

Chapter 22

Case Study Theme 2: Youth and Health – South Africa and India

22.1 Introduction

This chapter looks at two case studies on health provision and young women's reproductive health services from India and South Africa. The case study from India focuses on a youth-led audit of services, while the study from South Africa looks at initiatives to set up youth health centres with capacitated staff, guidelines and services. It is set against Goal 3: Good Health and Wellbeing.

22.2 The Youth-Friendly Health Services programme, South Africa

The following case study is based on a report¹ of a youth-friendly health services programme that was designed for greater access to health for young people in South Africa. It demonstrates a means of mainstreaming young people's concerns into healthcare provision. Instigated by an NGO called LoveLife, the programme was subsequently taken over by the Department of Health, South Africa.

Youth analysis of reproductive health issues and service provision: The concerns that resulted in the project included 2011 statistics in South Africa that indicated 12 per cent HIV prevalence among young women (aged 15–24 years) and 5 per cent among young men. Half of women had given birth by the

Box 22.1 SDG 3 Good Health and Wellbeing

Targets: 3.7 Universal access to sexual and reproductive healthcare services, universal health coverage; 10.2 mentions social inclusion

Main sector: Health

Issue: Youth access to services in health

Strategy: Youth-friendly health services, India and South Africa

age of 20 years, while two-thirds of adolescent (15–19 years) pregnancies were reported as unwanted. Nine per cent reported having had sex before the age of 15 years, with early sexual debut associated with increased risk of HIV infection, other sexually transmitted infections (STIs), adolescent pregnancy, forced sex and an increased number of lifetime partners, as well as with decreased use of condoms and other contraceptives. Knowledge about sexuality and reproductive health among young men and young women was limited, and young people reported a need for more information on relationships, pregnancy and STIs.

In this context, the response of the health sector to ensure young people's optimal access to services was less than satisfactory. Some concerns raised by young people were:

- Attitudes of health sector staff: They feared the judgmental attitudes of healthcare workers, which they saw as a barrier to their use of a range of health services in South Africa. Young people engaging in sexual activity were branded as 'naughty'.
- Violation of young people's right to confidentiality: Young people over the age of 12 in South Africa have the right to legally access health services without parental consent. These services include HIV testing and treatment, contraceptives and other reproductive health facilities. This right, however, was rarely upheld, with health officers often seeking permission of parents, or informing parents of the young person's healthcare needs, thus breaking young people's right to confidentiality.

It is in this context that the NGO LoveLife realised the importance of youth-friendly health services that provided sensitive help to young people to encourage their entry into safe, confidential spaces in healthcare where they felt valued, respected and their confidentiality protected, and where they also obtained the services they required.

The programme, called the National Adolescent-Friendly Clinic Initiative (NAFCI) and launched in 2001, targeted young people aged 10–24 and aimed to promote access to and utilisation of youth-friendly services (YFSs), improve the health status of young people, build the capacity of healthcare providers to provide YFS, and to promote services for HIV-infected and

HIV-exposed young people. It trained service providers on youth-friendly health services, improved facilities, and used multimedia campaigns and activities in the community and with other sectors. LoveLife supported the Department of Health (DoH) by developing training curricula, programme guidelines and implementation tools, and by facilitating YFS training for Department of Health practitioners at the department's request.

A set of 'adolescent-friendly' standards, which included those relating to the types of services provided, policies supporting adolescents' rights to healthcare and the clinic environment, were defined for clinics to work towards using a facilitated approach. These standards remain an integral component of the project. The DoH was an active partner from the programme's inception, and by 2005 350 clinics nationwide were involved.

A challenge with the programme has been the lack of monitoring and evaluation since the handover, which limits learning and improvement.

22.3 *Seen, Not Heard: Youth-led audit of sexual and reproductive health services in Lucknow, India*

The *Seen, Not Heard* study, youth-led research conducted by 12 young service users in Lucknow, India, in 2016, is progressive in its methodology of young people defining the research questions, designing and implementing the research, analysing the data and writing the report. The findings will inform policy-makers of issues young people face in accessing reproductive health services, as well as recommendations for improving information, services and access.²

The YP Foundation (TYPF) is a youth-led organisation based in New Delhi, India, that supports young people to create programmes and influence policies in the areas of gender, sexuality, health, education and governance. In the last 13 years, TYPF has worked directly with 6,500 young people to develop their perspectives and critical thinking on issues of social justice and human rights and set up more than 300 projects in India, reaching out to 450,000 adolescents and young people between the ages of 3 and 28 across 18 of India's total 29 states and 7 union territories.

