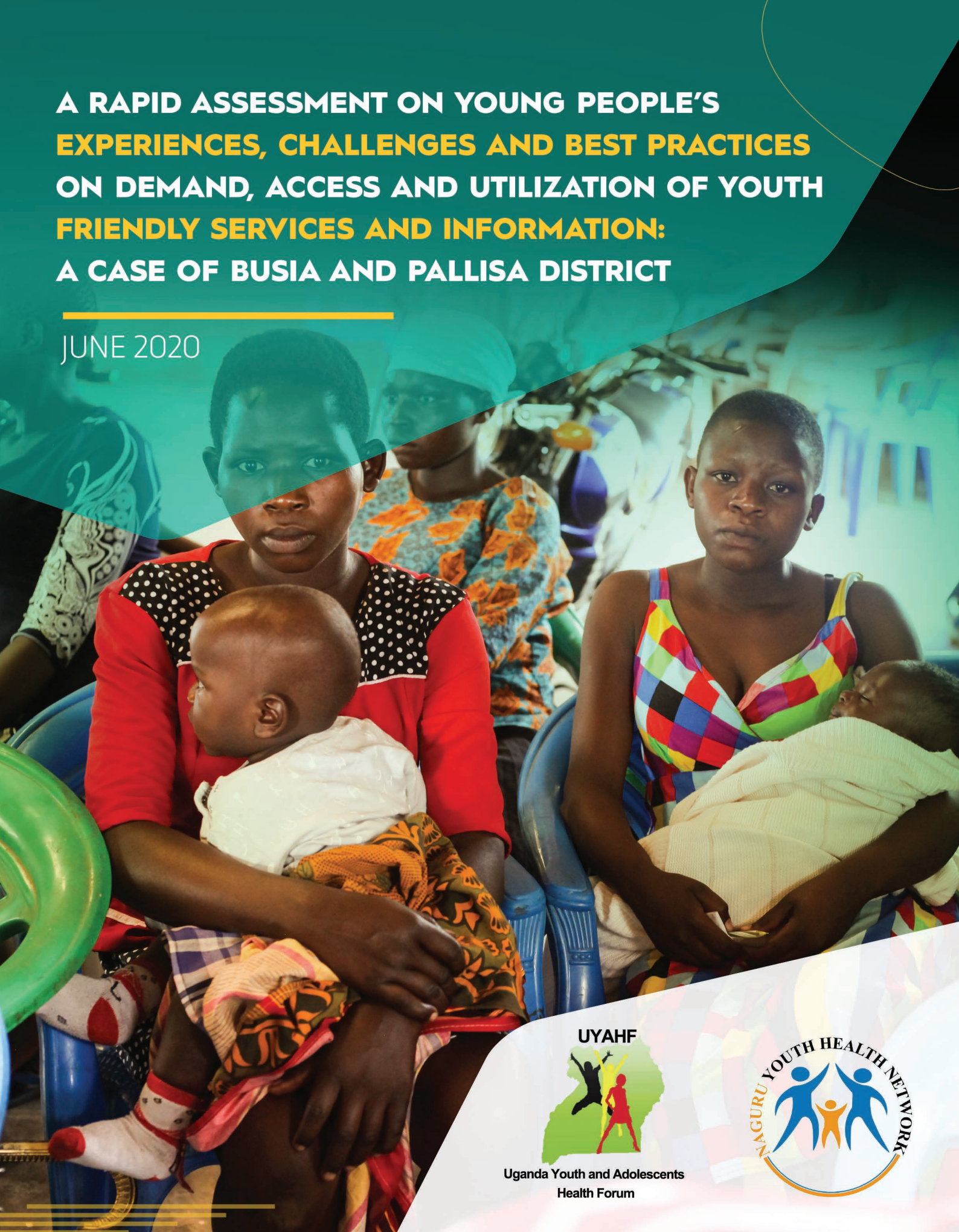
A RAPID ASSESSMENT ON YOUNG PEOPLE'S EXPERIENCES, CHALLENGES AND BEST PRACTICES ON DEMAND, ACCESS AND UTILIZATION OF YOUTH FRIENDLY SERVICES AND INFORMATION: A CASE OF BUSIA AND PALLISA DISTRICT

JUNE 2020



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Uganda Youth and Adolescents Health Forum

NAGURU YOUTH HEALTH NETWORK

Table of Contents

List of Tables

List of Figures

Acknowledgements

This work was commissioned by Uganda Youth and Adolescents Health Forum (UYAHF) and Naguru Youth Health Network (NYHN) . UYAHF and NYHN are thankful to all participants and respondents to the assessment particularly District Health Officers, Biostasticians, Healthcare providers in Busia and Pallisa District Local Governments who provided time for interviews and resourceful information to this assessment.

We thank all adolescents and young people in Busia and Pallisa district who participated in the assessment by providing time and giving their views and experiences on adolescent healthcare.

Thanks to our partners and all AFRIYAN members for the valuable inputs during the study inception and execution. We also thank Patrick Mwesigye and Winnie Apio at UYAHF and Arafat Kabugo from NHYN for coordination and management of the assessment.

The team is also very thankful to the team of independent consultants led by Mr. Senfuka Samuel and Associate Consultant Mr. Patrick Ojulong for the technical support and execution of the study.

Last but important, we appreciate the financial and technical support from the GFF CSO hub without it this work would not have been possible.

Acronyms

AFRIYAN: Africa Youth and Adolescents Network
CEmOC: Comprehensive Emergency Obstetric Care
CPRm: Modern Contraceptive Prevalence Rate
CSOs: Civil Society Organizations
DHIS2: District Health Information System 2
DHO: District Health Officer
DLGs: District Local Governments
EDHMT: Expanded District Health Management Team
FP: Family Planning
GFF: Global Financing Facility
HC: Health Centre
HIV: Human Immune Virus
HMIS: Health Management Information System
HSDP: Health Sector Development Plan
HUMCs: Health Unit Management Committees
IPs: Implementing Partners
KIIs: Key Informant Interviews
LC V: Local Council V
MoH: Ministry of Health
MoH: Ministry of Health
NYHN: Naguru Youth Health Network
PMNCAH: Partnership for Maternal, Newborn, Child and Adolescent Health
POP: Progesterone only Pill
RBF: Results Based Financing
RMNCAH: Reproductive, Maternal, Newborn, Child and Adolescent Health
SRH: Sexual and Reproductive Health
STIs: Sexually Transmitted Infections
ToRs: Terms of Reference
UNAIDS: United Nations Programme on Acquired Immune Deficiency Syndrome
URMCHIP: Uganda Reproductive, Maternal and Child Health Improvement Project
UYAHF: Uganda Youth Adolescent Health Forum
WHO: World Health Organization

Executive Summary

This study was a rapid assessment of adolescent health service provision in selected districts of Busia and Pallisa, both are currently undertaking the Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Sharpened Plan for Uganda 2016/17-2019/20 under the Results Based Financing (RBF) framework. However, Busia district has just been enrolled on the RBF in FY 2019/20 while Pallisa started rollout of RBF in FY 2018/19. Uganda currently has a youthful population with 55% under 18 years of age (UBO, 2016). Teenage pregnancy rate increased to 25% in 2016 down from 24.5% in 2011 (UDHS, 2016). This largely affects the adolescent age group of 15-19 years. As a commitment to reduce the high teenage pregnancy rate, ministry of health in its Health Sector Development Plan (HSDP) set a target to reduce it to 14% by 2020. In Busia, 28% of institutional deliveries at health facilities are adolescents between the ages of 10 -19 years while in Paliisa, adolescents account for 31% of health facility institutional deliveries1.

Adolescents aged 15-19 contribute 17.6% maternal deaths due to pregnancy related conditions (AHSR 2016) and Uganda continues to have one of Africa's highest unmet need for family planning among adolescents aged 15-19 years at 30.4% with total demand currently standing at 52.3% (UDHS, 2016). The adolescent birth rate in the teenage category (15-19) is 135 per 1000 live births, which is the highest in Sub-Saharan Africa and greatly impacts both the total fertility and population growth rates (UBOS 2011)2.

The MoH, development partners in collaboration with CSOs, have tried to shape policies and programs to reach out to adolescents albeit with limited success. There is need therefore for a coordinated pro-active and comprehensive approach that engages other ministries (education, gender, police, etc.) and active advocacy engagement to ensure current adolescent healthcare strategies suit and meet the needs of adolescent girls and boys. Uganda is currently using the Investment Case for RMNCAH Sharpened Plan as a blue print country strategy to deliver evidence-based adolescent health care. However, an analysis of the sharpened plan and its funding mechanisms depicts a low focus on adolescent health. Adolescents targeting for prioritized services under the RBF framework remains weak at the frontline level. All the assessed health facilities lacked adolescent health friendly corners or peer educators to reach out to adolescents. There was limited involvement of adolescents in the day to day provision of services and health workers at most did not see them as a group to target most.

1. Busia is just at the initial stage of initiation into RBF while Pallisa is among the initial pilot districts but already there is high exuberance among the health workforce. Analysis of the guidelines for RBF implementation shows a low scope of and focus on adolescent health services with an exception of MNCH.

2. The RBF will/has provide (d) an additional basket of funds to the health system. It is likely to raise health facility resources.

3. Health workers and district management has been trained in RBF implementation while in Pallisa a program by Naguru is conducting trainings of selected health workers on adolescent health friendly services provision.

4. Some health workers acknowledged receiving training in adolescent health care from implementing partners (IPs) in their areas although limited in number.

5. Adolescent health clinic days seem to have been adopted by most health facilities to encourage service use by adolescents but not very popularized. Many adolescents talked too seemed not to be aware of the clinic days.

6. In all health facilities – youth friendly corners were lacking but this is largely due to the limited infrastructure space at health facilities.

7. In some health facilities post abortion services are provided to adolescents. However, there is an inherent sense of fear among health workers of being taken to litigation process for any safe abortion conducted.

8. Family planning service uptake by adolescents particularly girls is increasing. However, across most health facilities cases of stock-outs of short-term methods were noted especially Depo-Provera, Seyanana, pills though the long term methods were in stock.

9. HIV services are quite strong and supported by health development partners – adolescent health HIV clinics are strong.

10. Direct engagement of adolescents in health facility planning, monitoring and evaluation or participation in service delivery using for example peer educators was weak owing to a lack of specific strategy or guidance provided to health facilities, lack planning targets specific for adolescents.

11. In terms of school health outreaches, they are not systematic and not conducted regularly unless schools request them mostly to undertake pregnancy tests; hence they are limited in service scope.

Challenges faced by adolescents and young people to access and utilize health services:

- Stock-out of medicines which increases their vulnerability especially those from poor households who are referred to clinics/drug shops to buy the prescribed medicines.

- There is also a challenge of inequity in supply which is caused by either cultural biases towards girls and young women accessing contraception as well as the misconception that men should be the decision makers in the family even when it has to do with access to health care.

- Lack of youth/adolescent friendly corners at the facilities at all the facilities assessed health facilities coupled with low responsive adolescent health service delivery approach.

- Long waiting time/delay to get services at health facilities partly due to a few health workers.
- Limited laboratory services especially to test and determine suitable family planning methods for them.
- Inadequate and poor hygiene and sanitation facilities particularly latrines at the facilities which are shared by the population at health centres.
- Weak integration of gender issues in health service and information provision.
- Lack of electricity especially in maternity wards in some health centres hence the expectant mothers are asked to buy torches to support their delivery at night.

Recommendations:

i. Adoption of specific indicators on adolescent health in the next round of RBF.

ii. Harmonization and adoption of relevant planning indicators for adolescent health in district plans.

iii. Creation of a specific and additional budget for adolescent health in district to operationalize the adolescent health plans and strategies.

iv. Improvement on data capture tools for adolescent health in health facilities.

v. Creation and improvement of space for youth friendly spaces in health facilities.

vi. Institutionalization and facilitation of peer to peer approach for adolescent health services.

vii. Roll-out of trainings in adolescent health friendly services for all health workers.

viii. Increment of stock of essential medicines and family planning commodities especially those with high demand.

ix. Integration of adolescent health in health facility Quality Improvement Committees.


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CAN DECIDE WHAT TO DO
WITH HER BODY,
WITH HER LIFE,
AND WITH HER FUTURE.
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She Decides
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1.0 Chapter One: Introduction

1.1 Background

Adolescents in Uganda are confronted with life threatening health risks related to unwanted pregnancies, HIV/AIDS and sexually transmitted infections (STIs). In Uganda today, age at first sexual intercourse is at 16 years and by age 18, more than 30% of adolescents are married (Census report, 2016). Currently, one in every four girls aged 15 -19 years is already a mother or pregnant with her first child (UDHS 2016). Uganda's teenage pregnancy rates are alarmingly high and increasing to a national average of 25% in 2016 down from 24.5% in 2011 (UDHS 2011, 2016). According to Busia and Pallisa district health performance reports for 2019, teenage pregnancy rates are estimated at 31% and 34% in Busia and Pallisa district respectively. The numbers are totally off the national target of 14% reduction set to be achieved by 2020 (HSDP 2016 - 2020). There is also variation of teenage pregnancy with educational attainment. It is higher among uneducated girls accounting for 35% compared to 17% of girls with secondary education (UDHS 2016). STI gender dimensions as well posts very troubling statistics with women aged 15-24 years who had ever had sex, 23% experienced an STI/genital discharge/sore or ulcer compared to 13% among boys (UDHS 2016). For many of these girls, pregnancy has little to do with informed choices but rather a consequence of discrimination, rights violations (including child marriage, rape, and defilement), and inadequate education, limited access to family planning and contraceptive services among others thus contributing to a high fertility rate among adolescents. In Uganda, teenage pregnancy particularly accounts for a significant proportion of maternal deaths with estimates putting it at 44% of the 7,200 annual maternal deaths occurring among teenagers and women aged 15 - 24 years. Correspondingly, 47% of the 297,000 unsafe abortions annually occur among girls aged 15 -24. This emphasizes the need to focus interventions around teenagers if the country is to reduce maternal mortality, unsafe abortions, teenage pregnancy and early marriages (DfID, 2014).

