ADOLESCENT SEXUAL REPRODUCTIVE HEALTH AND RIGHTS 
PROVINCIAL STAKEHOLDER FORUM

Workshops Report

19th November 2014
East London, South Africa
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EXECUTIVE SUMMARY

This is a workshop report of a successful Provincial Adolescent, Sexual and Reproductive Health and Rights (ASRHR) Forum held in the Eastern Cape Province on 19th November 2014. A range of government and civil society role-players addressing ASRHR, and adolescent and youth friendly services (AYFS), participated in the workshop. Participatory learning and action methods were used to facilitate rich and meaningful discussions of the context for ASRHR and AYFS, including success stories and challenges or bottlenecks. Some key goals were set by the workshop participants, as well as action-points for the way forward.

Key findings and outcomes of this workshop are highlighted here.

SUCCESSES AND GOOD PRACTICE

Firstly, there is significant energy and commitment from both government and civil society organizations to address ASRHR and improve AYFS in the Eastern Cape Province. There is a shared understanding of what is working well, as well as the challenges, and the workshop itself helped to deepen this identification between the different role players.

There is evidence of good progress in addressing ASRHR and especially in providing AYFS in the Eastern Cape. Key successes include developments in policy and strategy around AYFS, and training and mentoring of health-care workers.

Case studies of good practice were provided, including facilities that had managed to achieve fully-fledged adolescent and youth friendly services. Adolescent and youth friendly facilities have: 1) Welcoming services and people from the point of entry to exit of the clinic, 2) dedicated personnel for AYFS, 3) extended opening hours, 4) clear sign-posting, 5) availability of treatment, 6) support from the clinic supervisor, and 7) community and youth involvement. One additional key feature of adolescent and youth friendly facilities is the provision of a separate space for young people or a ‘Chill Room’.

NGO and peer education programmes have also been a key success in ASRHR and have assisted in the successful provision of AYFS. Peer education is an excellent way to reach young people, to educate them and to inform them about AYFS.

There is some momentum towards increased community and youth participation in AYFS, initiated by government and CSOs. The establishment of clinic committees that includes a youth representative from the community is a case in point.

CHALLENGES AND BOTTLENECKS

There are still many challenges and bottlenecks to addressing ASRHR in the Eastern Cape, and particularly in the provision of AYFS. A major issue is the attitude of older people in general towards youth sexuality. Young people struggle to access information about ASRHR because the attitude is that they should not be sexually active. There is poor communication and lack of information on ASRHR and AYFS provided in the home / by parents, at schools, as well as at the clinics.

Furthermore, young people will often be judged if they ask for or try to access information and services.

The attitudes of service providers, including health workers and the police, are a significant challenge that needs to be addressed. This is the major bottleneck to services becoming more youth-friendly. Young people will face prejudiced attitudes, lectures on their behaviour, lack of sensitivity, and poor levels of confidentiality, if they access clinic services. This is clearly a deterrent to AYFS.
It was said that training of health-workers has taken place, but this is not always translating into practice. One key point here was that everyone in the health-facility should be trained, from the security guard to the clinic manager – this will mean that everyone has improved attitudes towards young people. Training should include values clarification and also assist all service providers to provide improved psycho-social support to young people and adolescents.

Lack of co-ordination and inter-sectorial collaboration is a barrier to the successful implementation of ASRHR programmes. Lack of leadership and direction from both government and CSOs plays a significant role in this challenge.

Other challenges include lack of sufficient supplies and treatment at clinics, poor provision of termination of pregnancy services, and the need for improved monitoring and evaluation systems that capture the right information. Gender-based violence is a major issue affecting young people, and the lack of AYFS means that they are failing to get the level of treatment, counselling and criminal justice services that they need.

