size of the clinic (size determined the number of interviews and observations required) the external assessment was designed to be completed in one or two days. The assessment process could be intense as it required constant diligence to obtain the data required. Observations and client interviews sometimes needed to be done prior to noon because there were no clients in the afternoon. In this case, the health-care professionals were interviewed in the afternoon. In other clinics, the client load was heavy throughout the day, and it was difficult to find time to interview the staff before day's end. At the end of each day, the assessment team was required to review their data collection tools as a team to ascertain whether each tool was fully completed and to validate findings (there were questions identified in the data collection tool that required validation with the team prior to final scoring).

Data management

The scoring process for the external assessment required computerized data management. The programme needed to compute data from eight data collection tools with varying sample sizes and varying weights between criteria. The same standards and criteria were measured from various perspectives. For instance, competency of staff was assessed through the health-care professional interview as well as observation and thus needed to be correlated in the final score for each standard. Consequently, the programme was complicated and underwent many revisions. It was important that the scoring reflected the actual situation and much effort went into reviewing the data to assure accuracy. However, this process delayed the provision of feedback to the first clinics that underwent the external assessment.

The data were analysed using an Access database set up by Khulisa Management Services. Results were calculated to establish how many of the 10 standards and 41 criteria had been met. The scores of responses from the different tools were aggregated according to standard and criteria. Each question was weighted on a scale of 1 to 3 as follows:

1. **important** (questions that refer to the availability of documents and signage);

2. **very important** (for proper management planning, assessing and identifying the needs of staff, perceptions of team involvement, good supervision and training of staff);

3. **critical** (adolescents' perceptions and opinions about the nature of care received; activities to improve accessibility, remove barriers and promote services; activities to assess and identify adolescent health needs; quality improvement methodologies implemented; good clinical practice; and adherence to adolescents' rights).

Although each standard had a different number of corresponding criteria and questions, all the standards were weighted equally in the data analysis. Clinics were awarded a gold star if they achieved more than 90% on their overall clinic score, a silver star for a score between 60% and 89%, and a bronze star for a score between 30% and 59%.

External assessments

The first external assessment was conducted in April 2002. Decisions needed to be made regarding how to report the results. The aim was to provide the results in a way that the district leadership and staff could celebrate their success as well as plan for continuing improvements. The entire NAFCI programme team, consisting of the NAFCI director, the two coordinators, the programme assistant, the QAP technical adviser together with the district manager, delivered the results for the first clinics in person. At that time, the NAFCI programme team and clinic team planned the celebratory event together. The first recognition workshop was held in Cape Town in August 2002. Two clinics shared their experiences with NAFCI in creative ways. One clinic developed a script and a storyboard, while youth from the other clinic performed a skit depicting the clinic pre- and post-NAFCI. Local leadership discussed the lessons learned and reviewed the results of the external assessments with the group. Then small groups were formed to develop action plans for moving forward.

The strategy of celebrating success combined with marking a way forward for continued improvement remains important to the NAFCI process. However, with the increase of clinics undergoing assessment, it was not feasible for NAFCI to hold a major event at each clinic. Therefore, other approaches to providing feedback have been developed such as a meeting with clinic staff, management and key stakeholders

All clinics were anxious to know their results, and for that reason a feedback session was held at the clinic at the conclusion of the assessment. Providing feedback is a skill, so the assessment team was trained to outline noteworthy achievements and areas for improvement, as well as to present the feedback in a positive manner. In addition, a follow-up letter was sent to provide immediate written feedback to the clinic while it awaited the official findings. To foster continued improvement, the NAFCI coordinator visited the clinic shortly after the assessment to review the comments in the follow-up letter and to assist the team to develop an action plan. The final assessment report integrated the findings from all the assessment tools and provided a comprehensive account of the findings for each standard. The target for completing the report was two weeks after the completion of the assessment. However, this goal was unrealistic; a more realistic expectation would be from four to six weeks.

As could be predicted, the clinic staff were jubilant when they achieved gold status and disappointed when they received a lesser rating. However, staff and district leadership have responded positively to the feedback and have accepted the feedback to make further improvements. The accreditation process also provides an opportunity for clinics to apply for another external assessment six months after the initial assessment if they did not achieve accreditation. To maintain accreditation, the programme requires a reassessment within two years.

Piloting NAFCI

Selection of pilot clinics

A district approach for implementation was decided upon to ensure that NAFCI would be implemented as a sustainable district intervention rather than a stand-alone clinic intervention. Prior to initiating any activities, the NAFCI partners met with district health managers to discuss the programme and ask for their support. District meetings were held, and presentations made to district managers, clinics managers and some staff. The stakeholders selected the pilot clinics at this meeting. Many factors were considered in selecting clinics for the NAFCI programme, including poor use of clinic services by young people, high prevalence of STIs and HIV, and high rates of teenage pregnancies in the community. Districts targeted to pilot NAFCI were selected from those that were receiving support from the Health System Trust's Initiative for Sub-District Support (ISDS)*. Initially one clinic per ISDS district was to be chosen for the pilot but the meetings generated so much interest that some districts wanted to start with more than one clinic. Thus, 10 clinics were selected instead of the original plan of six.

Building capacity of programme managers

Following selection of the clinics in August 2000, the QAP facilitated a two-day workshop for the national and provincial reproductive health managers and clinic managers and representatives from key nongovernmental organizations and others who were to be involved in the implementation of the programme. The main objectives were to establish a basic understanding of NAFCI and gain stakeholder and management support for the programme. A force-field analysis was used to identify potential facilitating and restraining factors in programme implementation, as well as to develop action plans based on these assumptions. This activity assisted the managers in understanding the quality methodology and programme approach, as well as securing their support and engaging them in the process of implementation.

Subsequently, a three-day workshop was held with the pilot clinic managers, NAFCI coordinators, and district leaders. The content and activities were designed to assist the participants to promote NAFCI, communicate and implement the standards, and begin applying a quality improvement methodology. Each clinic left the workshop with a plan to introduce the NAFCI programme and standards to their staff and community. They also planned activities to create a community adolescent profile, involve adolescents in the planning and process, and initiate the standards and quality improvement activities.

A facilitated approach

NAFCI programme managers believed that setting and distributing the standards and programme guidelines were not sufficient for accomplishing the objectives. Therefore, they chose a facilitated approach. Participatory training workshops and coaching were ▶

* ISDS is an initiative to strengthen the district health management teams.

structured to build skills of coordinators in applying quality improvement techniques, including giving and receiving feedback, communicating standards, identifying and prioritizing problems, carrying out a cause-and-effect analysis, brainstorming and selecting solutions. The coordinators attended regular workshops to build their skills in facilitation and coaching and were mentored on site by NAFCI management and the QAP expert. The NAFCI coordinators provided continuing mentorship and "horizontal supervision". This element was critical to the success of the programme and, therefore, the coordinators worked with district managers to build their capacity to support clinics and sustain the programme. In addition, the programme managers developed various tools to help supervise and measure the progress of the programme, including a tracking sheet and an activity checklist.