As stipulated in many human rights treaties and covenants including the International Covenant on Economic, Social, and Cultural Rights, access to safe, affordable and voluntary family planning is a fundamental human right. This sets forth the government's obligation to ensure that health care services are: available in sufficient quantity; accessible in ways that are non-discriminatory and ensure that services can be accessed physically and financially; acceptable in the sense of being respectful of the culture of individuals; and of good quality.

This rapid assessment was conducted as a follow up action point from a meeting held in January 2019 convened by UYAHF in collaboration with Ministry of Health Reproductive and Infant Health Division, and the Uganda RMNCAH+N CSO platform for 14 youth led and youth serving organizations to learn about and orient them on GFF processes in Uganda and implementation of the Uganda Reproductive Maternal and Child Health Improvement Project so that they effectively and meaningfully engage with MoH, Districts, communities, World Bank and other relevant stakeholders. As a key outcome of the meeting, young people called for support to develop a joint youth advocacy action and coordination plan for GFF and the URMCHIP that would be informed by their challenges, needs and opportunities. The joint advocacy action plan is anticipated to improve the coordination of youth led and youth serving organizations in influencing GFF processes in country through enhancing participation, transparency, accountability and making it easier to keep track of Uganda's GFF commitments and implementation of the URMCHIP project.

Furthermore, the project also builds on recommendations suggested in the 'Meaningful Adolescent and Youth Engagement in the GFF'; a paper developed by Global Health Vision in March 2019 with support from PMNCAH on Meaningful Adolescent and Youth Engagement. UYAHF as a convener of this project, worked with Naguru Youth Health Network (NYHN) and members of AFRIYAN Network and with technical support from two consultants to a rapid assessment on access, uptake, availability and quality of youth friendly services intwo GFF districts in Eastern Uganda.

1.2 Purpose of the Assessment

The purpose of the assignment was to generate information to support national and district level evidence-based advocacy towards implementation of an adolescent responsive RMNCAH Sharpened plan for Uganda through URMCHIP.

1.2.1 Objectives

The objectives of the rapid assessment were: -

i. To determine the extent adolescent health is integrated and prioritized in the URMCHIP/RBF
ii. To establish the availability, accessibility and quality of youth/adolescent friendly services at health facilities in the target districts

iii. To assess uptake of adolescent health services in the target districts
iv. To explore the challenges young people (15-24 years) face in accessing and utilizing adolescent health related services in target districts.

2.0 Chapter Two: Methodology

This chapter provides a description of the assessment design and approach, sampling method, study sites, methods and tools used in the entire process of the assessment of adolescent health related services in the two districts.

2.1 Design and Approach

This was a case study which was undertaken using a mixed research method to collect both qualitative and quantitative data. It was based on the appreciation of the ToRs provided, overview and nature of information needs for the objectives. Initial phase entailed conducting a meeting with UYAHF and its partners to harmonize on assessment objectives, assessment sites, methodology, work plan and logistics.

2.2 Study Area

Busia and Pallisa districts in eastern Uganda were purposively selected by UYAHF as case studies since the organization in collaboration with other partners were implementing a similar campaign in the region, hence the findings would guide further advocacy interventions for improving the health outcomes of adolescents and young people. In addition, both districts were categorized by the Investment Case for RMNCAH Sharpened Plan as among the highest burden districts of unmet need for Family Planning and teenage pregnancy. However, the original target districts were Busia and Tororo but Tororo was replaced by Pallisa in consultation after finding out that it was in initial stages of implementing RBF. The consultants and client agreed to take on Pallisa because it had similar characteristics like Tororo but also it was in advanced stages of RBF implementation to offer better experiences.

Interviews at national level did not take place due to a public health emergency of COVID – 19 at the time of data collection. The closure of targeted offices, restrictive measures of movement social distancing and anxiety among the population made it difficult to collect data at national level. Mainly key informants not reached are ministry of health officials and youth led and serving organizations. However, this was mitigated by accessing and reviewing available literature on important subject matters.

2.3 Respondents and Participants

At district level, the assessment targeted the District Health Officer, health facility in-charges, adolescent health care providers, health facility peer educators and adolescents/young people. Below is a summary of participants and respondents that were involved in the assessment.

Table 1: Category of respondents/participants engaged in the assessment in Busia and Pallisa district

No.	Category	Type of Engagement
1	District Health Officers	Consultative meetings
2	Health unit In-charges	Administered Questionnaire
3	Health care providers	Administered Questionnaire
4	Peer educators	N/A
5	Adolescents/young people for exit interview	Administered Questionnaire
6	Adolescents/young people in community	FGD

2.4. Data Collection Procedures

A letter permitting the assessment in the two districts was obtained from Ministry of Health headquarters prior to fieldwork. A meeting was held with each District Health Officer (DHO) in Busia and Pallisa as an entry point into the districts. The DHOs were briefed about the objectives of the assessment and requested for their support in accessing health facilities, health workers and health facility/district information and community members. The meetings were also used to map and profile health facilities in the districts and those which were implementing RBF model. For Busia, it was in early/initial stages of RBF and implementation had not yet started whereas in Pallisa the implementation was on-going. Three health centres were picked from each sampling frame in each district. A simple random method was used to select three health facilities for data collection and below is a table 2 showing the sampling frame followed by table 3 of health facilities that were selected and assessed.

Table 2: Sampling Frame for Busia and Pallisa District

District	Name of Health Centre	Level of Care	Ownership
Busia			
	Busia Municipal	HC IV	GoU
	Busitema	HC III	GoU
	Bulumbi	HC III	GoU
	Lunyo	HC III	GoU
	Buhehe	HC III	GoU
	Buteba	HC III	GoU
	Lumino	HC III	GoU
	Mbehenyi	HC III	GoU
Pallisa			
	Gogonyo	HC III	GoU
	Kamuge	HC III	GoU
	Kameke	HC III	GoU
	Agule	HC III	GoU
	Apopong	HC III	GoU
	Mpongi	HC III	GoU
	Kasodo	HC III	GoU
	Pallisa Town Council	HC III	GoU
	Kibale	HC III	GoU
	Kaboloi	HC III	GoU

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Table 3: Health facilities assessed in Busia and Pallisa district

District	Name of Health Centre	Level of Care	Ownership
Busia			
	Busia Municipal	HC IV	GoU
	Buteba	HC III	GoU
	Lunyo	HC III	GoU
Pallisa			
	Gogonyo	HC III	GoU
	Kameke	HC III	GoU
	Kamuge	HC III	GoU

3.0 Chapter Three: Key Findings and Discussions

3.1 Introduction

The assessment report provides a situational assessment of youth/adolescent friendly health services in terms of accessibility, availability, quality and uptake of services in context of Uganda's Investment Case for RMNCAH 2016/17-2019/2020 rollout through Uganda Reproductive Maternal and Child Health Improvement Project. The assessment provides an ad hoc evaluation of adolescent health policy commitments implementation as envisaged in Investment Case for RMNCAH sharpened plan and Global Financing Facility/Result Based Financing model in Busia and Pallisa districts. In addition, the challenges young people age 15-24 years face in accessing and utilizing adolescent sexual reproductive health services in the districts.

3.2 Integration and Prioritization of Adolescent Health in the URMCHIP/RBF

3.2.1 The Investment Case for RMNCAH Sharpened Plan 2016-2020; adolescent health prioritization analysis

The RMNCAH Sharpened Plan was premised partly on the slow progress on RMNCAH performance indicators including persistent high maternal mortality rate, teenage pregnancy, neonatal mortality, Low CPRm, Low coverage of CEmOC especially at HC IVs. The URMCHIP was designed to operationalize Uganda's Investment Case for RMNCAH Sharpened Plan 2016/17 -2019/20. The Uganda RMNCAH sharpened plan Investment case 2016 to 2020 provides a country a blue print to improve RMNCAH targeted indicators with low coverage. The operationalizes what is termed as evidence-based technical interventions across the continuum of care and the target is to ensure effective universal coverage for mothers, adolescents, and children under the RMNCAH framework. The bottleneck analysis significantly noted that adolescents faced a relatively high burden of disease (more than 33% of the disease burden). Almost 28% of maternal deaths in Uganda are attributed to young girls aged 15–24 years and 60% of premature deaths among adults are associated with behaviors or conditions that began or occurred during adolescence.

The plan therefore introduced five strategic shifts for RMNCAH

i. Emphasizing evidence-based high-impact solutions;

ii. Increasing access for high-burden populations;

iii. Geographical focusing/sequencing;

iv. Addressing the broader context- education, empowerment, economy and environment within a multi-sectoral approach, with a particular focus on adolescents; and

v. Strengthening mutual accountability for ending preventable deaths.

3.2.2 Adolescent health related targets for national and sub-national levels in the RMNCAH Sharpened plan and URMCHIP

Box 1: Key adolescent health targets and commitments in RMNCAH Sharpened plan:

- Reducing teenage pregnancy rate from 24% to less than 14% by 2020 through building mechanisms for adolescent friendly health services being implemented in 100% of the districts.

- Increasing modern contraception use among women and girls of reproductive age encouraged. Specifically, the commitment is to increase uptake of modern contraception to 50% and reduce the unmet need to 10% by increasing access to family planning information, targeting youth, adolescents and addressing the social and cultural misconceptions about contraception. In the FP 2022 action priorities, Government of Uganda specifically committed to reduce the unmet need for FP amongst adolescents from 30.4% in 2016 to 25% by 2020.

- Ensuring post abortion care, adolescents leave the facilities with a contraceptive method.

3.0.1 Adolescent health prioritized interventions/packages under URMCHIP/GFF/RBF

Table 6: Packages and interventions for adolescent health under URMCHIP

3.0.2 Key proposed strategies in Investment Case for RMNCAH Sharpened Plan 2016- 2020 to effectively reach out to adolescents

Provision of appealing and actionable data/information on adolescent health	Expanding knowledge base of implementing partners, health-care providers, teachers, religious, community leaders and parents on adolescent problems using formal targeted trainings and information sessions. Refine collection of adolescent health data to measure adolescent health outcomes at the community level and act as a tool for propelling adolescent participation to enable young people to understand better the determinants of their health, and consequently feed into their communities and into service provision while also empowering adolescents and youth leaders with information and skills to be able to participate in relevant policy dialogue, service delivery and all forms of meaningful contribution. Ensure and allow for meaningful and effective youth participation and engagement through creation and facilitation of platforms like the adolescent health working group and working with youth networks and coalitions especially with the vulnerable groups like adolescents living with HIV, Adolescents with disabilities and very young adolescents especially girls.
School-based or school-linked health facilities promoted and implemented as adolescent health sites	The sites provide confidential care to adolescents, including health education, screening, acute care and mental health services, and preventive sexual healthcare. Support efforts to keep girls in school and tackle risky behaviors among adolescents. Provision of adolescent package of health services to address pregnancy timing and child birth, increasing incidence of HIV, other sexually transmitted infections, malnutrition (under-nutrition and obesity), alcohol and substance abuse, mental and psychological well-being management of communicable and non- communicable diseases, physical activity and immunizations (Human Papilloma Virus and Tetanus Toxoid). Working with schoolteachers offers opportunity to integrate sexuality and life skills education as well as offering adolescent health services.

	Adolescent's participation in managing and implementing adolescent health sites will catalyze peer-to-peer education and support.
Establish pipeline for rapid scale up on effective local context innovations	Mostly small-scale projects have produced the body of knowledge about how best to tackle adolescent health issue programs function. However, these have not been adopted and rolled-out for implementation universally within the health system.

3.0.3 The Uganda Reproductive, Maternal and Child Health Improvement Project3 and adolescent health integration

The URMCHIP was designed to operationalize Uganda's Investment Case for RMNCAH Sharpened Plan 2016/17 -2019/20. Implementation of URMCHIP started in May 2017 with the government of Uganda driving the process using an existing health sector structure and coordination mechanism, in close collaboration with funders. URMCHIP-RBF is co-funded by the International Development Association of the World Bank (IDA), Global Financing Facility Trust Fund (GFF) and the Swedish International Development Agency (SIDA) with a total funding of USD 165 million for the period 2016/17 -2019/20.

3.0.4 Roll-out of Result Based Financing in Busia and Pallisa districts

The National RBF Framework has fairly taken off in Pallisa district being enrolled in FY 2018/2019 and is just being introduced (FY 2019/2020) in Busia district by the time of this assessment with trainings of the district leaders and health workers being undertaken during this assessment. The RBF component aims to incentivize the District Health Teams (DHTs) and HC IIIs and IVs to expand the provision of quality and cost-effective RMNCAH services. As part of RBF, the project incentivizes health centres to support the VHTs in their catchment areas to promote community- based RMNCAH services. Health centres implementing RBF model are rewarded for performance based on the obtained score of prioritized quantity and quality indicators derived from the core package of services. The package comprises RMNCAH interventions at health facilities and the community level: (i) ANC; (ii) safe delivery; (iii) comprehensive emergency obstetric care; (iv) essential newborn and postnatal care services; (v) post-abortion care; (vi) family planning; and (vii) community-based RMNCAH services including nutrition, prevention and treatment of common childhood diseases and provision of adolescent health services. Health facilities may use the RBF incentive payments to cover basic operational costs, including staff incentives, maintenance and minor repairs, medicines and consumables, outreach activities, and the VHT program based on the guidelines issued by the MoH.