TYPF's work on sexual and reproductive health is based on the recognition of the lack of adequate information on sexuality

available to young people, paternalism and misplaced adult perceptions of sexual inactivity. Such populist attitudes can wrongly inform policies and provision of reproductive health services, reduce access to affordable and good-quality healthcare, and increase negative impacts on young people's physical and psychological wellbeing. TYPF's flagship programme, Know Your Body, Know Your Rights, advocates for the inclusion of comprehensive sexuality education in policies and government programmes to counter such attitudes and outcomes.

At the point of accessing services, young people's rights are legally circumscribed by laws that require parental consent for certain services, such as terminating early pregnancy for under-18s, which pushes young girls to accessing illegal and unsafe abortion services. A recently enacted law against child sexual abuse, the Protection of Children from Sexual Offences (POCSO) Act, contains certain clauses that prevent medical practitioners from providing services. Section 20 of the Act makes it mandatory for service providers to report any sexual acts between people under 18 years of age. In practice, this translates in to doctors refusing to provide sexual and reproductive health (SRH) services to young people under 18, since this then requires mandatory reporting.

The context is also one where young people are attaining puberty at increasingly early ages (as young as 8) and where, by age 16, most young people have engaged in sexual activity. Coupled with this, young people are not seen as capable decision-makers, owing to their explorative and experimental nature, and sexual education is seen as a dangerous catalyst to sexual activity.

This mind set has hindered any attempts (by government and NGOs) to make comprehensive sexuality education accessible. An Adolescent Education Programme (AEP) launched by the Government of India in 2007 is a case in point. The AEP was suspended in several states because of objections raised by teachers, parents and policy-makers on grounds that its explicit content was contrary to India's culture and morality.

This has affected young people negatively through increases in STIs, violence, early marriage, unplanned pregnancy, mental health issues etc. Increased rates of death due to HIV have also escalated so that it is in second position in the top ten causes of death among adolescents.

This is unlike in South Africa, where independent access to reproductive health services is assured legally for all youth above 12 through laws that provide them with such access and assure them confidentiality rights, which does not require parental notification (see story above). The obstacle observed in South Africa was that institutional and staff measures do not honour this legally binding right.

The research: Young people who were themselves service users led the research design, implementation and analysis. They set their own research agenda and conducted their own analysis based on their lived experiences as service users. The study was done in the above context of a lack of information and services.

The study aimed to:

- generate evidence through youth-centred processes;
- increase visibility of existing youth-friendly health services, in particular stigma-free access to reproductive health services;
- create a cadre of young leaders equipped to advocate for and assess stigma-free health services, including counselling and service provision; and
- contribute to existing information on the availability and quality of existing health services, especially for unwanted early pregnancies.

Training: A week-long training programme was designed to capture the team's collective views on what would make health service delivery 'youth-friendly'. Based on this input and that obtained from select external resources, standards of youth-friendly health services (YFHS) were delineated against which the quality of each service/health centre would be assessed. A mapping implementation tool were developed to facilitate collection of the corresponding data.

Researchers: Twelve young people trained throughout one year in sexual health and rights, with an express realisation and articulation that sexual health rights are in fact human rights. Researchers were aged between 18 and 27, with an average age of 23. Their research capacity was built through enhancing their capacity to lead a research study and conduct a social audit, enhancing their knowledge on current

government schemes and guidelines that endorse YFHS, and refresh their technical knowledge on sexual and reproductive health rights (SRHR).

Sites of intervention: The study was conducted with a variety of service providers, including government, private health providers, NGOs and illegal street-side service providers, who offered varying degrees of privacy, confidentiality, affordability, accessibility etc. to service users. While unauthorised street-side services offered confidentiality, they also provided the least safe methods/services.