Tracking sheets

Tracking sheets listed each of the standards and criteria to assist the coordinators follow progress towards meeting each standard. The coordinators assessed whether a standard was met, partially met or not met. If all of the criteria were met for a particular standard, the standard was "met"; if some of the criteria were met it was marked "partially met"; and if none of the criteria were met for the standard, it was marked "not met". This information was collected each month and provided an indicator for determining whether the clinic was moving towards accreditation.

Activity checklist

In addition to tracking achievement of the standards, key activities that needed to be carried out to meet the standards were listed on a checklist. The checklist served the dual purpose of assisting coordinators in providing support to clinics while also collecting the necessary information to document the NAFCI programme. The coordinator recorded the dates of completion of these activities (e.g. conducting a client flow analysis, adolescent needs assessment, and staff training needs assessment). Coordinators could use this activity list to help plan their visits to the clinics. (These documents are included in the NAFCI coordinator's manual.)

In addition, the coordinators conducted in-depth assessments of the clinics on a regular basis to determine how well the clinics within their provinces were progressing towards meeting the standards. NAFCI management used this information to improve the implementation process. These assessments led to the development of some of the publications to support the programme.

Support components

Publications

As the programme unfolded, it became clear that written materials were needed to support the programme. Table 2 lists the documents that were developed to support the implementation of the programme and the purpose of each of these documents. These include resources for NAFCI staff, Department of Health management, the clinics and the community.

Table 2. ***Publications***

PUBLICATION	PURPOSE
CLINIC SUPPORT MATERIALS	
NAFCI information leaflets	Clinic information leaflet that provides an introduction to NAFCI, including the aims and objectives of the programme
NAFCI adolescent sexual and reproductive health rights document	Leaflet outlining the rights and responsibilities of adolescents
Going for NAFCI gold: a clinic guide to the National Adolescent-Friendly Clinic Initiative	Manual providing step-by-step information on how to implement NAFCI, including standards, quality improvement methods and self-appraisal tools
NAFCI handbook of adolescent sexual and reproductive health care	Clinical handbook providing guidelines on how to manage common adolescent sexual and reproductive health problems
Networking the stars: the NAFCI resource directory	A directory of resources (organizations, institutions) within each province that can provide technical assistance and/or training to build clinic capacity to become adolescent-friendly
Grounds for respect: facilitating change towards adolescent-friendly services	Manual for orienting clinic staff on adolescent-friendly services, including values clarification as a main component and approach to facilitating change towards adolescent-friendly clinics
COORDINATOR SUPPORT MATERIALS	
NAFCI coordinator's manual	Orientation guide for new coordinators and on-the-job support material for coordinators, includes: ■ groundBREAKERS activity schedule ■ NAFCI frequently asked questions ■ clinic statistics data collection form ■ guidelines for a community bash (creating community buy-in) ■ standards tracking sheet (monitoring progress towards meeting the standards) ■ Position description ■ NAFCI provincial report 2002 ■ the team-climate questionnaire (assessing quality improvement team function) ■ NAFCI training needs analysis form ■ team activities (team-building) ■ clinical practice monitoring tools ■ clinical practice case studies.
EXTERNAL ASSESSMENT MATERIALS	
External assessor training manual	Manual for training new assessors in conducting an external assessment includes: ■ assessor competency assessment ■ NAFCI accreditation application form ■ scheduling process checklist ■ external assessment daily tracking sheet ■ examples of introductory and exit meetings ■ checklist of clinic documents ■ clinic record review form ■ provider-standardized client observations ■ assessor's guide to scoring.
External assessment tools	Eight data collection tools to conduct the external assessment

Chill rooms

Most clinics are encouraged to develop "chill rooms"—separate spaces where young people can meet. Peer educators conduct educational activities in these rooms and encourage young people to use the clinic services. The clinics are asked to provide a room or a space to set up chill rooms as part of their commitment to the programme. loveLife has provided resources to develop chill rooms at many NAFCI sites, including painting walls in bright colours, supplying video and music equipment and providing a range of informational materials.

groundBREAKERS

groundBREAKERS is a youth development programme funded by loveLife and coordinated with the National Department of Social Development. groundBREAKERS are young people, aged 18–25, who are given work experience in various loveLife initiatives for a year. They benefit from training relevant to their work placement, leadership and citizenship skills, as well as their own personal development. groundBREAKERS at NAFCI sites provide the interface between the clinic and the community. They provide peer education and support, represent the needs of young people on the quality improvement team, assist with quality assessments such as focus group discussions, and are involved in a range of outreach activities. Two training packages were initially developed for groundBREAKERS: healthy sexuality and motivational programmes.

When a clinic was targeted to implement NAFCI, advertisements were posted to recruit young people from within the community to become groundBREAKERS. Applicants were interviewed by NAFCI, loveLife and the clinic management. Two people were selected, preferably one of each sex. Selection criteria included a high school completion certificate, participation in community development activities (especially in the area of youth and HIV), and leadership and communication skills (see Box 5).

Box 5. Selection of groundBREAKERS

- **18–25 years old**
- **matriculation certificate**
- **participate in community activities**
- **leadership skills**
- **communication skills.**

loveLife provides oversight to the groundBREAKERS. Originally this oversight was provided by a staff member from the central office in Johannesburg. However, as the programme grew, the NAFCI coordinators became involved in providing onsite guidance and supervision along with the loveLife representative and a clinic staff member who was the local link between the groundBREAKERS and loveLife. The groundBREAKERS are oriented to their role at the clinic and are scheduled to participate in upcoming groundBREAKERS training programmes. In some instances, groundBREAKERS did not receive adequate orientation or support in carrying out their duties. In these cases, the groundBREAKERS found it difficult to integrate into the clinic environment and to initiate the outreach activities.

The national loveLife media campaign along with the groundBREAKERS outreach activities were significant contributing factors to the youth coming to the clinic. The campaign created visibility and interest in the "loveLife" brand that was associated with the NAFCI clinics. Higher levels of demand were then generated through the links established between the community-based institutions (e.g. schools, youth-serving organizations) and the clinic.

A case study of a clinic pilot of NAFCI is presented in Box 6.