Table 9: Performance Improvement Grants of sampled Health Centres in Pallisa District

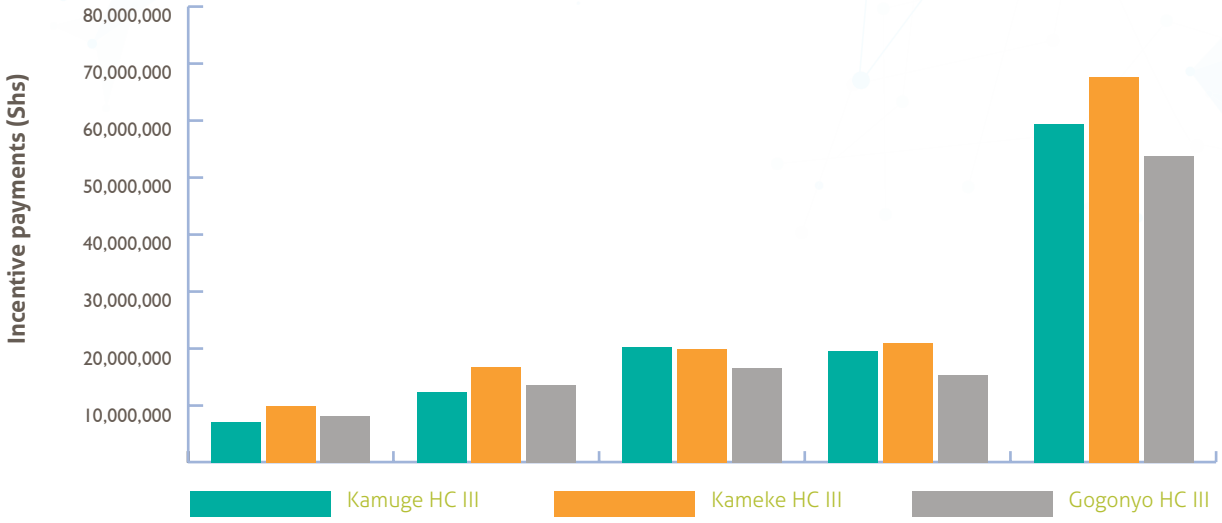
Name of Health Facility	Level of Care	Ownership	Startup Grants (Shs)
Kamuge	HC III	GoU	7,977,250
Kameke	HC III	GoU	12,393,938
Gogonyo	HC III	GoU	9,862,320
Total			**30,233,508**

Source: Pallisa District Local Government Health Department Statistics FY 2018/2019 and 2019/2020

Table 9 above indicates the three health centres which were assessed received a total of thirty million two hundred and thirty three thousand five hundred and three shillings as Startup grants in FY 2018/2019. Kameke HC III received the highest Startup of shs. 12,393,938 while Kamuge HC III received the least. The Startup grant per facility depends on performance of each health centre during the initial health facility assessment by RBF Unit as a criterion to qualify for implementation of RBF.

The Startup grants are meant to address key gaps identified during health facility assessments such as essential medicines, supplies and equipment, minor repairs to improve health service performance.

Figure 1: RBF Incentive Payments for Selected HCs in Pallisa District for FY 2018/19 and 2019/20



	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Total
Kamuge HC III	7,094,400	12,387,750	20,319,000	19,613,750	59,414,900
Kameke HC III	9,890,460	16,794,000	19,962,480	20,998,750	67,645,690
Gogonyo HC III	8,139,240	13,636,800	16,502,270	15,389,760	53,668,070

Kameke HC III's performance exceeded Kamuge and Gogonyo HC IIIs with a total incentive payment of shs. 67,64,569 in the four quarters of implementing RBF. It also shows its continuous increase in performance throughout the quarters unlike the other two facilities which registered back and forth performance over the same period of time. It should be note that these funds are paid alongside the disbursements of the quarterly unconditional PHC grants from central government; hence it is an additional source of revenue determined by the facility's performance on the agreed upon RMNCAH indictors. On the other hand, health facilities are empowered to utilize and reinvest the incentive payments received per quarter with the approval of their respective Health Unit Management Committees. The expenditures are made under set guidelines provided by ministry of health headquarters. These include among others procurement guidelines, guidelines for minor repairs and renovations athealth facilities. Below is a sample of utilization of incentive payments by Gogonyo HC III for the 4th quarter of 2018/2019 equivalent to thirteen million six hundred thirty six thousand eight hundred shillings (13, 636,800).

Table 10: Sample expenditure of incentive payment at Gogonyo HC III, Pallisa District

No.	Item	Amount (Shs)	% Share
1	Payment of staff incentives	5,200,000	38%
2	Facilitation of Health Unit Management Committee meetings	280,000	2%
3	Refreshments for general staff and departmental meetings	245,000	2%
4	Procurement of medicines and equipment	3,500,000	26%
5	Facilitation for departmental CME	55,000	0.4%
6	Photocopying of HMIS forms for data capture	345,000	3%
7	Improvement of data reporting through data validation	120,000	1%
8	Fuel for the mower to maintain facility compound	120,000	1%
9	Fuel for health facility motorcycle	100,000	1%
10	Facilitation for dialogue meeting	300,000	2%
11	Replacement of a door at the facility	500,000	4%
12	Facilitation to the bank, meetings and general monitoring and supervision	1,000,000	7%
13	Conducting integrated outreaches	1,628,000	12%
14	Facilitation for Village Health Teams(VHTs)	120,000	1%
15	Bank expenses	123,800	1%
	Total	**13,636,800**	**100%**

Source: Extracted from Health Facility reports and work plan

A review of the expenditure in the table above showed that the biggest portion of RBF revenue for the quarter was spent on staff motivation with a share of 38%. The health facility spent 26% of the incentive payment on procurement of medicines and equipment to improve the facility performance whereas 12% was used for outreach activities. The least spent on activity was continuous medical education at 0.4% of the revenue received in the quarter. It should be noted that the revenue spent on these activities and consumables is an addition to the conventional PHC and capital development grants received by the health facilities from the central government.

3.0.5 Key observed gaps within the RMNCAH Sharpened Plan and URMCHIP

- Although the RMNCAH sharpened plan investment case articulates the key strategies for improving adolescent health, the URMCHIP that operationalizes the RMNCAH sharpened plan conspicuously omits a component of adolescent health in its title and largely prioritizes maternal, newborn and child health related services.
- Across the districts reached for this assessment, there is evident lack of deliberate planning targets for adolescent health specifically compared to other RMNCAH related indicators.
- Adolescent health is still considered a multi-sectoral issue and as such there is evident lack of well distinct roles of different stakeholders neither are RMNCAH assemblies as a means to achieve mutual accountability by all stakeholders but also improve coordinated response as envisaged in the Investment Case for RMNCAH Sharpened Plan 2016-2020 happening in districts.

- The lack of adolescent health related platforms at local government levels compared to national level makes adolescents health a least considered priority in most local governments

- A review of the URMCHIP implementation manual reveals that though Post Abortion Care services are elaborated in the project appraisal document as one of the key service to be incentivized, the current outputs being incentivized omits post abortion care services. The focus on EmOC under RBF/GFF is specifically on childbirth complications.

- There is still animosity towards making family planning services especially modern contraceptives accessible to adolescents and young people especially below age 18. Experiences of health workers who conduct school health outreaches interviewed during this rapid assessment recounted that most school administrators discouraged health workers from talking about topics related to contraceptives in their schools in preference for abstinence messages. So most of the school health outreaches are targeting pregnancy tests, HPV vaccination, menstrual hygiene management for girls, health education on menstrual hygiene management, HIV and AIDS.

- Adolescent health involvement in service delivery, planning, monitoring is not well articulated in the plan and how that mechanism can be facilitated within the district health system. Though CSOs have attempted to build capacity and facilitate some engagements, they are often not sustainable because they are project tagged.

- Data on adolescent health is very scanty in HIMS tools in health facilities and such makes it difficult to measure progress being made on adolescent health in districts. The main data collection and reporting tool is the Health Management Information Services (HIMS); Form 105 which has some parameters on STIs and HIV, family planning, maternal health services especially ANC and deliveries, health talks. Stakeholders including health workers feel that it does not comprehensively capture specific and disaggregated adolescent health data. Largely, districts use maternity registers to estimate progress being made on teenage pregnancies. In both districts teenage pregnancies are estimated from a proportion of adolescents who deliver from health facilities which could omit numbers out there in the community who deliver outside the formal health system.

- Another proposed activity is to facilitate a space at the health facility where young people can gather, have access to adolescent health information and where youth groups can share evidence informed peer-to-peer information on adolescent sexual health. However, minimal efforts have been implemented to ensure availability of adolescent health corners in public health facilities. Some that run adolescent health clinic days often attract few adolescents for such specific days. Peer Educators system has not yet been institutionalized in most health facilities.

3.1 Availability, Accessibility and Quality of Youth/adolescent Friendly Services at Health Facilities

The World Health Organization Report "Health for the world's adolescents: a second chance in the second decade" suggests that to make progress toward universal health coverage, ministries of health and the health sector more generally will need to transform how health systems respond to the health needs of adolescents.

The World Health Organization global health standards for adolescents4, national adolescent health policy (MoH, 2004), the national adolescent health policy guidelines and service standards (MoH, 2012) were used to design the assessment framework for adolescent health in the two districts of Busia and Pallisa.

The findings are organised along the themes/standards which reinforce availability, accessibility and quality of care of adolescent health services: These standards are globally recommended by World Health Organization under the Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health care services for adolescents and also contextualized by Uganda in its adolescent sexual reproductive health policy guidance documents. These include:

i. Providers' characteristics/competences
ii. Facility characteristics and appropriate package of services
iii. Adolescents' health literacy and participation
iv. Data and quality improvement
v. Community support

3.1.1 Providers' Characteristics

In order to provide quality adolescent friendly health services, healthcare providers should have high level competencies, well equipped and provide services in an equitable and non-discriminatory manner. The assessment looked at key areas in connection to the providers of the services as represented in the figures and tables that follow under.

