

The Kingdom of Eswatini

ESWATINI MINISTRY OF HEALTH

NATIONAL GUIDELINES FOR ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

2021



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ACRONYMS

AA-HA	Accelerated Action for the Adolescents
AFS	Adolescent Friendly Services
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
AMICAALL	Alliance of Mayors Initiative on Community Action on Aids At the Local Level
ANC	Antenatal Care
APH	Ante-partum Hemorrhage
ARV	Antiretroviral
ASRH	Adolescent Sexual and Reproductive Health
AU	African Union
AWD	Adolescents With Disabilities
AYFHS	Adolescent Youth Friendly Health Services
CCF	Congestive Cardiac Failure
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CIC	Combined Injectable Contraceptives
CMIS	Client Management Informations System
COC	Combined Contraceptives
CRC	Convention on the Rights of the Child
CSE	Comprehensive Sexuality Education
DMPA	Depot-medroxyprogesterone Acetate
EHCP	Essential Health Care Package
EMONC	Emergency Obstetric Care
ESA	Eastern and Southern Africa
FAM	Fertility Awareness Method
FBO	Faith Based Organizations
FLAS	Family Life Association of Swaziland
FP	Family Planning
GBV	Gender-Based Violence
HCP	Health Care Provider
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System

HTC	HIV Testing and Counseling
HTS	HIV Testing Services
ICPD	International Conference on Population and Development Programme of Action
IEC	Information, Education and Communication
IPC	Infection Prevention and Control
IPPF	International Planned Parenthood Federation
IUCD	Intra-Urine Contraceptive Device
///LAM	Lactational Amenorrhea Method
LARC	Long-Acting Reversible Contraceptives
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LSE	Life Skills Education
MHM	Menstrual Health Management
MICS	Multi Indicator Cluster Survey
MNCH	Maternal Neonatal and Child Health
MOH	Ministry of Health
MOYSC	Ministry of Youth and Sport Council
NCD	Non-communicable Diseases
NGO	Non-governmental Organization
NRH	National Referral Hospital
OPD	Out Patient Department
OVC	Ophanaged and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHU	Public Health Unit
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
POI	Progesterone Only Injectables
POP	Progesterone Only Pills
RHM	Rural Health Motivators
RRH	Regional Referral Hospital
SADC	Southern African Development Community
SDG	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SHIMS	Swaziland Health Incidence Measurement Survey
SRH	Sexual and Reproductive Health
SRHMNAH	Sexual, Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition

ASRHR	Adolescent Sexual and Reproductive Health Rights
SRMNAH	Sexual, Reproductive, Maternal, Newborn, and Adolescent Health
STI	Sexually Transmitted Infection
SWAAGA	Swaziland Action Group Against Abuse
TVET	Technical Vocational Education and Training
UN	United Nations
UNDP	United Nations Development Projects
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
YFS	Youth Friendly Services

FOREWORD

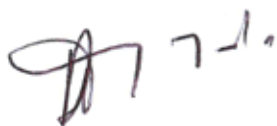
The country is accelerating efforts toward the realization of Sustainable Development Goals (SDGs) and strengthening the access and utilization of SRH services at all levels is one of the key initiatives that the Ministry of Health is targeting (see annex 2 for UN SDGs). High maternal mortality rate, high adolescent fertility rate, unmet need for family planning, and on-going problems with sexual and gender-based violence (SGBV) are some of the indicators that highlight a need for a comprehensive sexuality education and evidence- based interventions.

According to the ICPD's statistics on adolescent health, 80 million women each year have unwanted or unintended pregnancies, 45 million of which are terminated and of these abortions, 19 million are unsafe. And 40% of these abortions are done by women aged under 25 years, and about 68 000 women die each year from complications of unsafe abortions.

An estimated 340 million new cases of four common STI's and protozoal infections are acquired every year, at least a third of which affects people aged under 25 years. Such conditions contribute to global infertility WHO 2016.

Our youth population stands at 37.4%, which is a significant proportion of the Eswatini population. They are essentially the cornerstone of development and economic growth in Eswatini, however, this cannot be realized if they are subjected to a number of relentless challenges. Chief among these are the issues of unemployment, access to all health services especially sexual reproductive health services, access to education including remaining in school and eventually accessing tertiary education to name a few.

This document is drafted in response to the above stated challenges and will ensure that we transform the standard of SRH services for all adolescents and youth towards a brighter future. Essential to ASRH is the strengthening of preventative services through health education and information; this will help adolescents and the youth to make informed decisions regarding their health. Informed health decisions have an impact in the reduction of early sexual debut, teenage pregnancy and HIV & STI's incidence.