**GOALS AND ACTION-POINTS**

There were 5 key focus areas or themes that came out strongly in the workshop:

1) Changing behaviour and attitudes was clearly an issue of the highest priority for participants, followed by 2) increasing community involvement, 3) improving youth participation in ASRH policy and practice, 4) improving the design of youth friendly services, and 5) communicating knowledge about ASRH.

Action-points and to take away from this session include the need to prioritize values clarification training for all staff members at health facilities. Training must take place with clinic managers, because they set the tone for the working practice of the health facility. Some of these attitudes may be deeply embedded, and linked to culture: We must understand where attitudes are coming from in order to address them.

An additional action-point is to ensure meaningful participation in ASRHR planning processes, through creating platforms where young people can voice out their challenges and to strengthen youth working groups within the Department of Health.

Peer education programmes are proving very successful in providing appropriate education and information to young people and adolescents. We must support these peer education programmes and provide them with additional capacity-building so that they be more empowered to fulfill their role. We must also ensure that they have good working relations and support from health facilities and schools, and that they do not become over-burdened.

Inter-sectoral collaboration and co-ordination to address ASRHR and improve AYFS in the Eastern Cape was a major theme and action-point that recurred throughout the workshop. The strong participation and collective identification of success, challenges, and goals in this Forum clearly demonstrates the potential for meaningful working relationship between government and civil society role-players. Recommendations from participants in this regard included having a quarterly ASRHR forum, and establishing district-level forums.
INTRODUCTION
The workshop brought together a range of government and civil society role-players working to address adolescent and sexual reproductive health and rights (ASRHR) in the Eastern Cape. Particularly impressive was the range of stakeholders from both government representatives and from the CSO sector. The full attendance sheet is highlighted below.

NGOs

<table>
<thead>
<tr>
<th>Organisation Name</th>
<th>Contact person/Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soul City</td>
<td>Plenaar Motabene</td>
</tr>
<tr>
<td>Path Finder</td>
<td>Andiswa Msuthu</td>
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<tr>
<td></td>
<td>Clever Mubuyayi</td>
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<tr>
<td>Beyond Zero</td>
<td>Nomawethu Mfenyana</td>
</tr>
<tr>
<td>SFH</td>
<td>Sisa Puzi</td>
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<tr>
<td>LoveLife</td>
<td>Nomalizo Mlisana</td>
</tr>
<tr>
<td>RMCH</td>
<td>Tshayana</td>
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<tr>
<td></td>
<td>Maleqhoa Modise</td>
</tr>
<tr>
<td>TB HIV Care associa</td>
<td>Sandile Prusente</td>
</tr>
<tr>
<td>Gwebindlala</td>
<td>Rita Bushula</td>
</tr>
<tr>
<td></td>
<td>Portia Mngadi</td>
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<tr>
<td>NAPWA</td>
<td>Siyabulela Tsewu</td>
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<tr>
<td>Imthayelanga</td>
<td>Thandiwe Mdumisi</td>
</tr>
<tr>
<td>ECAC</td>
<td>Manuel Strack</td>
</tr>
<tr>
<td>Giz</td>
<td>Maja Opua</td>
</tr>
<tr>
<td></td>
<td>Heike Krumbiegel</td>
</tr>
<tr>
<td>Umzumvibu</td>
<td>Diko Siyabonga</td>
</tr>
</tbody>
</table>
It was intended that the broad focus of the workshop should be on ASRHR, with a particular focus on adolescent and youth friendly services (AYFS). This was to allow for a range of perspectives on how we tackle youth sexual and reproductive health and rights, and to include those participants that provide non-clinical, community-based services and programmes to youth. It was anticipated that the focus on AYFS would emerge organically from the broader focus on ASRHR, due to the strong representation of Department of Health and organizations involved with the provision of reproductive health services to youth.

This was a half-day workshop that utilized participatory learning and action methods to achieve meaningful engagement and interaction between role-players, to encourage ownership over the process, to share experiences of the successes and challenges on the ground, and to come up with collective solutions for the way forward.
OBJECTIVES OF THE WORKSHOP

The workshop was intended to:

1. Achieve a shared understanding of the current context regarding ASRHR and AYFS
2. Develop a common vision and to set goals for the way forward.
3. Share information on the policy and research context on AYFS nationally and in the Eastern Cape.