Box 6. The NAFCI experience of Nkowankowa clinic

Nkowankowa clinic pilots NAFCI: a case study

Nkowankowa Clinic in Limpopo province of South Africa was one of the 10 NAFCI pilot clinics. After completing the self-appraisal with the assistance of the NAFCI coordinator, Nkowankowa Clinic organized a quality improvement team which consisted of representatives from the clinic (nurses, clerks, cleaners, and mobile team nurse) and representatives from local youth organizations, schools and the community. The quality team was formed in March 2001. Several youth-serving organizations signed an agreement (Rural Action Group, Africulture and HURESIC) with the clinic to work together on outreach activities. A professional nurse assumed the role of team leader. The newly-formed quality improvement team participated in a values clarification workshop which assisted the group in recognizing the needs of adolescents and their own beliefs about providing reproductive health services to young people.

The team then planned various activities to create awareness of the programme. In a World AIDS Day celebration, loveLife sponsored a community event to create awareness of the NAFCI activities at the clinic and within the region. During World AIDS Day the organizations shared responsibility for the activities, e.g. training activities with youth, basketball, and discussions about sexual health. The objective was to mobilize the community with loveLife messages and to support the NAFCI activities taking place at the clinic. The district supervisor visited the clinic regularly to participate in the NAFCI activities.

Nkowankowa Clinic appointed two groundBREAKERS to provide school and community outreach programmes and also ran sexual health and life skills education sessions with young people at the clinic. With the introduction of the groundBREAKERS, an average of 500 males and females between 10 and 19 years participated in chill room activities per month. Sessions were held for younger and older groups of young people separately. This allowed the groundBREAKERS to focus their education on specific age groups. As part of the youth activities, the Desert Diamond Youth Group was formed at the clinic. The clinic staff and groundBREAKERS worked with this group to promote life skills by facilitating discussions on health care through role-play, drama, music and art. The clinic sponsored a picnic to foster teambuilding with the young people.

The clinic quality improvement team did its first self-appraisal and developed an action plan to address the gaps identified. On the basis of this plan, various activities were organized. One of the activities was to conduct a mini-survey to identify key youth problems. Data were collected from 95 students from two local schools. The results indicated that approximately 60% of the students were sexually active by the age of 14. The students identified several contributing factors: poverty, lack of communication between parents and children, ignorance, and peer pressure. The group used the problem-solving methods to address these problems.

Box 6: Continued

Meetings were held at three churches and with four local youth organizations. The quality improvement team discussed how to connect with different stakeholders in the community, e.g. community police forum, school governing bodies, pastors and principals of schools. Each member selected a group for which to make a presentation. For instance, talks were given at the LifeSavers Girls Guidance and a meeting was held with 50 school principals.

Another activity undertaken as a result of the self-appraisal was a staff training needs assessment. Accordingly, training was planned on topics such as emergency contraception, pre- and post-termination of pregnancy counselling and HIV. The NAFCI handbook became a guide to clinical practice, and tools were used to measure clinical competency and improve practice. Some activities involved structural changes, such as improved signage and repairs to toilets.

Self-appraisals were conducted monthly to track progress. By June 2001, 26 of the 41 NAFCI criteria were met, with eight criteria partially met. By November, the team felt that all of the criteria were met. The team worked to hold their gains while awaiting the external assessment.

An external assessment was held at Nkowankowa Clinic in June 2002. An external assessment team of five people conducted interviews and inventory assessments and observed clinical practice. Community members came to the clinic to support the staff. The staff felt they had been thoroughly scrutinized at the end of the day and laughed about having post-assessment stress syndrome. The clinic received a silver star. Clearly this clinic had transformed. The place was buzzing with activities. Clinic staff and young poeple were interacting in a positive way. Young people were participating in discussions regarding sexual health and life skills, routinely culminating in singing and dancing. The symbiosis between the clinic staff, youth and community was amazing. They had captured the spirit of youth-friendly services.

The clinic chose to continue to strive for gold and achieved its goal on a subsequent assessment in June 2005.

NAFCI was piloted for approximately 18 months. During this period, many requests were made for NAFCI to assist additional clinics to implement the programme. However, the number of clinics NAFCI could oversee was restricted due to limited staffing and funding. From the outset of NAFCI, it was recognized that it was difficult for the clinics to make progress without the assistance of a coordinator. For a short time, informal support was rendered to clinics interested in starting NAFCI, and the manual *Going for gold* was provided to clinics to run the programme on their own. This approach was informal and follow-up was not provided.

Scaling up and the rapid roll-out of NAFCI

Whilst NAFCI was being piloted there were ongoing discussions with the National Department of Health and the individual provinces to seek support and additional funding for scale-up. Efforts were also made to interest private companies and investors in funding the programme. The support materials that had been developed during the pilot phase were reviewed and revised for scale-up.

Soon after NAFCI started, dissemination workshops for the Youth and Adolescent Health Policy Guidelines were held. RHRU was invited to help put together these workshops and make presentations regarding NAFCI. As a result, a series of meetings were convened provincially to orient provincial and district managers about the National Youth and Adolescent Policy Guidelines and NAFCI.

During that period, different approaches of youth-friendly services were being implemented in South Africa. However, many provinces were keen to roll out youth-friendly services based on the NAFCI model. Therefore, in 2003, a decision was made to strengthen the partnership between the Department of Health and nongovernmental organizations and encourage district management teams to become more involved in the implementation of NAFCI. NAFCI coordinators shifted their focus from working and supporting single clinics within a district to working with a cluster of clinics in a region. A series of technical assistance/training workshops was conducted with two purposes:

- to train key staff on the implementation of youth-friendly services using the NAFCI model;
- to develop a roll-out plan, including training, support and targets (numbers of clinics) in the district.

NAFCI coordinators began providing more support and technical assistance to district management teams to oversee the implementation of youth-friendly services. Workshops to introduce NAFCI and provide follow-up support were provided for clusters of clinics in a district, rather than for single clinics on site. It was envisaged that the existing NAFCI clinics would act as demonstration sites or centres of excellence.

The clinics involved in the development of youth-friendly services benefited from NAFCI technical assistance and support. These clinics varied in terms of the additional youth services offered. For example, some clinics hosted voluntary peer education programmes, whereas other provinces paid a stipend, similar to the groundBREAKERS concept. Some clinics were able to provide chill rooms or similar spaces for young people to meet.

As part of this process, an adaptation of *Going for gold* was developed for clinics and district management to use as a hands-on guide. This was developed and piloted with both the Department of Health and NAFCI national, provincial, district and local clinic stakeholders. It culminated in a publication entitled *Towards youth friendly services: a booklet for health care providers wanting to make their services youth friendly* (RHRU, June 2005), and formed part of a broader intent to:

- give expression to the Policy Framework on Youth and Adolescent Health distributed and disseminated in 2003;
- strengthen the roll-out and integration of NAFCI into public health clinics;
- provide support for the groundswell of interest in and commitment to developing youth-friendly services.