Figure 2: Training In-charges on Adolescent Health

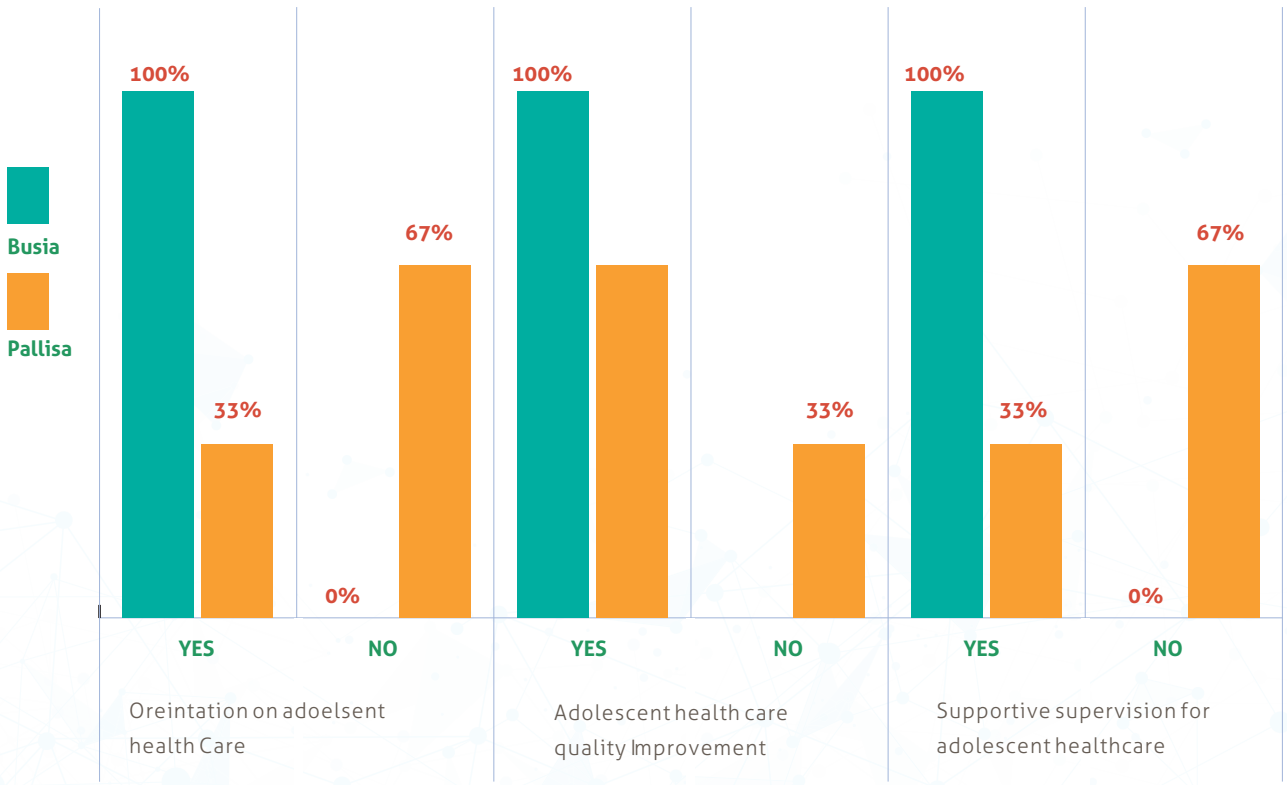


Figure 3: Components covered during the training on adolescent healthcare

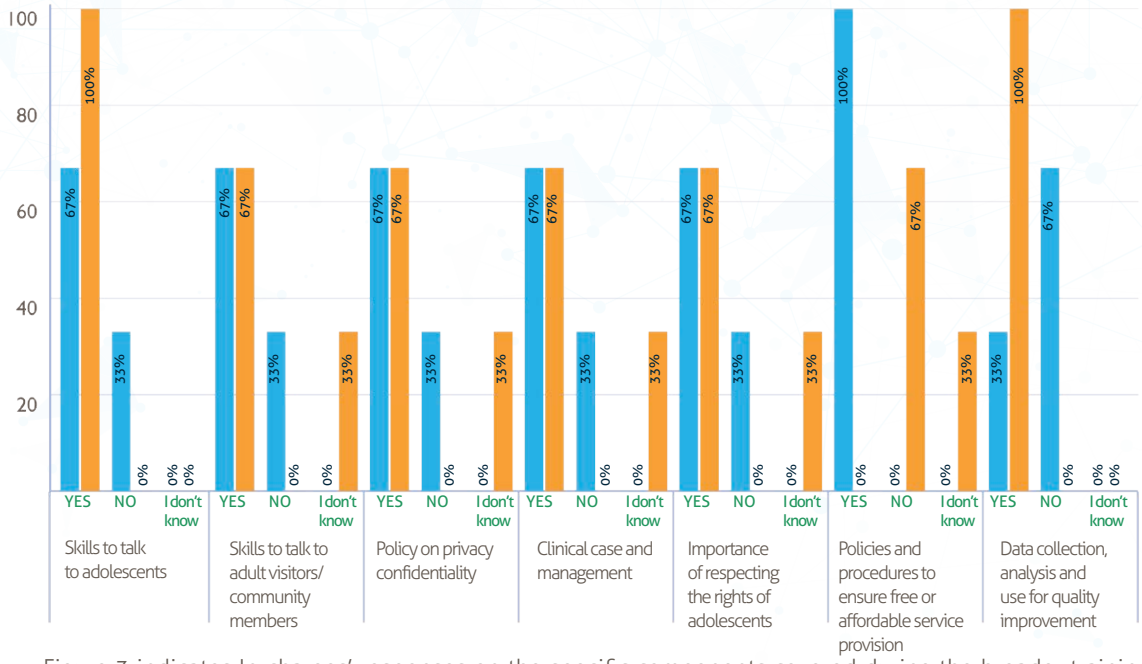
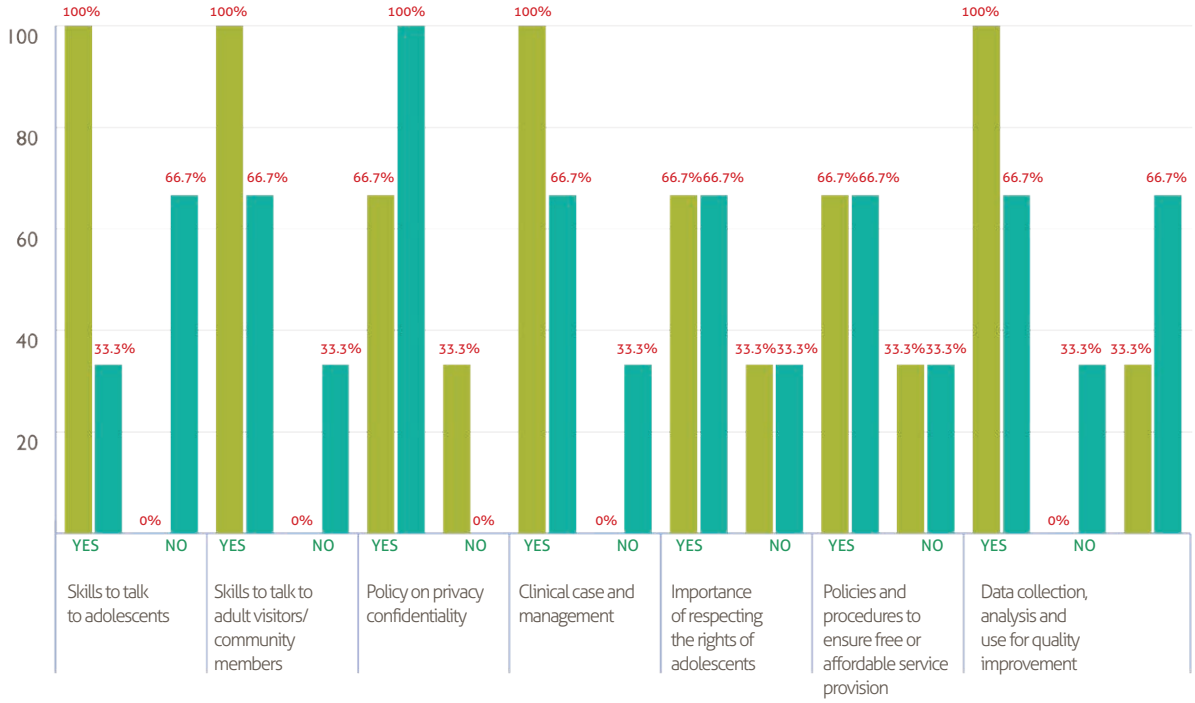


Figure 3 indicates In-charges' responses on the specific components covered during the broader training in adolescent healthcare. All In-charges in Pallisa said to have been trained in skills to talk to adolescents and data collection, analysis and use for quality improvement while those of Busia also reported to have covered a component on policies and procedures to ensure free service provision. The rest of the components including clinical case management, respecting the rights of adolescents to information and health care, policy on privacy and confidentiality, Communication skills to talk to adult were covered by some In-charges across the two districts while others did not cover them.

Figure 4: Training of healthcare providers in Pallisa District Busia District



Healthcare providers who were mainly midwives/nurses had received varying training in adolescent healthcare. In Pallisa District all received training on skills to communicate to adolescents and adults or community members, Clinical case management of adolescent clients, data collection, analysis and use for quality improvement. In Busia all those interviewed received training on privacy and confidentiality of clients.

Figure 5: Availability of a budget to ensure provision of selected adolescent health support

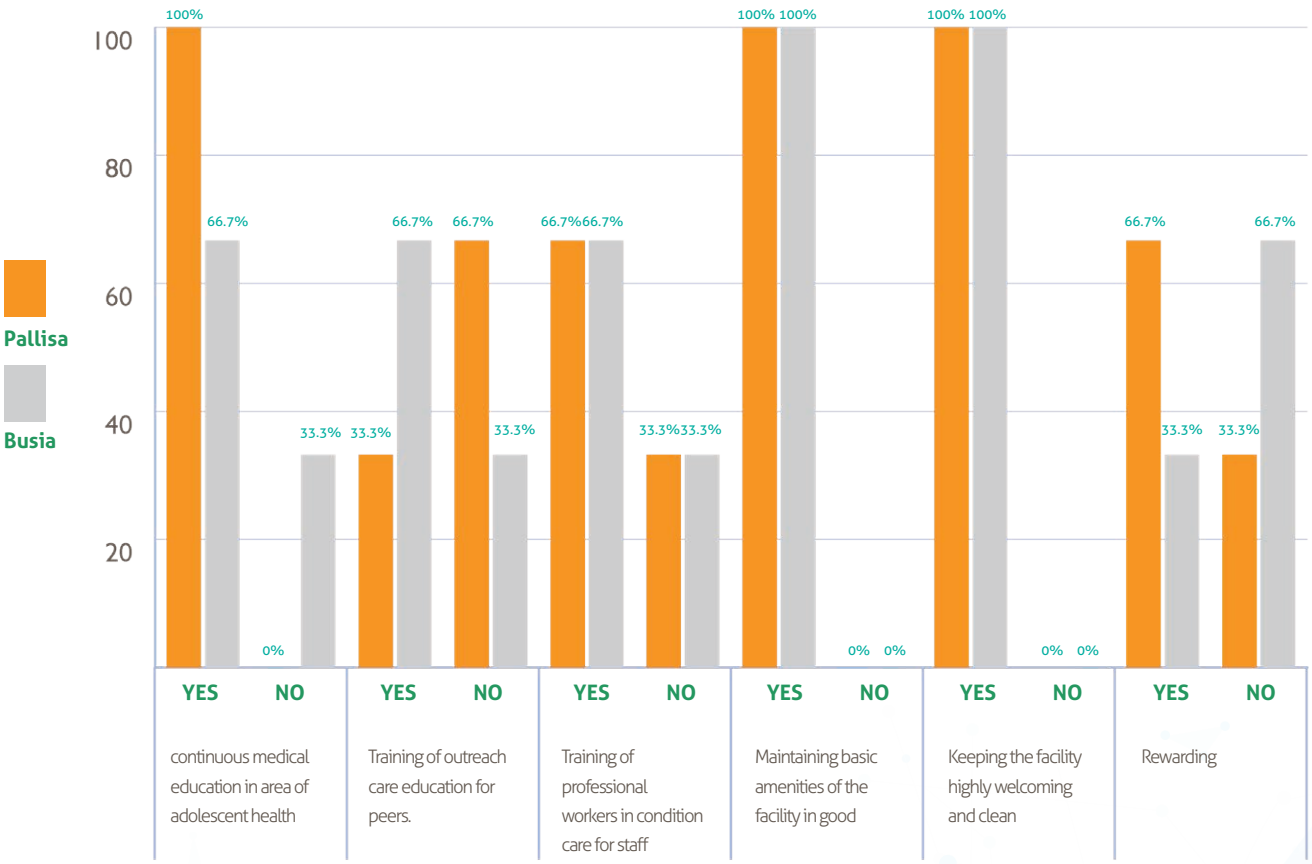


Figure 5 above shows that all the assessed facilities reported to have a budget to mainatain basic amenities of the facility and keeping the facilities welccoming. This is largely through PHC grants. Some facilities reported not have funds to train adolescent peer educators, continuous medical education in area of adolescent health, and motivating high permoning health workers. RBF incentives can be a potential source for meeting some of these activity costs in case the activities are aimed at improving service delivery and quality of care.

Figure 6: Availability of guidelines/Standard Operating Procedures at the health centre

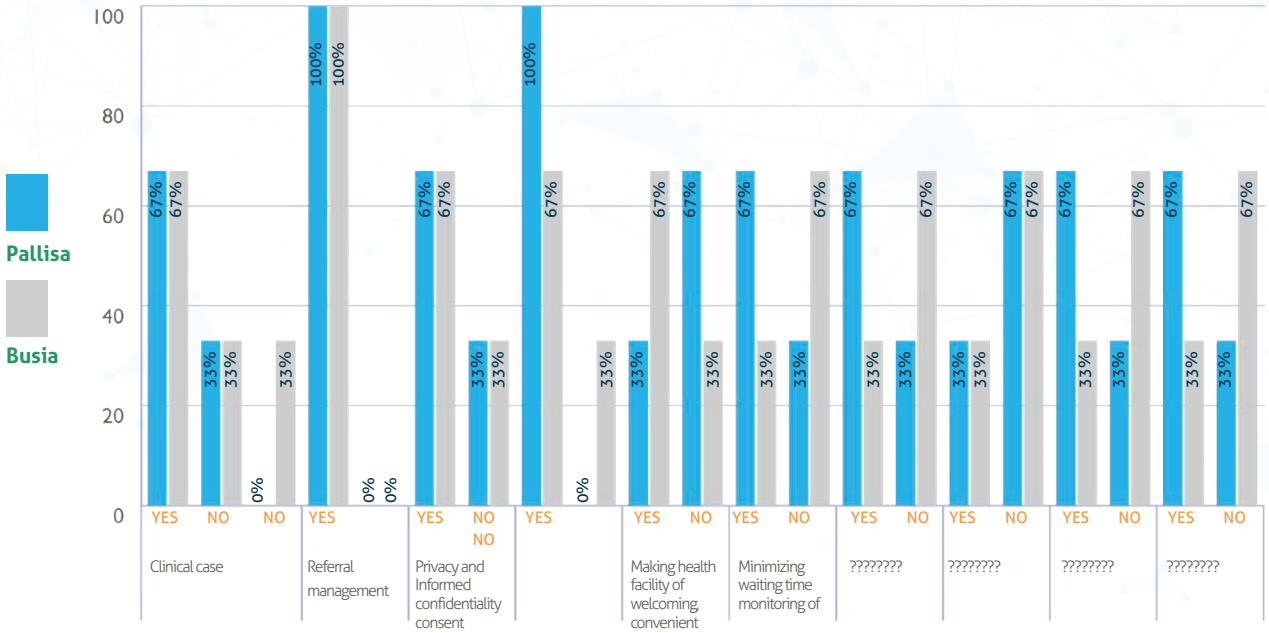


Figure 6 reveals that most key policy documents to guide In-charges and healthcare providers in the provision of adolescent health services were not available at health centres. Out of the 10 key selected policy documents, only two were reported by all In-charges to have it at the health centre i.e. referral and informed consent guidelines. In-charges in some facilities reported not having these policy documents at their respective facilities. This could be an issue of poor dissemination of information from ministry of health headquarters to districts and from districts to end users at health centres. It could also be sheer lack of self-drive by health centre managers to get the policy documents.

Figure 7: Healthcare Providers' awareness about the selected guidelines/standard operating procedures

Healthcare providers in both districts were all fully aware of the referral guidelines and this aligns to the fact that all In-charges in earlier figure 6 reported that referral guidelines are available at the health centres. In addition, healthcare providers in Pallisa District were also aware about guidelines on informed consent by mentioning at least three measures to protect the privacy and confidentiality of adolescents. They were also aware about guidelines for services provided in the facility and in the community. The absence of key policy documents related to adolescent healthcare at health centres could be one of the reasons why some healthcare providers are not aware about them.