1. The first objective of achieving a shared understanding of the context for ASRHR and AYFS was planned to take place in two phases:
   a) Identifying success stories / best practice examples of what is working well on the ground.
   b) Reflecting on the challenges and bottlenecks to providing ASRHR and AYFS.

2. The second objective of developing a common vision, goals and actions would be achieved through:
   a) Voting and prioritizing key areas of focus
   b) Goal-setting and action planning.

PARTICIPATORY LEARNING AND ACTION METHODS

A participatory learning and action approach was used to facilitate meaningful participation and interaction between participants, to encourage critical reflection on the issues at stake, and action-orientated thinking.

Participatory learning and action (PLA) is a practical, adaptive research strategy that enables diverse groups and individuals to learn, work and act together in a co-operative manner, to focus on issues of joint concern, identifying challenges and generating positive responses in a collaborative manner.¹

PLA methods used here included small group discussions and reflections, story-telling, and voting and prioritizing. Five main activities were planned:

1. Firstly, participants were asked to write down their hopes and expectations for the workshop, and to share them in the wider plenary.
2. For the second session of identifying successes and challenges, participants were divided into small groups of up to 6 participants. Composition of the groups was mixed, with a deliberate effort to bring role-players from different organizations and departments together in different groups.
3. For this session, participants were asked to share a) success stories of what is working well in the field of ASRHR and AYFS, and b) challenges and bottlenecks. Where appropriate, participants were asked to share stories that illustrate the successes or the challenges that they had experienced. Responses were then shared in the plenary session.
4. The third session comprised a PowerPoint presentation from Linda du Plessis and Alice Clarfelt on a review of the Maternal, Newborn, Child, Women’s Health and Nutrition

5. The fourth session was facilitated as a voting and prioritizing activity. Participants were presented with seven focus areas, which were distilled from the earlier discussions about successes and challenges. They then voted for the focus area they thought needed to be prioritized, by marking it with an ‘X’ on the flip-chart board.

6. The fifth and final session was an action planning session facilitated as a ‘World Café’. Participants were asked to move to one of the seven groups where each key focus area had been allocated as the topic for discussion. Participants then discussed the key focus area, and generated a) a goal for addressing this area / issue and b) actions for how to go about achieving this goal. Groups then presented their goals and actions in the plenary discussion. During plenary discussions participants were organized into a horseshoe seating arrangement so that they could see and interact with each other.

**FINDINGS**

**HOPES AND EXPECTATIONS**

Participants were asked to reflect on their hopes and expectations for the workshop. A range of perspectives were shared, including broad hopes for improvements that they would like to see with regard to AYFS in the Eastern Cape:

In summary, participants hoped to:

- Get information that is going to work towards improving the health of women and young girls, particularly when it comes to dealing with the challenge of teenage pregnancy.
- Improve our sexual and reproductive health programmes so that we can see impact in terms of behavioural change amongst adolescents, in particular so that they stop substance abuse and adopt safer sexual practices.
- Understand the role of the Provincial role-players on ASRHR
- Ensure that SRH programmes and activities are prioritized, especially within school health programmes.
- Understand how Restless Development will support Department of Health in terms of infrastructure, making it youth friendly and accessible.
- Stop working in silos and see networking, collaboration and joining of resources all to advance AYFS in the Eastern Cape for all. This will mean strengthening synergy between the various stakeholders.
- Ensure that what is discussed here is implemented after the workshop.
- Be supplied with reproductive health guidelines and policies and supported with equipment, e.g. cervical cancer screening tool.
- Find solutions to reduce maternal death.
BEST PRACTICE EXAMPLES AND SUCCESS STORIES

In small groups, participants reflected on what in their view is working well to address ASRHR, including the development of AYFS. They were asked to consider what is the most significant change they have witnessed in their professional and personal experience. Facilitators were allocated to each group to document what emerged from discussions. There were many examples of good practice, which fell under the themes of: Developments in policy and strategy, successful provision of clinical AYFS, including youth friendly spaces, NGO and peer education programmes, training of services providers, community-driven interventions, and community participation in AYFS.