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CHAPTER 1: BACKGROUND AND USE OF GUIDELINES

1.1 Definitions

WHO described adolescence as the “period in life when an individual is no longer a child, but yet an adult. It is a period in which an individual undergoes enormous physical and psychological changes. In addition, the adolescent experiences changes in social expectations and perceptions. Physical growth and development are accompanied by sexual maturation, often leading to intimate relationships.”

This guideline adopted WHO defined age of adolescents as individuals in the 10–19-year age group. It is important to note that the needs of adolescents vary with their sex, stage of development, life circumstances and the socio-economic conditions of their environment.

1.2 Eswatini’s Adolescents Demographics and Socio-economic Information

There are approximately 247,605 (23%) of adolescents in Eswatini’s total population of 1,093,238. Adolescents accounts for half (23%) of the total population of 56% below 25 years of age. Table “” shows the regional and national distribution of adolescent population in Eswatini.

Table 1: Distribution of adolescent population in the year 2017 of the population census

Region/ National	Population	Adolescent population	Adolescent population (%)
Hhohho	320,651	71,214	22%
Manzini	355,945	74,652	21%
Shiselweni	204,111	50,916	25%
Lubombo	212,531	50,823	24%
Eswatini	1,093,238	247,605	23%

1.3 State of Adolescent and Young People in Eswatini

Eswatini has had achievements in education and life expectancy (UNDP 2018), reinforced by improvements in primary education and the introduction of technical vocational education and training (TVET), despite the latter sector is largely unregulated. The increased life expectancy has mainly been achieved through strengthened health education and behavioral change interventions, as well as improved access to health commodities and services. According to the country's recently updated Youth Policy, 2020 these achievements in health and education are undermined by the persistence of harsh realities and challenges faced by young people in the country, as discussed below:

HIV/AIDS

HIV/AIDS continues to be one of the most pressing challenges facing young people in the country with heightened vulnerabilities for girls and young women. HIV prevalence among adolescent girls aged 15 – 19 years is 10.2 percent, compared with 1.9 percent for males of the same age. In the age group 20 – 24, HIV prevalence among females is 38.2 percent, compared with 12.3 percent for males in the same age group. HIV incidence is also significantly higher among adolescent girls aged 15 – 19 compared with males of the same age group, standing at 3.84 percent and 0.84 percent, respectively.

Adolescents living with a disability

According to the Census of 2017, the population of children with disabilities in Eswatini within the age range of 0-19 stands at 55 613 (making up 31.6 percent of all disabled people in the Kingdom). Adolescents with disabilities (AWD) have distinct health needs as well as socio-economic challenges. These AWD often have an unmet need for SRH services, as a result of exclusion from SRH programming, negative attitudes of service providers, lack of capacity of health providers to meet their needs, long queues at health facilities, distant health facilities, high costs of services involved, unfriendly physical

structures and often (mis)perceived as not being sexually active.

The AWD are sexually active as young people without disabilities, but they are three times more likely to experience sexual violence, putting them at increased risk of unwanted pregnancy, STIs, and HIV. AWD has less access to health (including mental health and psychosocial support) and legal services. Adolescents with disabilities are at increased risk of other human rights violations such as sexual violence, exploitation, and forced marriage. This guideline also applies to AWD, highlighting the MOHs commitment to ensuring access to SRH services for this group of adolescents.

Teenage Pregnancy

The adolescent birth rate in the country stands at 87/1000 adolescents and teenage pregnancy is one of the main factors contributing to school drop-out rates. Early sexual debut is one factor influencing early and unintended pregnancies, with a median age at first sex being 16 and 18 years for girls and boys, respectively. Another contributing factor to early pregnancy is early marriage, with 9 percent of AGYW married by age 18 (MoH UNICEF 2014). The drivers of teenage pregnancy in the country include low education, poverty, low SRH knowledge, gender inequality, and limited access to SRH-related services, especially family planning.

Gender-Based Violence

Young people in the country continue to experience very high levels of violence, particularly girls. The national estimate is that one in three women has experienced some form of sexual violence by the time they are 18 years (UNICEF 2007). This reflects the harsh reality that violence is experienced by children very early in their lives at a time when all that they should be occupied with is school and playing. The Deputy Prime Minister's Office (2014) reported that 48 percent of Adolescent Girls and Young Women (AGYW) aged between 13 – 24 years reported experiencing some form of sexual violence. Boys aged

14 years and below are not spared from this violence, as 68 percent of them reported to have experienced violent physical discipline, while 88 percent of boys and girls aged 14 or below reported experiencing psychological aggression or physical punishment. However, the reporting of cases of violence by young people has remained low, with less than violence reporting such incidents. It is with the hope that more cases of violence will be reported with the recent passing of the Sexual Offences and Domestic Violence Act, 2018.