Partnerships and additional funding

Initial funding for NAFCI was received from the Henry J Kaiser Family Foundation. From the beginning, the South African government provided both financial and logistical support through the staff time and commitment to the programme, funding to support the roll-out to additional clinics and also funding for the groundBREAKERS programme. USAID and the United Kingdom's Department for International Development (DfID) provided technical assistance to support the programme.

In 2003, Anglo-American Corporation, a mining giant in South Africa, entered into a partnership with loveLife to accelerate the roll-out of adolescent-friendly clinics in communities associated with its operations in South Africa. The partnership* was one of Anglo's social responsibility initiatives to provide a bridge between workplace and community, particularly in the light of the high prevalence of HIV in mining employees in South Africa. Thirty-eight public health clinics benefited from Anglo-American funding to implement NAFCI.

When NAFCI began promoting adolescent-friendly services, the Cape Town Unicity Local Authority developed a close partnership with NAFCI. The Unicity demonstrated strong management and leadership support for the pilot sites, and was eager to see a rapid roll-out of the programme in its region. This interest resulted in the Unicity funding the expansion of NAFCI. A partnership agreement was entered into, whereby NAFCI would oversee the development of adolescent services in Cape Town. As a result, 24 additional clinics were integrated into the NAFCI programme.

In addition, the Global Fund to Fight AIDS, Tuberculosis and Malaria provided the funds to scale up the programme from 60 to 350 clinics in two years. By October 2005, 350 clinics† were participating in the NAFCI programme, with the roll-out to 171 additional youth-friendly clinics overseen by local health service structures. Table 3 depicts the scale-up from 2000 to 2005 and Figure 3 shows the timeline for the implementation of NAFCI.

* Implemented under the auspices of the Anglo-American Corporation Community HIV/AIDS Partnership Project.

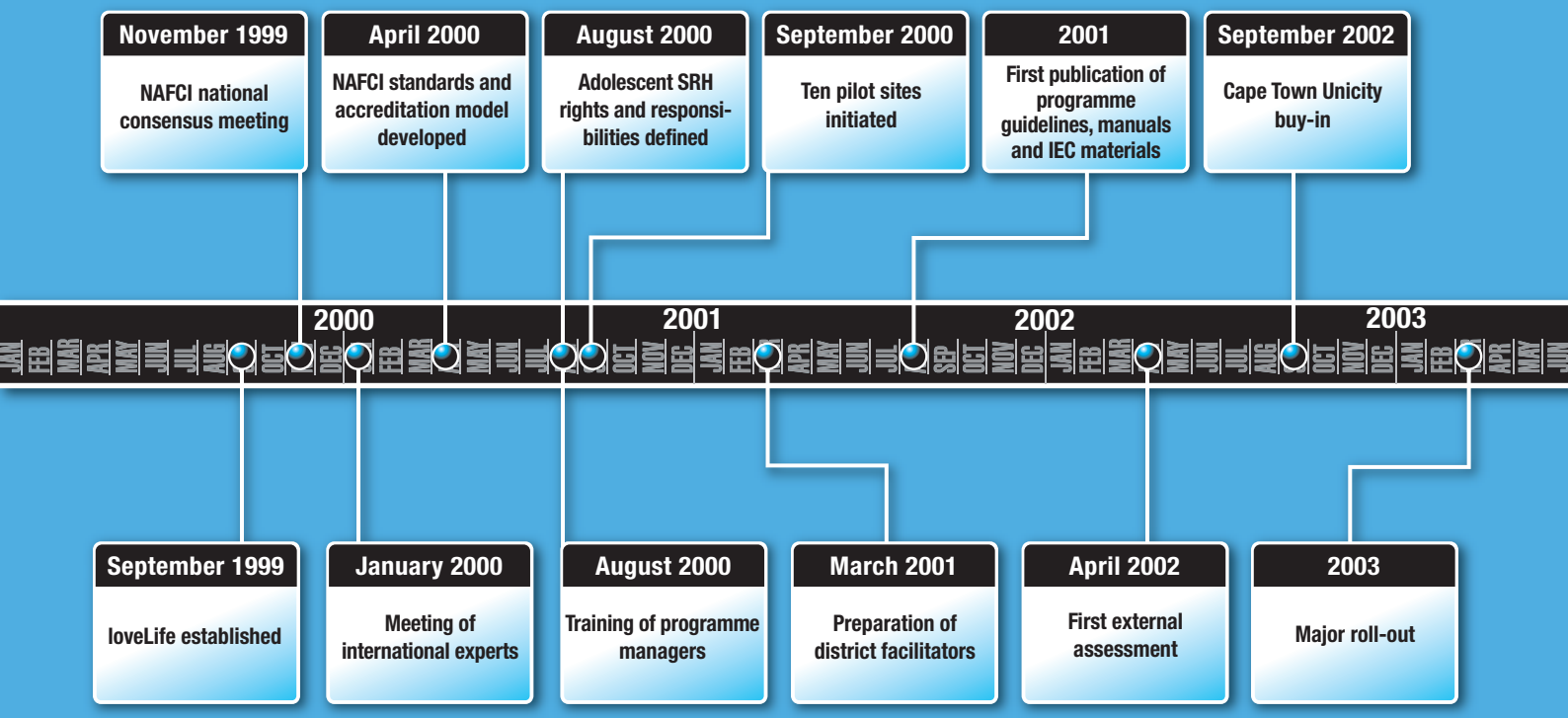
† loveLife annual report, 2005.

Table 3. **NAFCI clinics 2000–2005**

	YEAR					
	2000	2001	2002	2003	2004	2005
Number of clinics participating at the beginning of the year	0	8	18	54	82	235
New sites initiated during the year	10	10	37	28	154	116
Clinics not actively supported by a NAFCI coordinator	2	0	1	0	1	1
Total active NAFCI sites at the end of the year	8	18	54	82	235	350

Half of the NAFCI clinics are situated in three of the nine provinces: Western Cape (20%), Eastern Cape (17%) and KwaZulu Natal (13%), with the other clinics distributed throughout the other six provinces. In most provinces, distribution is roughly proportional to population size. The Western Cape is the exception, as additional funds were provided by the Western Cape Provincial Government, which afforded an accelerated roll-out in that region.

Figure 3. **NAFCI timeline**



Results

Development of indicators

Measuring the success of the programme was of critical importance. The first objective of NAFCI was to make health services accessible and acceptable to adolescents. Consequently, use of services was identified as a key indicator. In addition to use of services, it was felt that youth attendance in the chill room was important. Chill room attendance reflected the young people's comfort in coming to the clinic for activities that promoted healthy lifestyles. Youth visiting the chill room for the first time suggested an effective marketing strategy, whereas repeat visits showed that youth felt at ease returning to the clinic. Indicators were established to measure the success of the programme including:

- number of adolescents using the clinic, according to age
- number of new adolescent clients using the chill room
- number of repeat adolescent clients using the chill room
- number of clinics that have received accreditation.