Developments in policy and strategy around AYFS

- The policy and legal framework has developed significantly around ASRHR and AYFS.
- AYFS framework plan is in place in the O.R. Tambo district
- It is encouraging to know that new School Governing Bodies (SGBs) have been developed, and are aware of the guidelines for ASRHR and AYFS. They are in a position to focus on effective implementation of effective programmes.
- DHIS is now going to implement a standardised tool to monitor AYFS.

Successful provision of clinical AYFS

- There is a dedicated service for young people in Ethembeni community health care centre and it was voted “Centre of excellence”. This is a key success story: Ethembeni community health care centre is one of the most youth friendly service centres. It is well-secured and everyone is friendly starting from the entrance to the consulting rooms. There are clear signposts for directions within the clinic. There is a youth friendly corner to access information and chill room for young people to sit and share their experiences and learn from each other. Treatment is always available. There is support from the supervisor, community and other stakeholders
- There are a greater number of AYFS access points within hospitals.
- In a clinic in eThembeni they have both male and female nurses who provide welcoming sessions to patients. They also have accessible information in the form of pamphlets.
- In some areas, mobile health services have been provided within communities. This is so that parents are also able to access services, as well as school-going youth.
- Extending clinic-opening hours has led to longer operating hours, and has had a positive effect.
- Some clinics have dedicated nurses for AYFS

Youth-friendly spaces or ‘chill rooms’

- Some clinics have a youth friendly corner or a chill room that provides a comfortable space for youth and a point at which to access important information about SRHR and services. These chill rooms also have recreational activities such as games, and professional development facilities, such as a computer to type CVs. Some activities are directed towards men, because they fail to access SRH services as compared with women.
- If young people can go to chill rooms it means that they will access the services for other things, and not just for treatment / medical attention. This increases motivation to go to the clinic because it takes away from the stigma associated with accessing HIV and SRHR services, as people will not necessarily be identified as doing such. It is important that the entrance to the clinic consulting room be right next door to the chill room, so that young people do not have to go into the public space again when they do choose to access services from the chill room.
**NGO and peer education programmes**

- There is a very successful implementation of condom distribution in Spaza shops through an NGO called Society for Family Health (SFH). They are meeting a huge demand for condoms during out of normal working hours and in non-traditional spaces. This must be made a priority in other interventions.
- Peer education programmes are very successful. There are many peer education organizations / initiatives that are responding creatively to the demand: They are telling young people the youth friendliness of the services, they are also marketing them. Peer education is a good way to inform and educate. A lot of information has been disseminated to young people about youth friendly services. Peer educators should be community based as well as facility based.
- The presence of informed young people in health facilities creates demand for, and improves uptake of, AYFS. For example LoveLife’s Ground-breakers will give health talks to young people to encourage them to use different contraceptives, and to dispel the myths around them.
- The visibility of Love Life in clinics and schools has increased stakeholder relations, especially in Mt. Frere.

**Training and capacity building of service providers**

- Training of service providers has taken place, and participants were very enthusiastic about the AYFS programme. Champions were also trained; one per facility. Mentoring has been provided to those who have been trained. Some professional nurses were trained to be master trainers on AYFS and this has led to a change in their attitudes towards youth accessing services.
- In Nyandeni, nurses have been fully equipped with training on implanon as birth control, which meant that in this sub-district, young people were using effectively. This is very different to areas where the health workers were not as well trained, which resulted in young people not using this contraception properly.