Figure 8: Use of guidelines for information, counseling and clinical management by

All healthcare providers from Busia District who responded to the assessment indicated to be using guidelines or decision support tools such as job aids for information, counseling and clinical management of HIV; STIs; ANC/delivery/PNC; post abortion care; family planning; menstrual hygiene; immunization; nutrition; skin problems; injuries; and common health conditions like fatigue, diarrhoea, headache. However, for Pallisa, few of the healthcare providers reported to be using the guidelines as presented in figure 7 above.

Figure 9: Taking of routine psychosocial history of adolescent client during consultation/service provision

Figure 9 above, shows that all healthcare providers who responded to the assessment in Busia District routinely take psychosocial history of adolescent clients when they go for consultations. A few in Pallisa District do not routinely take all psychosocial history of their clients. Taking psychosocial history helps to understand better the problem presented by an adolescent but also it has a potential to build an interpersonal relationship between the provider and client.

Figure 10: Expected practice from healthcare provider during interaction with

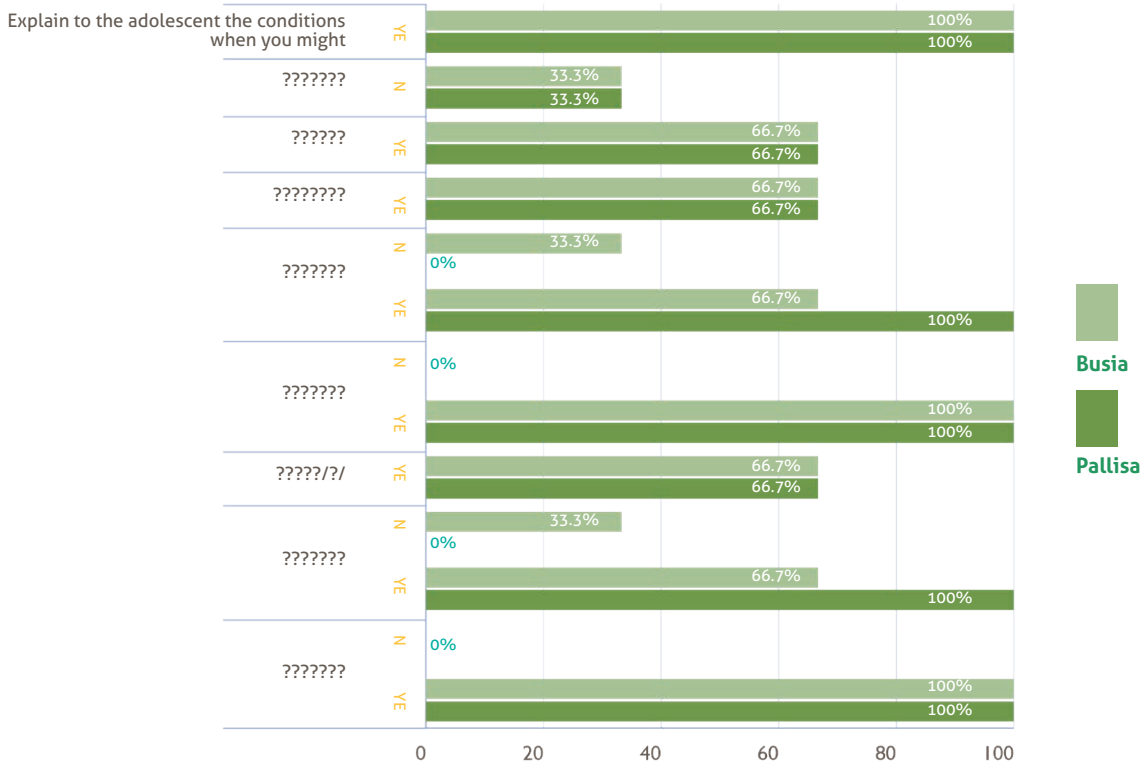
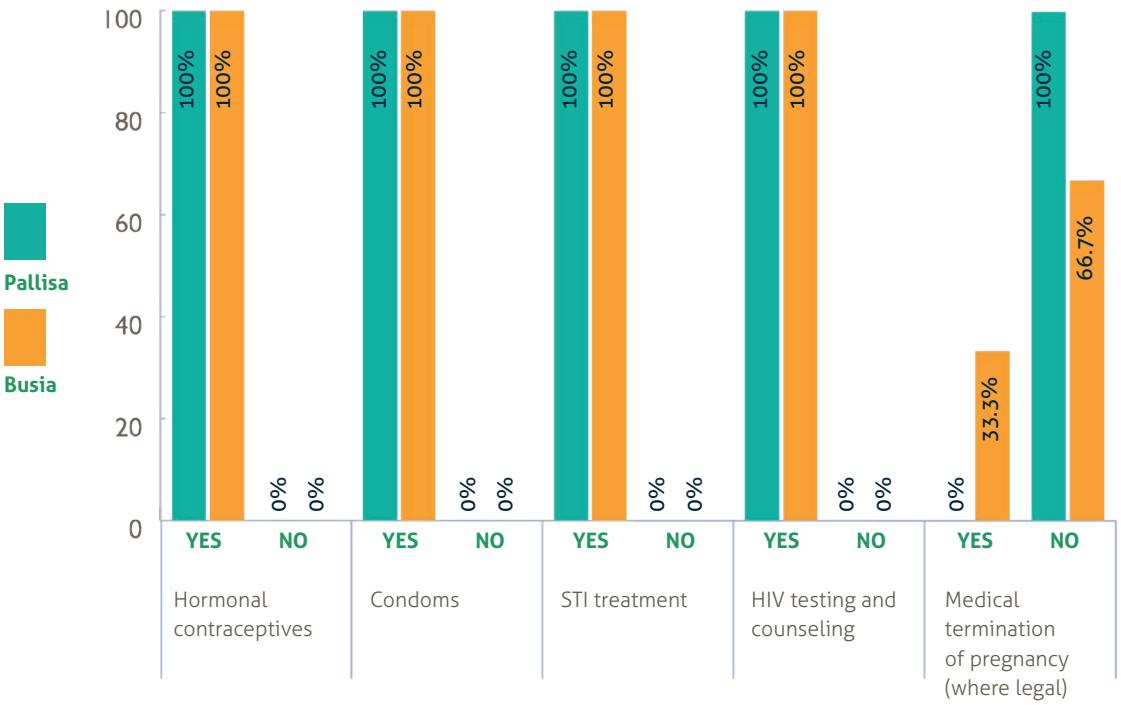


Figure 10 demonstrates that some healthcare providers do not practice basic procedures when interfacing with the adolescent clients. For example not obtaining assent from a young adolescent and consent from his/her parent/guardian for a service or procedure, not ensuring privacy and confidentiality. This relates to absence of policy guidelines and low awareness of healthcare providers about key policy guidelines relating to adolescent healthcare provision state in earlier figures.

Figure 11: Whether a healthcare provider would provide the selected services to an adolescent client



Healthcare providers in both districts were positive about providing the selected services to all adolescents regardless of sex, age and marital status. However, some healthcare providers were not ready to medical termination of pregnancy where it is legally allowed. This could be understandable due to Ugandan's restrictive legal framework for pregnancy termination and the societal morals attached to the service.

Table 11: Demonstration of client centred care by healthcare provider to adolescents

Service	Pallisa District (n=3)	Busia District (n=2)
Health workers were respectful	100%	100%
Non-judgmental health workers	100%	100%
Rights were explained	100%	0%
Asked for consent before treatment	67%	50%
Friendly healthcare providers	100%	100%
Healthcare provider was respectful	100%	100%
Involved in decisions regarding your healthcare	33%	50%
Information shared will not be disclosed	100%	50%

Respect, equity, non-discrimination and nonjudgmental are key aspects of a provider of adolescent health services. Table 11 above indicates that adolescent clients in both districts felt that other health workers and healthcare providers were respectful, friendly and non-judgmental. However, none was asked for his/her consent for the service given and adolescents not involved in decisions for their healthcare.

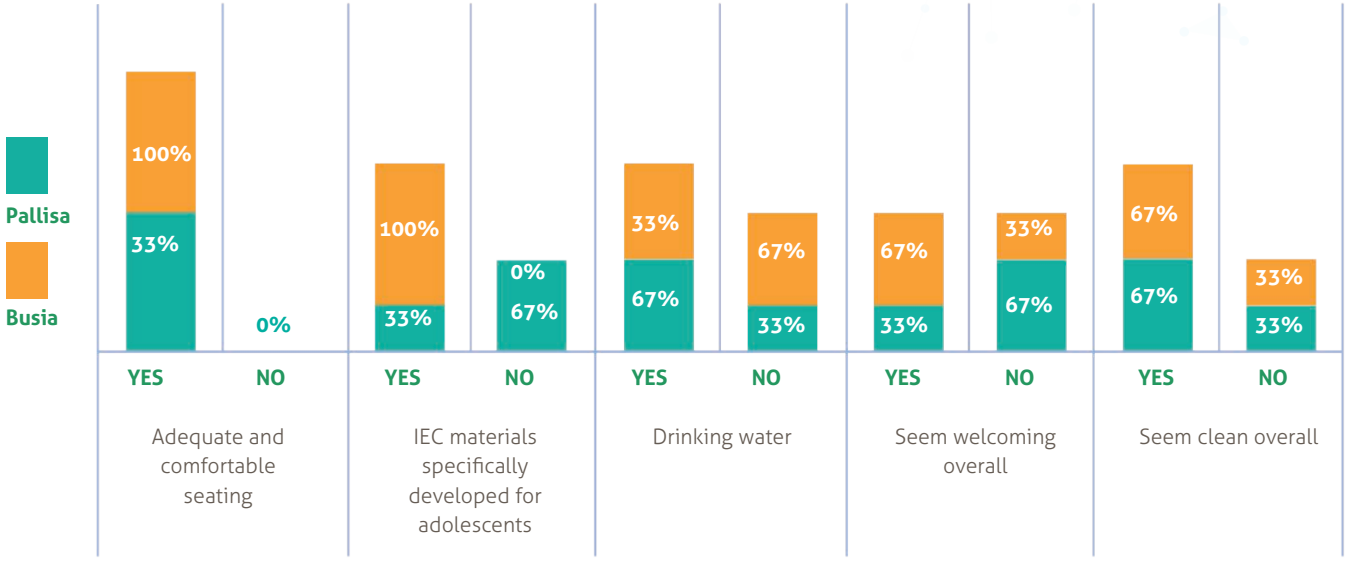
3.1.2 Facility Characteristics and Appropriate Package of Services

Table 12: Availability of a sign post with working hours of the facility

Service	Pallisa District (n=3)	Busia District (n=3)
A signboard that mentions the facility operating hours	100%	67%
A signboard clearly visible	67%	67%
A signboard mentions hours for adolescent health clinics	0%	67%

All health centres assessed in Pallisa had a sign post with the general facility operating hours and 67% of those sign posts were visible to clients though all of them did not mention specific working hours for adolescent health clinics. In Busia only 2 out of the 3 assessed facilities had a sign post with genera facility working hours and specific hours for adolescent services.

Figure 12: Characteristics of the waiting area at the



The waiting area at all health centres in the two districts had adequate seats, however other characteristics of the waiting areas were missing in some facilities such as drinking water, IEC materials for adolescents, some were not very clean and welcoming.

Figure 13: Availability of basic amenities/furniture and infection control measures