Clinic statistics forms were revised to include the age breakdown for young people. Data collection forms were developed for the chill rooms.

Overview of programme implementation

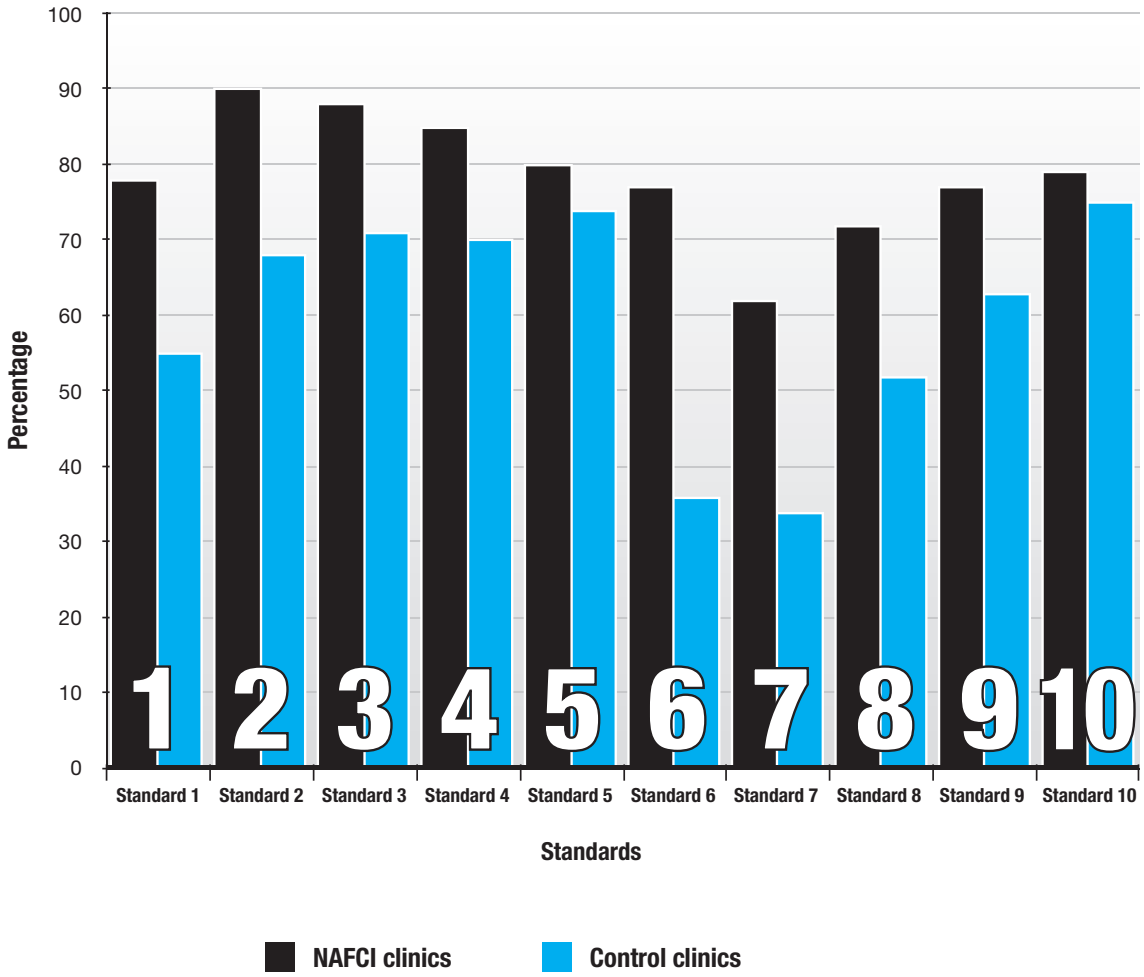
The NAFCI programme expanded significantly from 2003 to 2004. The number of clinics implementing the programme almost tripled from 2003 when 82 clinics were implementing the programme to 235 clinics by December 2004. In 2005 there were 350 clinics formally participating in the programme, with an additional 171 "associate" youth-friendly clinics [28].

By the end of 2005, 212 external assessments had been completed. The majority of NAFCI clinics that had been externally assessed complied with 80-90% of the NAFCI standards and criteria and a large proportion (35%) complied with more than 90%. Significant improvements were also seen from the baseline scores of these clinics to the external assessment scores after at least six months implementation of the programme. The average score for NAFCI clinics that have been externally assessed was 85% while the average baseline score was 29%. On average this represents a 56 percentage point improvement from baseline to external assessment score.