**Community-driven interventions**

- Research conducted in Bizana found that the community, parents, teachers and the principal of one schools had developed their own strategy for addressing teenage pregnancy. They came to an agreement that whenever a child got pregnant, the parents would be informed and would have to accompany the child to school on a daily basis. The method ensured that parents were pressured to talk to their children about being sexually active and what came with, for example pregnancy. That reduced the rate of teen pregnancy in the area instantly. When parents considered that they would have to attend the school with children, or hire someone to do that, they were much more motivated to change their behaviour and talk to their children about pregnancy.
- Research in one area proved that there was a high teenage pregnancy rate in child headed families. In one community, neighbours decided to take action in the form of taking the role of parents to the child-headed families. This helped reduce teenage pregnancy.

**Community participation in clinical AYFS**

- Some health facilities have engaged with communities to do community mobilization sessions when they embarked on providing AYFS. Subsequently, older women or ‘gogos’ from the community would come to the clinic and talk to young people accessing services, providing educational sessions.
• The composition of the clinic committee now includes youth. This is good because young people know what they want. These young people are usually peer educators, but if none available then they will invite a young person from the community.

CHALLENGES
Remaining in the same groups that were organized for discussing success stories, participants moved on to reflect on and share challenges and bottlenecks in addressing ASRHR, including the provision of AYFS. Participants were asked to consider what challenges they know of or experience in their work, and to provide stories or examples that illustrate the nature of these challenges. This activity generated energetic discussions. Groups shared similar challenges to others – demonstrating that there is a shared understanding of the context and the gaps in provision of services. Challenges included: Attitudinal barriers to AYFS within the community as a whole, and at health facilities, lack of supplies and infrastructure at clinics, poor youth knowledge and uptake of safer sex methods and contraception, poor services in response to GBV and termination of pregnancy, inadequate systems of monitoring and evaluation, and lack of inter-sectoral collaboration.

Attitudinal barriers in communities prevent effective ASRHR
• In communities, there are religious barriers to using condoms.
• There are challenges with schools: The principals of schools expel students for pregnancy, which is evidence of prejudice, and judgemental moralistic attitudes towards young people and sexuality.
• ASRHR issues are not being discussed in the home; parents don’t talk to their children, or vice versa.

Attitudes of service providers are a barrier to AYFS
• Attitudes of health workers and SAPS are a challenge to provision of AYFS.
• There is real lack of youth friendliness amongst services. For example, you are discriminated against if you turn up using school uniform. This is a real barrier and obstacle. There is a lack of confidentiality for young people who access services. Health service providers are judgmental and will give lectures on morality.
• Judgemental attitudes of nurses and teachers towards ground breaker’s dressing code makes them less empowered to continue doing sessions in school and in clinics.
• Lack of support from the management for AYFS.

Lack of supplies and infrastructure at clinics
• Lack of supplies at clinics.
• Lack of sanitary pads for young girls in school makes them miss school.
• There is no dedicated nurse for persons with disabilities who really understand the plight they are living in.

Poor knowledge and uptake of safer sex and contraceptive methods amongst youth
• Condoms and other forms of contraception, for example Implanon, are not being used properly.
• There is acceptance of risky lifestyles amongst youth.
Gender-based violence is a serious challenge which services are failing to address

- For victims of gender-based violence there are particular issues with the service at police stations: for example lack of proper counselling and privacy.
- We need to have well-functioning, effective Thuthuzela centres at all police stations.
- Story of a child who was raped by her uncle. She didn’t want to tell her stepmother. The child was crying at school, and dropped out at school – they didn’t want to talk about it. Since then a youth peer educator spoke to her. We advised her to go to social worker, but they did nothing. Social workers are overburdened, they are doing everything.
- There are well known cases of the perpetrators paying off the parents of victims of GBV. This means the young survivor is forced to forgive what has happened to her/him.