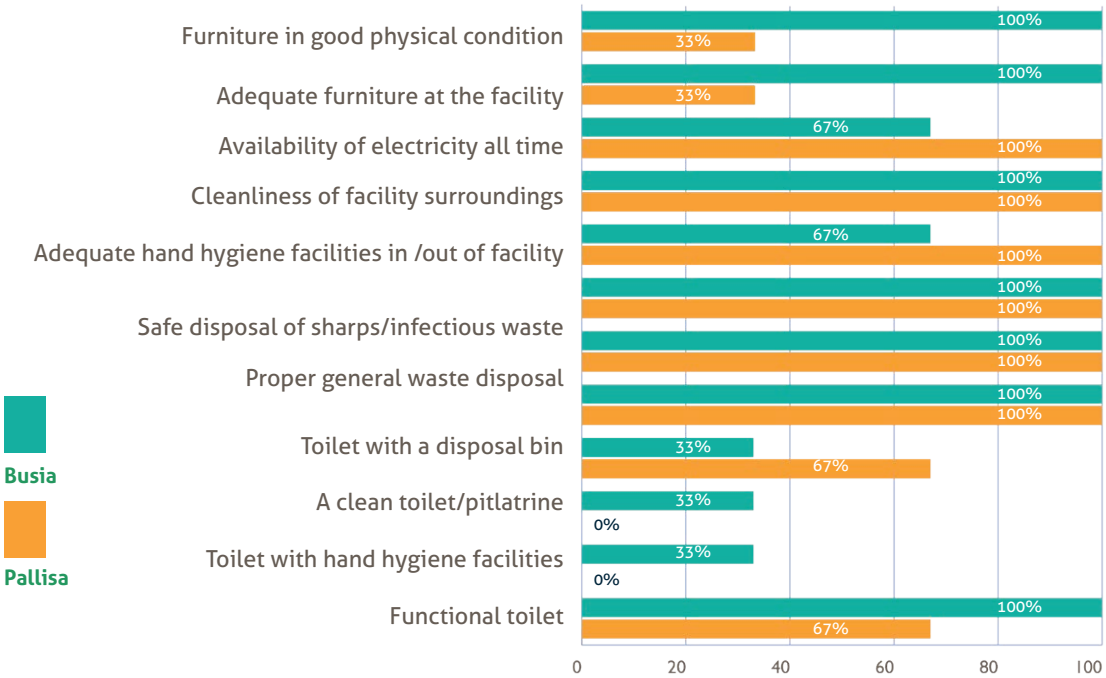
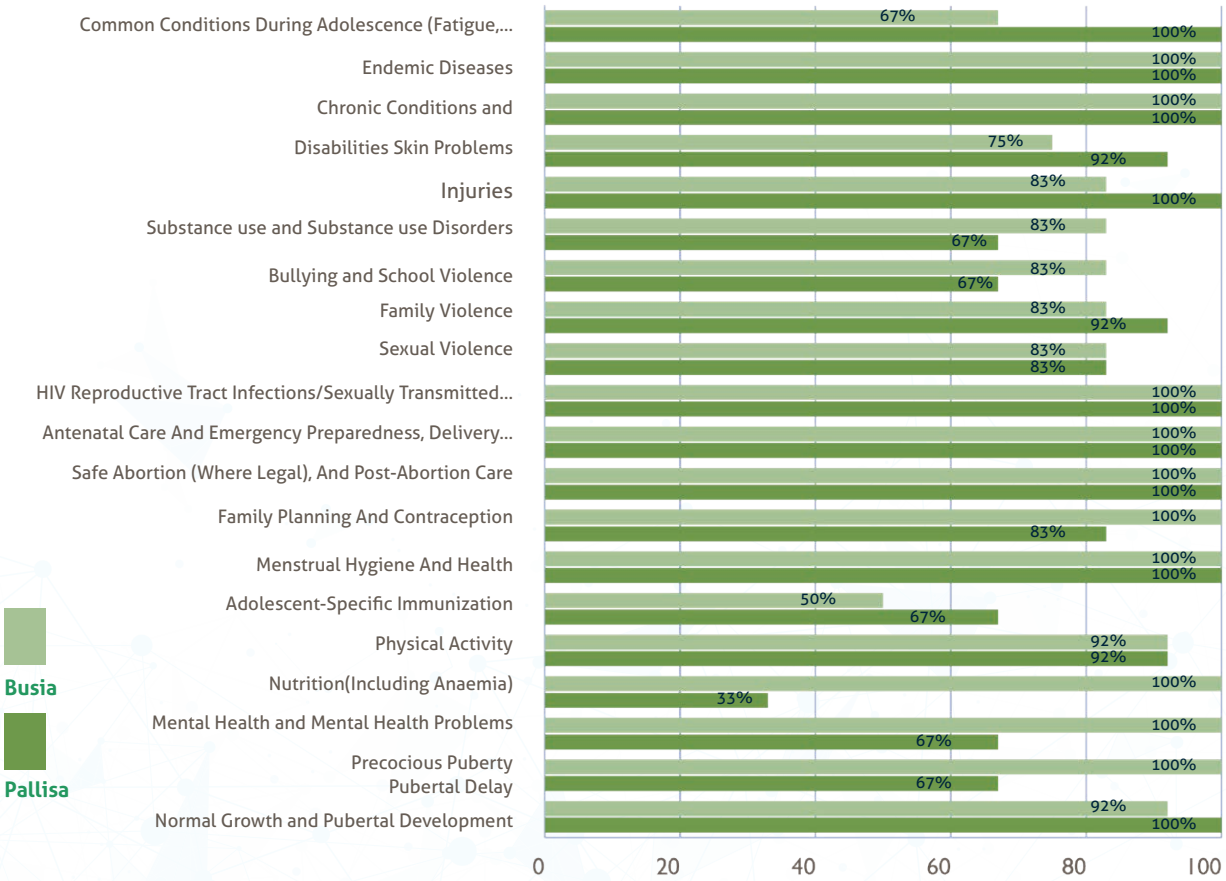


Figure 13 shows that health centres in Busia District relatively had more availability of basic amenities, furniture but with a shortfall in sanitary facilities. Pallisa lacked adequate furniture and inadequacies in toilet/latrine facilities.

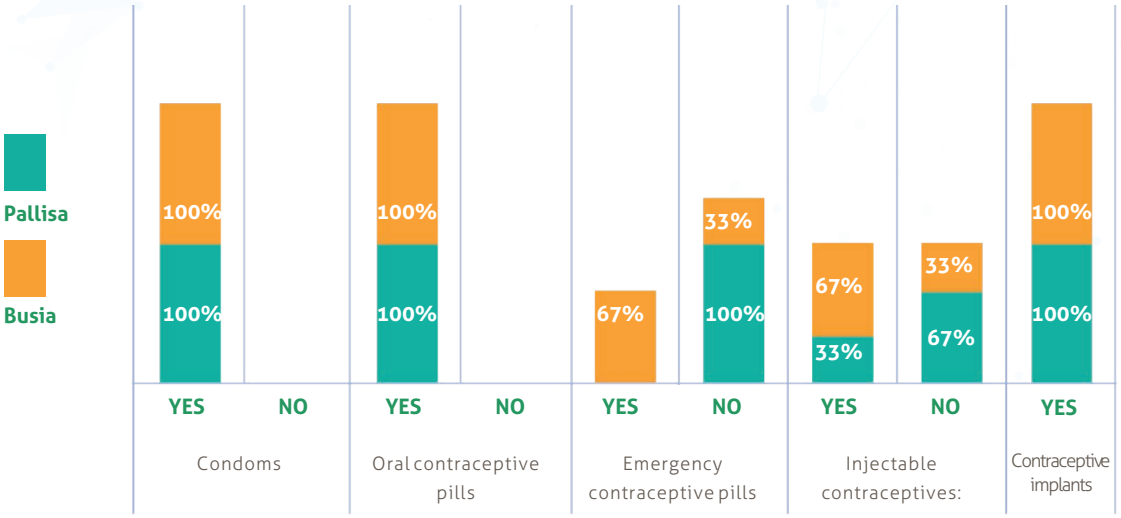
Figure 14: Availability of adolescent health services and information at sampled health facilities



Busia and Pallisa District provide a range of adolescent health services according to responses by healthcare providers. A number of health conditions are attended to in terms of case management, counseling and provision of information. All healthcare providers who participated in the assessment in both districts reported to be providing adolescent sexual and reproductive health services such as STIs, HIV, ANC, delivery, PNC, family planning, adolescent specific immunization.

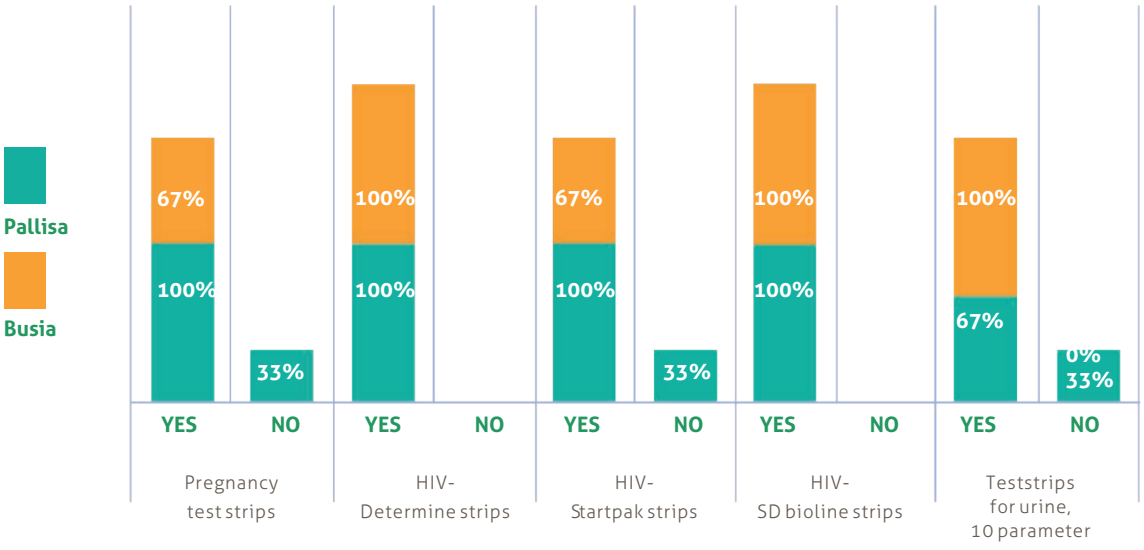
They also reported to provide services and information for other health conditions or needs with exception of some facilities. These conditions include non-communicable diseases, domestic and social violence, nutrition and physical activity, injuries/accidents, mental health and substance abuse.

Figure 15: Availability of contraceptives at health facilities



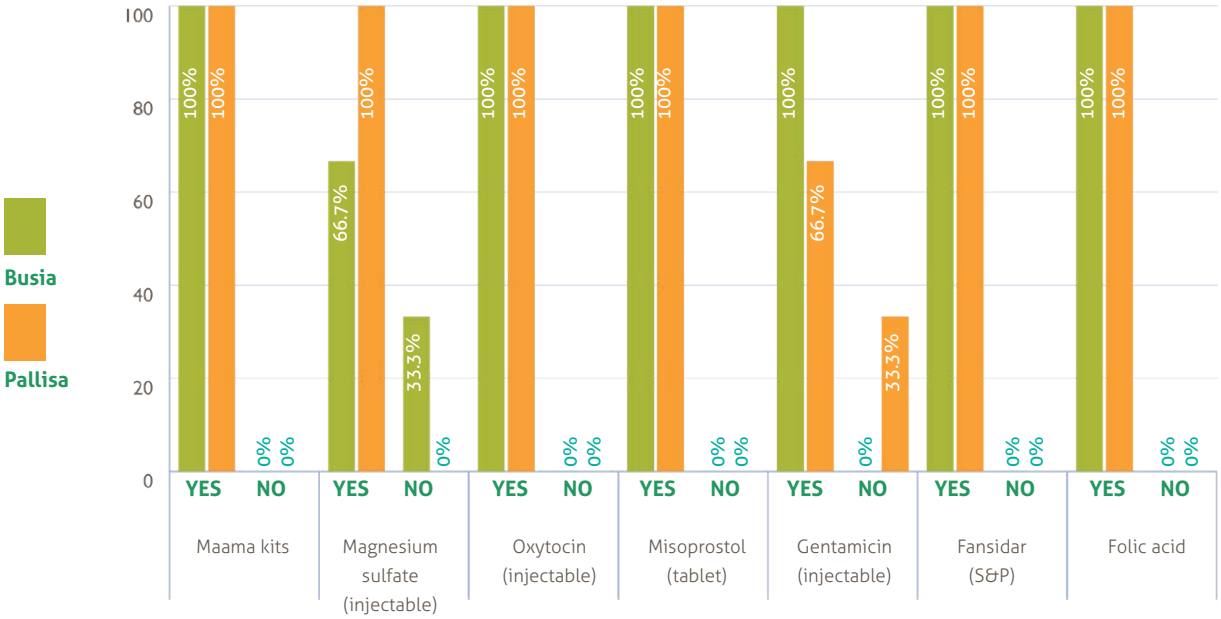
The figure above shows that at the time of assessment some facilities in both districts had a stock-out of some contraceptives including emergency pills and injectable whereas condoms, implants and oral contraceptive pills were in stock. This has an implication on many users who prefer injectable contraceptives and young girls and people who may face sexual violence.

Figure 16: Availability of HIV Test kits and other Test kits



Health facilities in Pallisa District had stock of all HIV and pregnancy test supplies unlike a facility in Busia which had stock-out of pregnancy test supplies and Startpak strips for HI; and a facility in Pallisa lacked Test strips for urine which is a key sample in investigating certain conditions especially during goal oriented ANC.

Figure 17: Availability of medicines and supplies for maternal healthcare



Health centres assessed in Pallisa district had stock of maternal healthcare vital medicines and mama kit supplies with only one which had stock-out of injectable magnesium sulfate for treatment of hypertensive disorders in pregnancy. Busia was also had stock all of vital medicines with exception one facility which had no injectable Gentamicin for sepsis treatment.

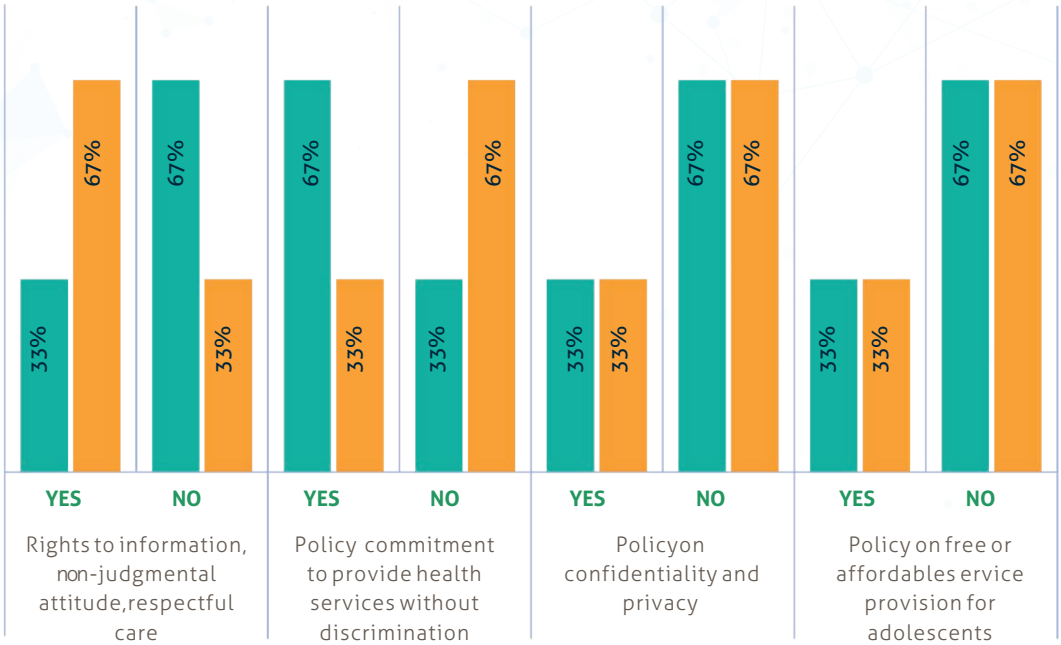
Table 15: Key characteristics of the health facility as experienced by the adolescent clients

Characteristics	Paallisa District (n=3)	Busia District (n=2)
A youth corner dedicated to serve adolescents	0%	0%
A specific room for examination/ treatment with privacy	100%	50%
Adequate seating in waiting room	67%	100%
Basic amenities like electricity, water, waste disposal	100%	50%
Toilets/pit latrines and clean	100%	100%
Convenient hours of service provision for adolescents	33%	50%
Adequate medicines and supplies	67%	100%
Necessary equipment is available& functioning	33%	0%
Staff protect privacy& confidentiality of adolescents	100%	50%

The National Policy Guidelines for SRH services 2012 outline adolescents as both a target and priority group under adolescent sexual and reproductive health. It further provides for youth friendly corners within a health facility as one of the service delivery points. However, a key finding in table.