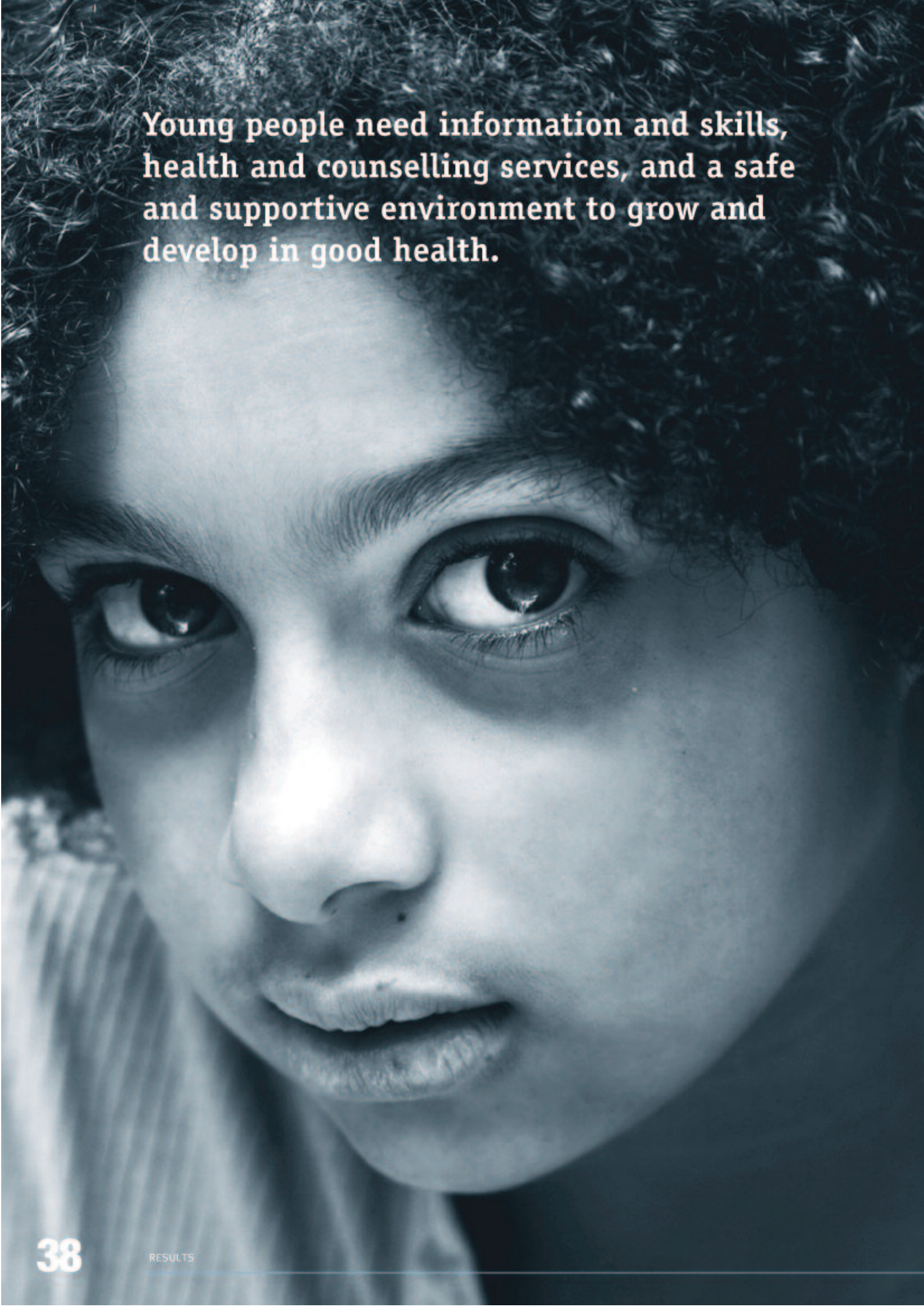
Results from the 2004 analysis of 11 NAFCI clinics and 11 research sites showed that NAFCI clinics performed significantly better (95% confidence level) than control clinics on overall clinic scores ($p < 0.001$), and on all standard scores except standard five on sufficient supplies and equipment (although NAFCI clinics performed better than control clinics on this standard, the difference was not statistically significant)[29]. While NAFCI clinics in the research group improved further on almost all standards with statistically significant improvements from the 2003 to 2004 analysis, there were statistically no significant differences between the control sites' scores for 2003 and for 2004.

Figure 4 shows the performance of the 11 NAFCI intervention clinics as compared to the control sites.

Figure 4. ***Comparison of NAFCI clinics to control clinics (n = 11)***



The research findings indicated that even the control clinics met some of the standards and criteria without implementing the programme. Control clinics managed to attain scores that met a level for accreditation; for example, the highest scoring control clinic attained silver star level and the lowest attained bronze star level. This finding was due to the control clinics meeting "generic" quality-of-care indicators (e.g. infection control or having stock available) rather than specifically adolescent-friendly services criteria. Prior to implementing NAFCI, none of the clinics, NAFCI or control, had any specific policies or services for adolescents or activities involving young people. In addition, staff had not received adolescent-friendly services training, and there were no community outreach activities focused on the young. It was these criteria that differentiated the NAFCI clinics from the control clinics in this study.


Young people need information and skills, health and counselling services, and a safe and supportive environment to grow and develop in good health.

Lessons learned

Obtaining support for NAFCI

Strong leadership at all levels is a crucial ingredient to implementing an adolescent-friendly programme. From its inception, the NAFCI programme operated in partnership with the Department of Health. The promotion of adolescent health was identified as a priority by the Department of Health, and the development of adolescent-friendly services was supported. This commitment was reflected in the adoption of various health policies and strategic plans*. National policies and guidelines provide the foundation needed for implementing programmes such as NAFCI.

Support at the provincial, district and local levels was equally important. When the district or clinic managers failed to support and take a lead in implementing the programme, the process floundered. The NAFCI coordinators expended a lot of energy trying to move clinics along when management was not involved. In these cases, decisions needed to be made regarding whether to continue with the clinic or not. Change management strategies were important in obtaining buy-in from staff, management and volunteers as well as for engaging the team in programme activities.

Provincial management made the initial selection of clinics, and this choice could potentially make or break the programme. District leaders sometimes wanted to start with clinics that were struggling. However, when initiating a new programme, identifying innovative clinic managers who can facilitate change is more important. The most successful clinics had a motivated clinic manager and, in the best situations, a district supervisor actively participated in implementing the process.

Collaborating with stakeholders throughout the process warranted special attention as well as building upon existing structures. For instance, some clinics had been involved in other projects using quality methodology. Therefore, it was important to build on this knowledge. In South Africa, there are multiple projects being undertaken at the same time. Communication between all parties was essential to success.

Technical support

The importance of coordinators assisting clinics to implement the standards cannot be underestimated. Simply developing and distributing standards will not meet the objectives. The NAFCI coordinators received in-depth training in the standards, quality methodology and monthly in-service training sessions to assist them to implement the programme successfully. The guidance of the coordinators provided the support and knowledge necessary to implement the standards. Coordinators need to be readily accessible to the clinics to provide this support. Therefore, identifying and training coordinators within the current system may prove more effective and sustainable. For example, district managers could incorporate this role within their current responsibilities. Strong, motivated coordinators always achieved better results.

* For example: *School health policy and implementation guidelines*, Department of Health, 2003; *Policy guidelines for youth and adolescent health*, Department of Health, 2001; *HIV/AIDS & STD strategic plan for South Africa 2000 – 2005*, Department of Health, 2005; and the *National strategy on prevention of teenage pregnancy*, Department of Health (pending).

The results of the assessments began to reveal some consistent areas for improvement across the clinics (e.g. psychosocial and physical assessment). An opportunity existed to use this information to identify the key cross-cutting areas for technical support and to establish national (or at least provincial) initiatives to address them.

Clinic team commitment

Creating buy-in with clinic staff includes emphasizing the reasons and the importance of focusing on youth. This was accomplished by sharing statistics regarding the reproductive health problems of South African youth and through the values clarification workshops. Identifying staff who were champions of youth services also helped create buy-in with the rest of the staff. In view of this experience, involving all categories of staff was deemed an important factor in successfully implementing NAFCI. Box 7 summarizes the steps taken to ensure clinic buy-in.