Termination of pregnancy services are not being offered

- There is poor delivery of termination of pregnancy services: These are not being offered as they should be and there is a lack of confidentiality.
- A story was related of a young person aged 19 who was raped and reported the case to her mother who wanted to keep it quiet. She became pregnant, and her mother tried to help her get a back-street abortion. The particular health-care facility in the area was the missing link.

Training of service providers is not leading to impact

- Training has taken place but has not led to sufficient impact, for many reasons:
- We still need to train more nurses. Just a handful of nurses have been trained.
- Training for AYFS is not a one-man show. Everyone in the facility should be trained on AYFS, especially Managers. The nurses are trained, but they don’t succeed in implementing AYFS because they don’t have support from managers. AYFS is about changing attitudes.
- Trainings need to be held again and again, because it is not a once-off.
- If you are a CSO partner, you don’t have control over the training process and where trained nurses are allocated. Sometimes nurses are trained and then immediately moved to another unit. This presents a challenge. Maybe we need to train more nurses.

Need for improved monitoring and evaluation

- Measurement indicators don’t measure what they are supposed to.
- Indicators need to be broken down so that they are outcome based. Information captured should include: How many youth are accessing services, and WHAT services are they accessing?

Need to provide psycho-social support as part of AYFS

- We fail to bring psycho-social support for young people, we usually look at the medical side of things, and not the psycho-social areas. There is non-adherence to treatment, there is a lot of rape, there is poverty, there is death – there is a lot of baggage – it needs to be addressed.
- Lay counsellors: Do we capacitate them to take on this heavy burden of lay counselling? The capacity building is not enough.

Lack of co-ordination and inter-sectoral collaboration.

- There is real lack of coordination of different stakeholders. Underpinning this is unclear leadership (including amongst CSO’s and amongst the various government departments) leading to lack of integration of services.
- Health care workers rely on LoveLife Ground breakers to do their work (i.e. not working together as partners).
• CSOs are clustered too closely together: They need to be based more in rural areas and assisting with activities such as co-ordinating outreach, transport to clinics etc.
• Integration of social workers into the youth friendly programmes is needed.

PRESENTATIONS ON POLICY AND RESEARCH CONTEXT FOR AYFS
A PowerPoint presentation was given by Linda du Plessis and Alice Clarfelt on MNCWH&N Strategic Plan Review, and an assessment of AYFS in 5 districts in the Eastern Cape Province, compiled by Solutions for Innovation Policies Programmes and Technologies.

In this presentation, progress and good practice in addressing ASRHR and AYFS nationally, and in the Eastern Cape, was reported on. Challenges and bottlenecks were also captured. Combined recommendations from both the Strategic Review and the research into AYFS in the Eastern Cape were presented. Key questions for reflection and discussion were drawn from these policy and research documents:

Many of the successes, challenges, recommendations, and questions to take forward into discussion had already been mentioned in the group discussions held prior to the presentation. The presenters therefore draw links between the content of the presentation and the contributions that participants had made earlier. There were very few questions after the presentation, however it was evident that participants listened attentively, and took notes.

VOTING AND PRIORITISING
Participants were asked to vote for their preferred focus areas, which had been distilled from the second session of the day on success stories and challenges in addressing ASRHR and providing AYFS. The findings are reflected in the table below:

<table>
<thead>
<tr>
<th>Planning Action Together</th>
<th>Vote…. (mark x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increasing community involvement</td>
<td>xxxxxxxxx</td>
</tr>
<tr>
<td>2. Measuring outcomes</td>
<td></td>
</tr>
<tr>
<td>3. Changing behaviours and attitudes</td>
<td>xxxxxxxxxxxxxxxx</td>
</tr>
<tr>
<td>4. Improving youth participation in ASRH policy and practice</td>
<td>xxxx</td>
</tr>
<tr>
<td>5. Improving the design of youth friendly services</td>
<td>xxx</td>
</tr>
<tr>
<td>6. Improving poor infrastructure</td>
<td></td>
</tr>
<tr>
<td>7. Communicating knowledge about SRH</td>
<td>x</td>
</tr>
</tbody>
</table>