Findings: These included inadequate distribution of clinics, unregulated pricing by private healthcare providers, making them unaffordable for young people, lack of counselling services in private facilities and, again, unaffordability of services where they were available. Other findings included a lack of information or misinformation on SRHR, provider bias preventing access to services for single/unmarried young people, especially young girls and women, medical diagnosis overriding patient's informed choice and consent, stigmatising of HIV-related services, and absence of counselling services creating anxiety and uncertainty among young people.

Recommendations: These comprised basic SRHR knowledge for all service providers; non-judgemental and rights-affirming service delivery; wide dissemination of good-quality information on young people's sexual and reproductive health and services; affordability of commodities and services; accessible facilities and information; expanding the outreach of adolescent-friendly health clinics; fast-tracking the selection, appointment and training of peer educators; improving infrastructure to ensure privacy for patients; mainstreaming comprehensive sexuality education; and lifting the region's ban on the Adolescent Education Programme (AEP).

22.4 Implications: what enablers/disablers influenced the process?

The two programmatic and research-based initiatives above have several implications for youth mainstreaming in the health sector and demonstrate both enablers and disablers in relation to the Enablers Framework in Chapter 4 (Table 22.1).

Table 22.1 Youth and health case studies: analysis of enablers and disablers

Enablers/disablers	Elaboration
Societal	<ul style="list-style-type: none"> Negative attitudes and misinformation about young people's sexual activity
Structural – macro	<ul style="list-style-type: none"> Public funding constraints for additional financing of youth-friendly spaces Private healthcare service delivery not regulated to ensure access to affordable, quality healthcare for the most marginalised
Structural – meso	<ul style="list-style-type: none"> Low visibility of political will for legally sanctioning youth health rights, particularly reproductive health rights Where rights are legally sanctioned, a lack of political will to translate law into practice
Organisational – structures	<ul style="list-style-type: none"> Collaboration between youth-led organisations and healthcare facilities Collaboration between non-governmental and governmental health sector stakeholders on youth issues Meaningful, long-term rights-based training of staff on youth and health rights Institutional vision and transformation Recognition of the need for separate medical healthcare spaces for young people to ensure privacy and confidentiality
Organisational – process	<ul style="list-style-type: none"> Meaningful youth participation and youth-led research processes Integrating youth work into youth and health processes
Impact	<ul style="list-style-type: none"> Greater access for young people of youth-friendly services, with confidentiality and privacy respected (South Africa) Youth-centred knowledge provides recommendations for institutional transformation in provision of youth-friendly healthcare services (India)

Governments and other stakeholders considering mainstreaming youth in healthcare facilities need to:

- inquire into fiscal commitments for additional funding to sustain a youth-friendly healthcare structure and staff training;
- transform healthcare institutions to integrate young people at all levels of design and planning of healthcare services;
- measure impacts of young people's access to health services, and outcomes for young people of healthcare disaggregated for youth as a specific age cohort with specific healthcare needs;

- commit to legal enactments to ensure young people's access to health and reproductive health facilities; and
- ensure that legal provisions are translated into practice through staff and organisational capacity building.

The youth sector's role:

- work with the health sector to impart youth-led research skills and youth work skills; and
- work with the health sector on youth empowerment factors in relation to young people as health service receivers.

22.5 Conclusion

Both studies above demonstrate the need for institutional and attitudinal transformation to provide meaningful youth- and gender-sensitive services to young people. They also demonstrate the need for collaboration across youth-focused stakeholders, including government departments, young service users and services.

Notes

- 1 World Health Organisation 2009.
- 2 This case study is drawn from material available in the full report, *Seen, Not Heard: Youth-Led Audit of Sexual and Reproductive Health Services in Lucknow* (YP Foundation N.D.).

References

- World Health Organization (2009), *Evolution of the National Adolescent-Friendly Clinic Initiative in South Africa*, World Health Organisation, Geneva, available at: http://apps.who.int/iris/bitstream/10665/44154/1/9789241598361_eng.pdf
- YP Foundation (N.D.), *Seen, Not Heard: Youth-Led Audit of Sexual and Reproductive Health Services in Lucknow*, available at: <http://www.theypfoundation.org/wp-content/uploads/2016/10/SeenNotHeard-English.pdf>