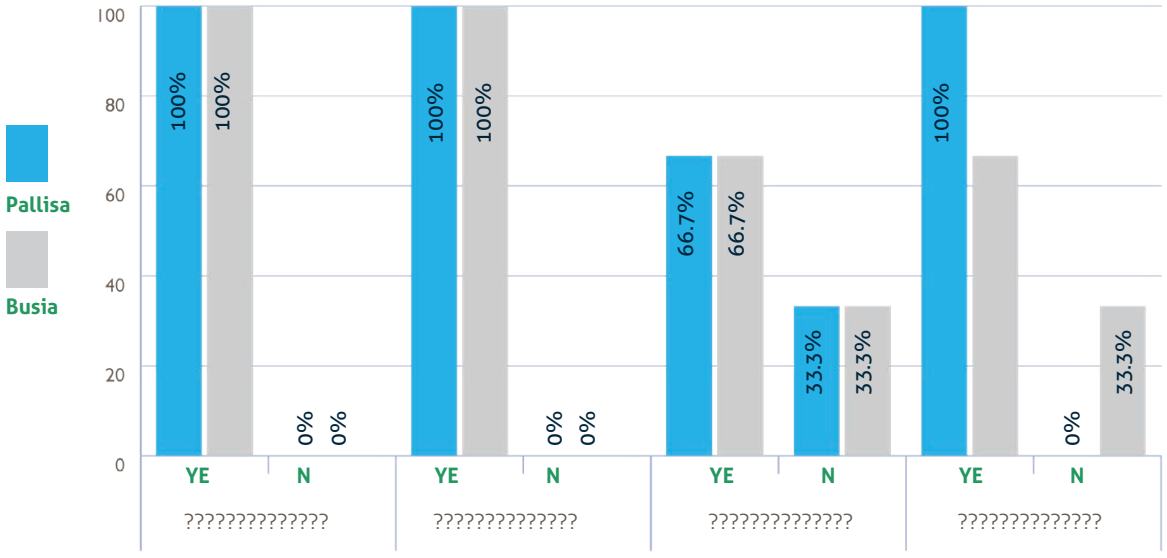
15 above is that none of the six health facilities assessed including a HC IV in Busia has a youth/adolescent friendly corner. This falls short of ministry of health commitment to establish youth corners in health facilities throughout the country. The facilities use an integrated service delivery model which has proved not to set specific targets for adolescent health. Also 3 out of 5 adolescent clients felt that the facilities' working hours were not convenient for adolescents. Furthermore, 4 out of 5 adolescent clients felt that their facilities lacked the necessary equipment for effective delivery of adolescent health services.

Figure 18: Display of Information in the Facility the Time of Assessment



The display of information about rights, policy commitments, privacy and confidentiality in health facilities was not consistent. This denies clients an opportunity to understand their rights and obligations in regard to their health.

Figure 19: Observed visual and auditory privacy features at health facility



It was observed that all facilities in the two districts had curtains on the windows and communications between those at reception waiting clients were private. However, there was no separation between examination and consultation rooms in some health facilities.

3.1.3 Adolescents' Health Literacy and Participation

This section focuses on adolescents' health literacy and participation in their health facility activities at both facility level and in community outreaches.

Table 16: Adolescent's health literacy about rights and health services at the facility

Literacy issue	Paallisa District (n=3)	Busia District (n=2)
First visit to the facility	0%	100%
Repeat visit to the facility	100%	0%
Came alone at the facility	0%	50%
Accompanied by a parent/guardian at the facility	100%	50%
Accompanied but had some time alone with healthcare provider	100%	50%
Support from parent/ guardian to use the health facility	100%	100%
Informational materials for adolescents e.g. video, TV	33%	50%
Materials covering nutrition, HIV, Family planning, TB, ANC	33%	50%
Liked the informational materials	33%	50%
Healthcare provider talked about how to prevent diseases, stay healthy.	0%	50%
Saw a plan for outreach activities for adolescent heath	67%	0%
Outreach workers are trained to conduct health education	67%	100%
Rights of adolescents displayed at health facility	0%	0%
Can tell his/her rights e.g. confidentiality, privacy, non-discrimination	100%	100%

It was a repeat visit to health facilities for adolescent clients of Pallisa and they were accompanied by a parent or guardian. For Busia, it was the clients' first visit to the healthcare facilities. Provision of information related to the services and rights of adolescents is weak given the experiences of adolescent clients.

Table 17: Involvement of adolescents in specific activities by health facility

Activity	Paallisa District (n=3)	Busia District (n=2)
Involvement of adolescents in the planning, monitoring and evaluation of health services	0%	33.3%
Involvement of adolescents in any aspects of service provision	0%	33.3%
Involvement of Vulnerable groups of adolescents in the planning, monitoring and evaluation of health services and service provision	0%	33.3%

Table 17 shows healthcare providers and health centres do not meaningfully involve adolescents in health facility activities related to adolescent health. These were responses by healthcare providers during the assessment interviews. This is a missed opportunity to ensure that the services and information provided is responsive to the health needs of young people but also attracting more service uptake by young people. It is important for health facilities to have deliberate engagement forums that involve young people in health facility activities.

Figure 20: Adolescent clients on participation of adolescents in health facility activities

Adolescent clients shared that they are not participating in their respective health facility activities such as helping facility staff in adolescent units, planning for services, improving quality of care, community outreaches and performance reviews. The adolescent clients views correspond to the feedback of healthcare providers in table 15 on whether adolescents are involved in their health facility activities. All healthcare providers who participated in the assessment in Pallisa reported that adolescents are not involved in facility activities and in figure 19 adolescent clients of the same district reaffirmed it.

3.1.4 Data and Quality of Care Improvement

Quality of care depends much on quality and accuracy of data and information to inform decisions for improvement of care. Therefore, data collection, analysis and reporting on adolescent health are vital in planning for continuous improvement.

Figure 21: Regularity of Support Supervision on Adolescent Health Care by In-charges

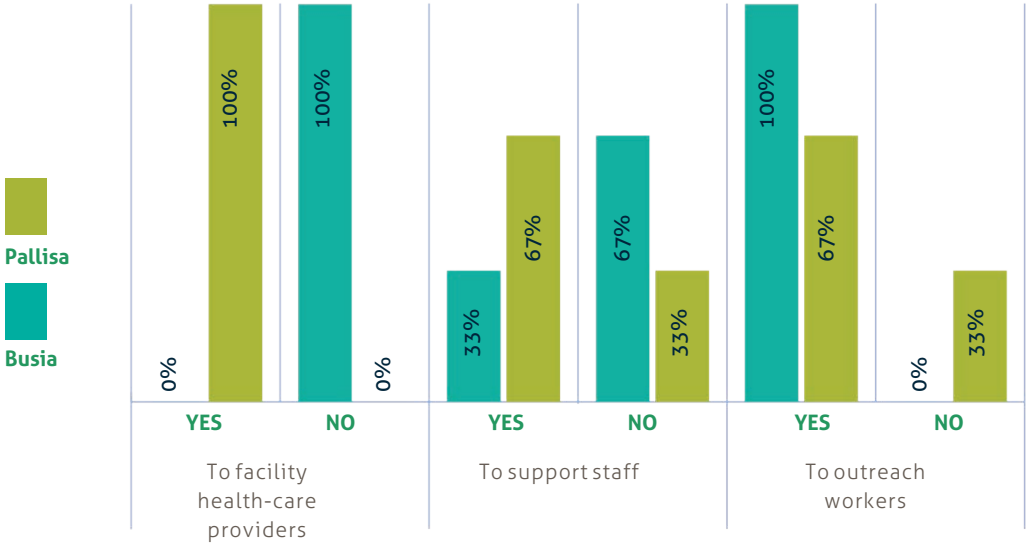
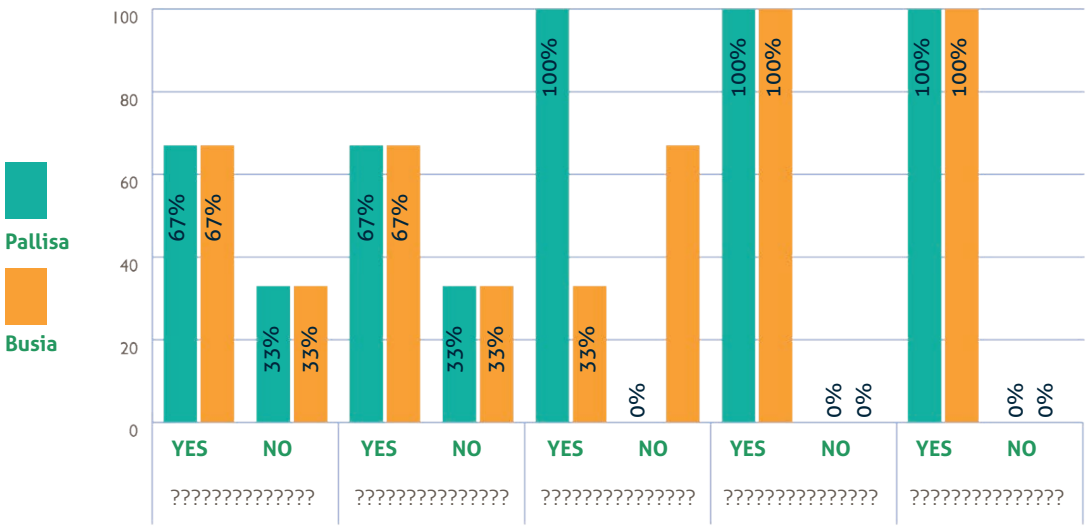


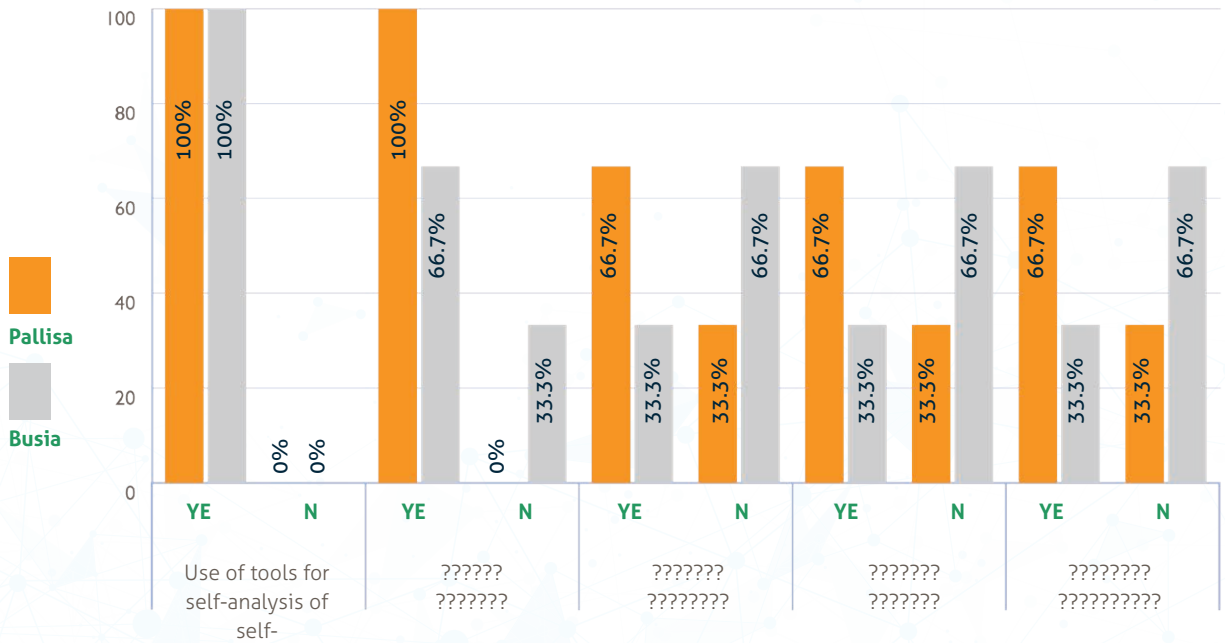
Figure 21 indicates that not all health centre In-charges provide regular support supervision on adolescent health to health workers particularly adolescent healthcare providers, support staff and outreach workers. This has a risk of affecting the quality of care given to adolescents who access the services at both facility and in communities.

Figure 22: Regularity of Health Facility Self Assessments



Although In-charges reported to hold regular health facility self-assessments to improve adolescent healthcare services, it was also found out that some In-charges do not assess some areas of interest to enable the facilities identify adolescents' expectations of the services, adolescents' experience of care and quality of care as shown in figure 22.