1) Changing behaviour and attitudes was clearly an issue of the highest priority for participants, followed by 2) increasing community involvement, 3) improving youth participation in ASRH policy and practice, 4) improving the design of youth friendly services, and 5) communicating knowledge about ASRH.
GOAL-SETTING AND ACTION PLANNING

An important stage of the workshop was to move forward from critical reflections on the context for ASRHR and AYFS, to goal-setting and action planning. After the first four workshop sessions, participants had interacted with each other pro-actively, shared many similar examples of good practice and challenges, and there was a sense of positive energy in the room.

The five focus areas that were voted for above were allocated to five different groups. Participants were then asked to move the focus area of their choice. Each group discussed the following questions:

1. What is our goal in addressing this issue?
2. How can we in the room (Government & CSOs) work together now to achieve it? What next? Action points?

There was a little confusion in this process, which resulted in two groups choosing ‘changing behaviours and attitudes’, meaning that one key focus area was not discussed. Group discussions generated carefully considered goals and concrete action-points.

CHANGING BEHAVIOUR AND ATTITUDES

The goal: To ensure health care workers have positive and welcoming attitude to adolescents and youth who access services.

Action points:

1. We need to understand where these attitudes are coming from, in order to address them – for example culture might be a reason.
2. All the levels of facility staff, including clinic managers, and the security guard, must buy in to AYFS and be included in the curriculum design and training. This means that everyone has a positive attitude towards youth, from the point of entry to the health facility. Training must include values clarification.
3. In the point above, we must prioritize attitudes and values clarification for managers. Once the attitude of managers is youth-friendly it has a positive effect on the rest of the facility team: Everyone who is employed follows the culture set by these managers.
4. Training and mentoring of service providers must be continuous starting from the policies & procedures they have to follow and must include counselling skills.
5. Job ads/leaflets are needed with good information about how providers should respond to young people.
6. Management of health facilities must be accountable and enforce policies and procedures.
7. We can advocate for more staff members where there are shortages and male nurses.
8. We can form a coordinating entity that can be responsible for organising regular meetings and gatherings to discuss and address issues like attitudes towards young people.
9. We can also sensitize people and community members.
IMPROVING YOUTH PARTICIPATION IN ASRH POLICY AND PRACTICE

The goal: To ensure ownership of young people in implementation of SRHR service and programmes in the province.

Action points:

- We can create a platform where young people can voice out their views.
- We can ensure meaningful participation in ASRHR planning processes.
- We must strengthen youth working groups within the Department of Health as a coordinating body.
- We can build the capacity of SANAC youth sector.
- At clinic committees, there should be a young person from the community who represents youth as well as a peer educator from the health facility. It is important to include a young person from the community itself.

IMPROVING THE DESIGN OF YOUTH-FRIENDLY SERVICES

The goal: To improve the design of AYFS so they are more youth-friendly

Action points:

- To have trained nurses who are committed to implement AYFS
- In schools everyone should own and take leadership in the NGO programmes of AYFS
- Peer educators should sign attendance registers every time they enter and exit the clinic
- We need to provide more assistance and support to Ground Breakers. Ground Breakers are treated as teachers in schools; the Life Orientation teachers’ responsibilities are put on the shoulders of these peer educators.
- Continuous engagement is very crucial.

INCREASING COMMUNITY INVOLVEMENT AND PARTICIPATION

The goal: To increase community involvement and participation in AYFS.

Action points:

- To hold the ASRHR Forum quarterly.
- To establish district level forums on ASRHR
- To pilot an ASRHR initiative in BCM.

CLOSURE

At the end of the workshop, participants reconvened in the plenary session – having shared their goals and action-points. The director of Restless Development thanked everyone for their participation, and asked for commitment for the way forward. The session was then closed.