Box 7. Creating clinic buy-in

- **increase awareness of the youth crisis**
- **values clarification (exploring attitudes and beliefs towards adolescents)**
- **identify champions for youth services**
- **involve all categories of staff.**

The selection of the team leader has a direct effect on team effectiveness. Team leaders need to be selected on the basis of their interest in meeting the goals of the programme. They also must have authority and the respect of their peers, as well as the skills to lead meetings and manage change. In addition, the team leader needs to have the time to devote to the process.

Maintaining the integrity of the team also was a challenge. Various factors affected team function, such as staff rotating frequently within the clinics and a very high turnover of staff. Consequently, training was not a one-off event but an ongoing activity. At first, teams were unable to function when there was a change in leadership. But over time, the NAFCI coordinators assisted the teams in learning how to function. As the teams matured, members began to accept the accountability for carrying out the action plan even when a member originally assigned had been transferred, went on leave or left the post.

Capacity-building

Coordinators need training in change management, group facilitation skills, quality methodology and implementation of standards. The NAFCI coordinator's manual was developed to provide the content for training coordinators. District supervisors and the clinic quality team leader also benefit from this training, particularly as the district supervisor is responsible for the oversight of programme implementation.

The values clarification workshop (refer to *Grounds for respect: facilitating change towards adolescent-friendly services*) is vital to the implementation of adolescent-friendly services, because it involves all levels of staff working together to examine attitudes that could be barriers to providing adolescent-friendly services.

Staff training in the standards and quality methodology is also needed. *Going for gold: a clinic guide to the national adolescent friendly clinic initiative* provides the content for these training activities. Training sessions are required but, more important, coaching and mentoring of staff are essential to implement the quality methods and tools. A training needs assessment helps the team to identify the specific needs of staff in terms of providing reproductive health care based on the essential service package. What this means is, various target groups have different training needs, which need to be planned and ongoing. The trainers need expertise in the areas of quality improvement and sexual and reproductive health. These resources may be available within the district and it is valuable to investigate the resources that are available and link the clinic team to those resources.

The external assessment team also needed training prior to carrying out their role. The *External assessor training manual* provides the structure for this training programme.

Youth involvement

Young people are vital to the success of this programme. Involving them is central to all aspects of improving youth services, including collecting data, education, and promotion.

Young people need supervision and support to ensure that they can make a meaningful contribution: It was important to have at least one member of staff in the clinic who would oversee the work of youth volunteers. Peer educators needed guidance and support on the content of their programmes, and to ensure their work was manageable and aligned to their own level of maturity.

Young people need recognition and encouragement: Peer educators and youth volunteers were often left to get on with their work, which was seen as useful but outside the mainstream business of the clinic. This attitude was demotivating, resulted in a high drop-out rate, and the investment in training of young people was lost. Successful, sustainable placements provided recognition through training, T-shirts and recognition awards for good service.

Young people need structures and activities in which they can become involved. Assignments gave young people a sense that their participation was not tokenism; they could participate meaningfully, learn new skills, and the clinic benefited from their work. Some examples in NAFCI sites included representation on the quality improvement team, and participation in client satisfaction surveys, client flow analysis and adolescent health needs assessments.

Clinic staff worked hard to promote and provide new youth services. However, it was difficult to meet the demands of the routine workload and initiate these new activities as planned. For this reason, the groundBREAKERS have become excellent youth advocates and provide a needed resource for responding to the needs of youth.

Community involvement

The level of community involvement by a range of stakeholders (e.g. traditional leaders, councillors, educators and religious leaders) was an important contributing factor to the vibrancy and outcome of the process. The community also consists of the young people's parents and guardians, who can reinforce health promotion messages. In the case of NAFCI, communities provided valuable feedback relating to the needs and challenges of young people, how the clinic could be more responsive to these needs and how the clinic was perceived by the consumers.

Communities often played an active role in the quality improvement process. Some exciting and heart-warming examples of how the community contributed to the quality improvement process included volunteers organizing cleaning campaigns, constructing latrines and providing water where there was no running water. Communities also provided the ongoing support clinic staff could not provide—communities were home to the referral agencies, both formal and informal (e.g. nongovernmental organizations, community-based organizations, support groups, faith-based organizations and caring trusted adults).

Communities could also hinder progress. One clinic was involved in a dispute with the community. The NAFCI coordinator and management took a lead in working with the district management and other organizations to resolve the issue before initiating NAFCI clinic activities.

Data collection

Collecting statistics was a source of problems, as each clinic had a different method of collecting information. Some clinics collected information for the age group 10–24 years whereas the NAFCI target was 10–19 years. Operational definitions were needed for some categories. For instance, some clinics reported provision of 3000 condoms per month, and others reported 18 per month as they were counting the number of young people who were given condoms as the primary method of contraception. Obviously, the clinics were collecting data regarding condom use differently. Finding ways to obtain the desired data without increasing the workload or duplicating efforts was difficult. Most staff did not link available data (clinic log books, community profiles) with improving services for youth. Collecting data in the chill room was equally challenging. The groundBREAKERS sometimes had difficulty tabulating the weekly and monthly attendance records. Ultimately, the coordinators entered the data into a spreadsheet. However, getting the data from the clinics to a central location was difficult at times due to the lack of access to computers or fax machines. Therefore, it was important to oversee the data collection to assure accurate and complete data collection.

NAFCI promoted the measurement of clinical practice through observations of practitioners while they provided services. Direct observation can be threatening to clinicians, especially if they fear a supervisor is looking for mistakes. Therefore, moving away from the approach of critical oversight to a coaching/facilitating approach was important. All clinics needed assistance in monitoring clinical practice and incorporating this activity into their regular work. When implementing a team approach, managers needed to be trained in coaching/facilitating management. NAFCI did not focus sufficient attention on this aspect of the programme and thus some managers were not as effective in implementing the programme as they might have been.

Accreditation score

The accreditation score was based on the absolute standards (number of standards met). Some felt that calculating relative improvements (percentage of improvement) would have been more fair and representative of the amount of change that had taken place. For instance, a clinic improving from 10% to 60% may have been more significant than a clinic that improved from 70% to 80%. In future development of programmes, this issue should be revisited.

Resource limitations

Improving quality is not the same as using more resources. However, resources in developing countries are always a challenge. One of the common problems is staffing. The first approach used to address this concern was to conduct a client flow analysis to find ways to improve work flow and, thus, use of staff. Some clinics had only two or three staff members. These clinics benefited by involving the community and youth in the NAFCI team. Increasing the staff complement was not focused on since the programme did not have the resources or the mandate for this and also because the project demonstrated that the standards could be met in small clinics with few staff.

NAFCI learned at an early stage that improvement of services needed to be rooted within the primary health-care system to secure, support and sustain changes. This process involves management support, as well as transformation of broader systems, e.g. drug management and infection control policies.