Figure 23: Support supervision and motivation to healthcare provider



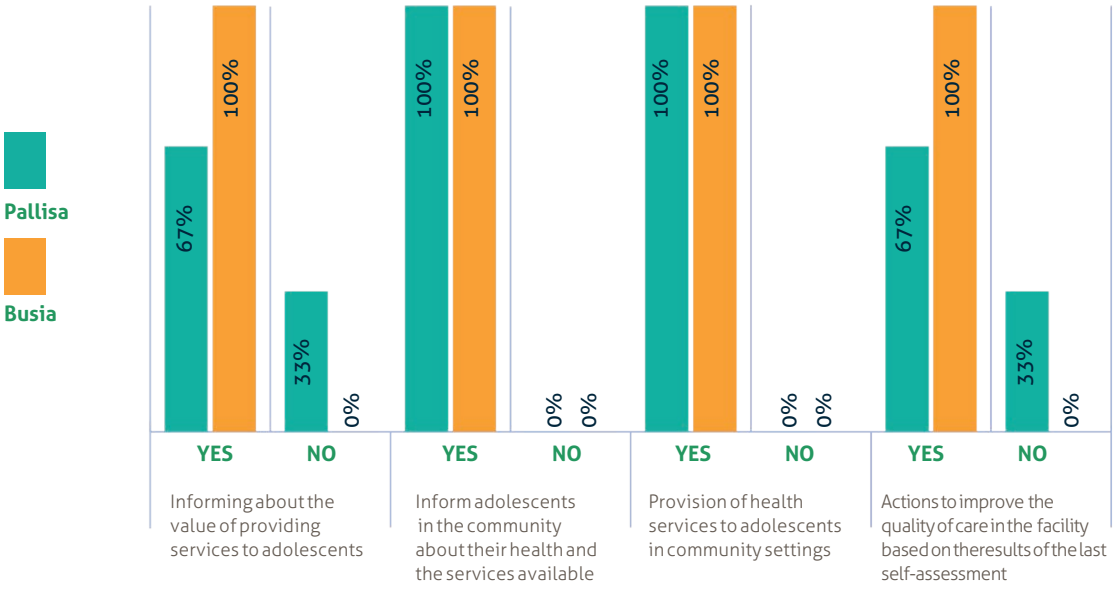
All healthcare providers interviewed reported to be aware of some tools for self- monitoring of the quality of care in the facility and use the tools for self-monitoring of quality for adolescent health

services. However, the findings also show that some healthcare providers do not get adequate support from the supervisors to improve QoC, not motivated to improve QoC and comply with standards and no rewards for high performance.

Figure 24: Healthcare providers' discussion with In-charges and actions to improve adolescent health services

Access to services and quality of care is made better if working hours are convenient to clients, less waiting time for service, open door policy for services and implementation of actions based on self- assessments of the quality of care. Figure 24 shows that some healthcare providers do not hold discussions with their In-charges or do not implement actions out of their self-assessments on adolescent health quality of care. If adolescents' complaints on quality of care experienced at health facilities or in community outreaches are not addressed, it is more likely to negatively affect access and uptake of the services. This is worsened by unavailability of key policy guidelines and standard operating procedures at health facilities in addition to low awareness of these policy guidelines by health care providers as earlier indicated in figures 6 and 7.

Figure 25: Availability of Health Facility Documentation Plans on Key Aspects of Adolescent Health



In-charges of health centres assessed in Busia District reported to have documented plans to inform adults at health facilities or in communities about the value of providing services to adolescents; inform adolescents in the community like schools, clubs, meetings about their health and the services available; provide health services to adolescents in communities; improve the quality of care in the facility based on the results of the self-assessments. In Busia some of the health centres did not have all the plans.

Figure 26: Data Collection and Reporting on Adolescent Health

Figure 26 above reveal that some health facilities in both Pallisa and Busia have gaps in collection of age and sex disaggregated data on utilization of services by adolescents, and integration of adolescent health in facility quality of care reports.

Table 18: Availability of reports/records and tools on adolescent health activities at health facility

Records and tools	Paallisa District (n=3)	Busia District (n=2)
Stock of medicines and supplies register	100%	100%
Referral register	100%	67%
Records of adolescent health outreach activities	100%	33%
Records of outreach activities with parents, teachers on adolescent health	100%	67%
Record(s) of formal partnerships with community organizations	67%	67%
Tools for facility self-assessment of the quality of adolescent health care	33%	67%
Reports on self-assessments of quality of adolescent healthcare	67%	67%
Records of support supervision visits on adolescent healthcare	0%	33%
Reports to the district on cause-specific service utilization by adolescents	0%	33%
Reports to the district on QoC that have a focus on adolescents	67%	67%

Table 19: Health facility work with stakeholders especially parents and organizations

Stakeholder	Paallisa District (n=3)	Busia District (n=2)
Agencies and organizations in the community to develop health education and behaviour oriented communication strategies and materials and plan service provision	33.3%	33.3%
Organizations from health, social, recreational, legal sectors to establish referral networks for adolescent clients	33.3%	66.7%
Informing adults during health facility visits about services available for adolescents	33.3%	66.7%
Support materials to communicate with parents, guardians and other community members and organizations on adolescent health services	33.3%	66.7%
Informing adolescents about the availability of health, social and other services	66.7%	33.3%

Figure 27: Availability of Health Facility Documentation Plans on Key Aspects of Adolescent Health

The findings in table 17 and figure 27 show existing gaps in terms of health facilities' engagement and partnerships with community organizations, partners, parents, adolescents and other interrelated sectors. Partnering and collaborating with stakeholders in adolescent health has a potential of synergizing efforts, resources in terms of financial, and nonmonetary support and benefits.

3.2 Uptake of Adolescent Health Services in the Target Districts

The consultants reviewed available service use data specific to adolescents from the Health Management Information System and health facility service use registers. Generally, the interest was placed on sexual and reproductive health (SRH) services with specific focus on maternal health and family planning services for the sampled health facilities in the two districts. In addition, the analysis focuses on adolescents and young people age 10-24. The analysis of trends in uptake of key adolescent health services over the time of the Uganda Reproductive, Maternal and Child Health Improvement Project (URMCHIP) implementation period between 2018 and 2019 is shown in the two districts as follows.

3.0.1 Uptake of Family Planning Services, Pallisa District

The Pallisa District health department statistics on Family Planning services for FY 2018/19 show that adolescents age 10-19 access and utilize the service at health facilities and more important to note is that they are sexually active. Gogonyo HC III had the highest uptake of 183 clients and Kamuge HC III had the least uptake of only 42 clients in the financial year. A total of 328 clients accessed and utilized the service in entire financial year.

Each quarter indicates only new users of the service. However, the consultants did not explore factors which contribute to the drop or increase in the number of new users across the period under review. This explanation applies to all other uptake trends under this section (3.6).

As it is for adolescents aged 10-19, Gogonyo HC III had the highest uptake of family planning services by young people aged 20-24 with 437 clients, followed by Kameke HC III with 169 clients and Kamuge HC III with 127 for the 2018/2019 financial year. The overall uptake was 733 clients in the financial year.

The figure above indicate the overall uptake of family planning services by adolescents and young people aged 10-24 with 1061 clients in FY 2018/19. Gogonyo HC III with 620 clients, Kameke HC III with 272 clients and 169 for Kamuge HC III.

3.0.2 Utilization of Antenatal Care Services – ANC 4th Visit, Pallisa District

It should be noted that Antenatal care (ANC) from a skilled provider is important to monitor pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy. This service is more important for adolescent and young pregnant women. The Pallisa District Health Department statistics for FY 2018/19 show that Kamuge HC III had the highest number of young people aged 10-24 who attended the ANC 4th visit (590). The overall total number of young people who attended the ANC 4th visit in the three assessed health centres was 1,087. The national average ANC 4th or more visits is 60% (UDHS, 2016).

3.0.3 Health Facility Deliveries, Pallisa District

Figure 32 above shows that Gogonyo, Kameke and Kamuge HC IIIs provided skilled delivery services to adolescents age 10-19. Kameke HC III delivered a total of 203, Gogonyo and Kamuge HC IIIs delivered 189 and 185 in FY 2018/19 respectively. A total of 577 health facility based deliveries were conducted at the three health centres.

Kameke HC III delivered the highest number of young women (316) age 20-24 in FY 2018/19. Overall, 842 deliveries were conducted by the three health centres in the year.

Figure above indicate that 519 health facility based deliveries of adolescents and young people aged 10-24 were conducted by Kameke HC III, 464 by Kamuge HC III and 436 conducted by Gogonyo HC III in FY 2018/19. The three health centres conducted an annual total of 1,419 deliveries. At national level, the average health facility based deliveries stand at 73% and deliveries conducted by a skilled provider at 74% (UDHS, 2016).

3.0.4 Uptake of Family Planning Services, Buisa District

BUSIA HC IV

According to the Busia District Health Department statistics, emergency and short term family planning methods are used by adolescents aged 10-19. The highest used contraceptive by adolescents at Busia HC IV was the injectable with 562 users in 2019. This was followed by Implant, Male condom, Microgynon, Ovrette/ POP with 483, 432, 225 and 181 users respectively. Least used methods include Intra-uterine device (IUD), Female condoms and Lo-Feminal with 9, 48 and 0 users respectively. Overall, 1,940 users were recorded for all the methods in 2019.

The mostly used modern contraceptive by young people aged 20-24 at Busia HC IV in 2019 was IUD and Injectable with 1,260 and 1,259 users respectively. It was followed by Implant method at 864, Microgynon at 476, male condom at 99 and female condom at 86 users. The uptake for all family planning methods by young people in 2019 was 4,121 users.

BUTEBA HC III

At Buteba HC III the mostly used contraceptive by adolescents age 10-19 in 2019 was Implant with 86 users. Injectable and Male condoms followed with 59 and 39 users respectively. There was no registered use of Female condoms by this age group in the entire 2019. The total users for all methods were 195.

Injectable contraceptive registered the highest number of users by young people age 20-24, followed by Implant with 97 and Male condoms with 58 users at Buteba HC III in 2019. Like adolescents, there were zero users of Female condoms in this age group. The total number of users of all methods in 2019 stood at 314 at this health facility.

The highly used contraceptive by adolescents aged 10-19 at Lunyo HC III in 2019 was the Implant with 134 users and Injectable with 42 users. There was very low uptake of other methods and with some methods registering zero (0) uptake. The uptake of all methods in 2019 was 182 users among the age group.

The figure above shows that Implant method was highly used by young people age 20-24 over other methods at Lunyo HC III in 2019. The Injectable method followed with 77 users and 23 for IUD method whereas the rest of the methods registered 0 to 2 users. Overall, the uptake of all methods by this age group at Lunyo HC III was 261 users in 2019.

3.1 Challenges Adolescents and Young People Face in Accessing and Utilizing the Health Services

The challenges adolescents and young people face in accessing and utilizing adolescent health services were largely health system based. These were expressed during focus group discussions and service exit interviews and are given below in their order of frequency i.e. high to low.

I. i)Stock-out of medicines. The group discussions revealed that on some visits to the health centres, adolescents and young people do not get medicines for certain health conditions due to reported stock out of the medicines. This increases the vulnerability of those from poor households because they are often referred to clinics/drug shops to buy the prescribed medicines yet they lack the money.

"We are often referred to clinics to buy missing drugs after prescriptions." FGD member in Pallisa District

II. Lack of youth/adolescent friendly corners at the facilities. All the facilities assessed lack an adolescent and young people responsive service delivery approach which is a barrier to many of them to access and utilize the available health services.

There is no private place where to access condoms for boys because they are shy to openly ask for condoms from health workers. Some medical workers are unnecessarily harsh to young people" FGD member

III. Long waiting time/delay to get services at health facilities. Adolescents complained of waiting for long before they get served and this was partly explained by presence of few health workers to attending to them. This is a disincentive to them to visit health centres to utilize the available adolescent health services.

"Sometimes there may be only one health worker serving many patients and you have to wait. We have inadequate seating facilities at the maternity" FGD member

IV. Limited laboratory services. Adolescents and young people expressed limited availability of laboratory services in their health facilities especially testing to determine a suitable family planning method for a client to avoid severe side effects, testing of typhoid, abdominal scanning services.

V. Inadequate and poor hygiene and sanitation facilities particularly latrines at the facilities which are shared by patients, girls, boys, women in labour, men.

VI. Healthcare providers and gender was also found to be a challenge to young people in accessing and utilizing health services. It was expressed by members of focus group discussions that some boys or girls shun to get services especially when the only available health worker at the health facility to serve them is of the opposite sex. They prefer to be served by a health worker of their sex so that they can openly share their health conditions.

VII. Lack of electricity especially in maternity in some health centres which is unattractive to young mothers to seek delivery services because they are asked to by torches .


box
sweater
hut
toothbrush
umbrella
apple
camel
UYAHF

4.0 Recommendations

1. Adoption of specific indicators on adolescent health in the next RBF rollout beyond ANC, Deliveries, FPs. Revision of the Investment Case for RMNCAH Plan for Uganda is underway and there is a writing team for the adolescent health thematic area in ministry of health.

2. Harmonize and adopt some planning indicators for adolescent health in district plans with specific targets for health facilities and districts

3. Create a specific budget for adolescent health in district to operationalize the plans and strategies to improve focus on adolescent health

4. Improve on reporting tools to capture outputs specific to adolescent health in health facilities

5. Create and improve space for youth friendly spaces in health facilities

6. Institutionalize and facilitate a peer to peer approach for adolescent health reach and functionalization of the youth friendly corners

7. Rollout trainings in adolescent health friendly services for all health workers. It is important to ensure standardized adolescent specific curriculum/training modules across health facilities.

8. Integrate adolescent health in health facility Quality Improvement Committees with specific priority performance indicators.

9. Increase stock of essential medicines and family planning commodities especially those with high demand such as injectable contraceptives and emergency contraceptive pills

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