The teams were challenged with finding ways of dealing with problems related to equipment and supplies. The quality improvement approach provided an avenue for resolving these issues. For instance, if the lack of resources was due to a stock-out, the team considered the causes. Was it due to poor inventory management or was there a lack of supplies at a central level? Depending on the cause, different actions were taken. For instance, one clinic had a problem with pregnancy test stock-outs, which was a central distribution problem. They talked with the district level supervisor to develop a plan to maintain adequate stock. Another clinic had problems having clean linen, most particularly for the delivery room. Laundry was being sent to a local hospital; however, when they reviewed the cost of transporting the laundry to and from the hospital as well as the delays that occurred, they determined that a washing machine at the clinic would be more efficient and cost-effective. They submitted a budget proposal based on these assumptions and now are doing laundry on site.

Another consideration related to resources is the funding sources. NAFCI benefited from funding from the government and nongovernmental organizations. Another avenue to explore is the large manufacturers, as they have a vested interest in the health of their workers. Small-scale private investors can also support clinic activities; one pilot clinic obtained support from a general store to conduct a workshop on HIV.

Losing momentum

The time it took for the clinics to reach the point when they felt ready for external assessment varied, as did the outcome of the external assessment. The prolongation of the process resulted in some clinics losing the momentum and gave rise to the need to start again with a new cycle, including the re-establishment of the quality improvement team. The standards need to be moved forward as a package rather than implementing them one at a time; otherwise the programme may become stalemated.

Sustainability

Pilot programmes risk being unsustainable. Designing and implementing the programme in collaboration with the Department of Health was critical to the potential transition from pilot to institutionalization. First, the standards were developed in line with the provincial health-care standards. In addition, the quality improvement processes and skills imparted to staff were integrated into the normal function of the clinic. The external accreditation process was centrally designed and, even though this approach works, a separate, dedicated team is difficult to maintain. New and creative accreditation models need to be explored using the resources and systems that already exist within the provinces. Measurement and evaluation was incorporated into the facilitative supervision visits of the district managers.

Conclusions

The NAFCI programme identified public health clinics as a vehicle for providing services to deal with the HIV epidemic. NAFCI is a quality improvement approach. Quality improvement focuses on client needs as well as relying on data to make improvements in the system. This approach is facilitated by management; it is not management-driven. The driving force is a team (youth–clinic staff–community) working together to achieve the goal. These quality teams are working towards responding to the needs of South African youth in order to decrease HIV, teenage pregnancy and STIs. NAFCI is not a vertical programme; it is a quality improvement approach that benefits all clients who use the services. The tools and skills taught are universal and comprehensive rather than vertical. At the same time, focusing on youth is necessary to address specific health-care needs and the looming issues of the HIV epidemic.

The standards were developed to reduce the barriers that young people encounter when seeking public health services. Concerns expressed by youth were identified and the standards were written to address these issues, such as lack of privacy and confidentiality, poor quality clinical services and rudeness of health-care providers.

The findings of the data collected to date show that the clinics can implement the standards regardless of size and location. The clinic environment is cleaner, privacy is maintained, and infection prevention measures are carried out more consistently. The clinic staff have been transformed into a team that takes responsibility for the quality of care. They have the skills to solve problems and take action, and staff attitudes in many clinics have changed dramatically towards youth.

Young people are coming to the clinic chill room to learn more about sexual and reproductive health. Their vibrancy can be felt within a NAFCI clinic. The young people in these clinics have joined hands with the clinic staff and community leaders to address the adolescent reproductive health problems within their community. More young people can be found in the clinics. In addition, outreach activities are being conducted in schools and with other youth organizations. Organizations within the community are being linked to work towards a common goal. This element of the programme is critical to the success of NAFCI and concurs with the findings of an evaluation of youth-friendly service programmes in Zambia, where the authors suggested that community acceptance of reproductive health services is an important factor of success [30].

Annex 1

A brief overview of loveLife

loveLife's strategy

loveLife's strategy is to sustain a high-profile media strategy targeted principally at 12–17-year-olds and aimed at changing sexual behaviour. An equally critical but smaller component is aimed at parents. This media strategy is supported by a variety of community interventions, all focused on ensuring that South Africans actively engage with loveLife and its messages. loveLife's strategy is three-pronged:

- build awareness by stimulating more open and better-informed communication about sex, HIV, sexuality and gender relations;
- develop the necessary public health services, institutional support and outreach programmes for young people;
- ongoing monitoring and research around loveLife to measure the impact of loveLife programmes on young people and to alter/improve programmes based on the findings of the research and monitoring.

loveLife's programmes

Print and media

- *S'camto groundBREAKERS* is a multipart television series produced by young people for young people that deals with issues of self-actualization and healthy living. It is screened on SABC 1, South Africa's largest television channel.
- *S'camtoPRINT* is a lifestyle magazine distributed fortnightly nationwide through the Sunday Times.
- *thethaNathi* is a youth newspaper distributed fortnightly through the *Star, Pretoria News, Daily News and Cape Argus*.
- The *lovefacts* pamphlet is specifically designed for teenagers, supported by Tell me more.
- *Radio* shows are broadcast weekly nationwide on 17 radio stations, including SABC African language radio stations.
- *Advertising on billboards, watertanks and taxis* promotes the brand, provokes discussion and points to the free sexual helplines.

Community outreach

- A national network of 16 *Y-Centres* provides educational, recreational and sexual health services in resource-poor communities.
- *NAFCI: The National Adolescent Youth Friendly Clinic Initiative* is a major drive to establish adolescent-friendly services in South Africa's 5000 public clinics.
- A nationwide year-long school sports programme, the *loveLife Games*, reaches about four million students.
- National youth education and outreach programmes use a six-carriage train, the *loveTrain*, and two mobile broadcast units, the *loveTours*.
- A youth development programme, *groundBREAKERS*, involves volunteers aged 18–25 who are placed in various loveLife initiatives for a year. They receive a range of skill-specific and generic training focusing on their development as young people.
- A national network of *youth facilitators* aged 12–17 operate across all initiatives. They are called *mpintshis*.
- *The loveLife Franchise* a national programme of support to community-based organizations.
- *thethajunction* is a toll-free national sexual health helpline receiving more than 30 000 calls per month. There is also a special helpline (0800 121 100) for parents seeking guidance on communicating with their children.

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World Health Organization

South Africa

Following a WHO review of initiatives demonstrating increased use of health services by adolescents, policy-makers and programme managers requested more detailed information on what was being done to improve quality, including friendliness, and scale up of service coverage. In response, WHO's Child and Adolescent Health and Development (CAH) department has supported the documentation of three outstanding initiatives in developing country settings.

This document describes an initiative for quality improvement in adolescent-friendly services implemented in public sector primary health care clinics in South Africa.

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