Sexual and Reproductive Health in Eswatini: Program and Guiding Policy Context

Currently, the country has an SRH Program, mandated to coordinate the health sector's response to SRH through well-integrated service delivery and capacity building for health care providers. The program addresses adolescents' sexual and reproductive health services through a sub-program housed within the SRH Program as well as through the school health program for in-school adolescents. Non-governmental organizations such as the Family Life Association of Swaziland (FLAS), SHAPE, UNICEF, UNFPA, AMICAALL, Lusweti, Supper Buddies, Bantwana, Baylor Swaziland, Swaziland National Youth Council, etc. continue to play a key role in providing services to young people in the country. Save the Children focuses on advocacy and rights as well as SWAAGA.

These guidelines are in line with national, regional, and international legal documents Eswatini Government committed to through enactment of key national policies and being a signatory to several regional and international commitments including the International Conference on Population and Development (ICPD) Programme of Action (1994), Maputo Plan of Action 2007 – 2010, the AU Continental Policy Framework on SRHR and the Southern African Development Community (SADC) Protocols.

The Sustainable Development Goals (SDGs) transformative agenda positions the adolescents and youth at the center of development as envisaged in goals 3, 4, and 5. These goals express good health and well-being; quality education and gender equality respectively. In addition to the international and regional legal documents, Eswatini is also committed to the updated Global Strategy for Women's, Children's and Adolescent health (2016 – 2030) whose 3 main objectives are to survive, thrive and transform, recognize adolescents' right to health, education, well-being and their full and equal participation in the society.

Through the National Policy on Sexual and Reproductive Health, the Government of Eswatini outlines policy statements on SRH elements that Government shall implement with partners. This includes the AYSRHHR and elements which provides that Government shall provide comprehensive sexuality education, information, and integrated SRH services to all children, adolescent and young people at all levels of health care delivery systems and other relevant settings according to the age and need. Additional policy documents that support AYSRHHR include the Sexual Offences and Domestic Violence Act (2018), National Youth Policy (2020), National Health Policy (2007), National Health Sector Strategic Plan III (2018), National Population Policy Framework (2002), and the Education Policy.

Finally, Eswatini has a Children Protection and Welfare Act (2012) and the Persons with Disabilities Act (2018) which provide the legal framework to support the provision of AYFS.

1.4 Rationale for Revision

In a 2015 and 2016 study initiated by the MoH to assess the AYFHS status of the National Health Facilities (HF), the findings revealed that youth-friendliness of health services in the country is generally poor. This was reaffirmed by UNFPA in a report published in 2019, which revealed that

poor access to SRH information and services continue to persist. A very limited number of healthcare facilities in the country have youth-friendly services, and this deters young people from accessing SRH information and services from these institutions. This is despite having national standards developed and disseminated to facilities on how facilities can respond to young people's SRH needs.

These gaps, coupled with new developments by the SDG's, Sexual Offences and Domestic Violence Act (2018), National Youth Policy (2020), National Health Sector Strategic Plan III (2018), and Swaziland Essential Health Care Package II (2017) among others informed the revision of the ASRH Guidelines (2013).

The revised guidelines aim to provide a framework for the provision of comprehensive adolescent and sexual reproductive health services including youth friendliness and the sexual and reproductive rights accompanied with provision to such services. The guidelines also provide an implementation framework for coordination, monitoring, and evaluation. It will also be used as a reference document for assessing the quality of care and compliance with a set of accepted standards.

1.5 Purpose of the Guidelines

The document aims at providing comprehensive and integrated information and services for the provision of quality Adolescent Sexual and Reproductive health.

Goal

The Sexual, Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (SRMNAH&N) Strategic Plan 2019 – 2023 has outlined the goals as it relates to ASRH. The prioritized interventions around adolescence were aligned with Accelerated Action for the Adolescents 2017 (AA-HA). Five high impact strategies are presented

below for adolescents:

- Ensure availability and promotion of high impact integrated, comprehensive, and quality adolescent friendly SRH interventions at all levels of care.
- Empower adolescents and young people with correct, adequate knowledge and skills to demand for and access SRH services including FP.
- Engage with 'gate keepers' including parents, religious and traditional leaders to promote demand and utilization of comprehensive ASRH services.
- Promote active and meaningful participation of adolescents and young people in design, implementation, monitoring, and evaluation of ASRH health services.
- Integrate interventions for prevention, treatment and care among adolescents living with HIV/AIDS

Objectives

The goals highlighted above will be met through the following specific objectives:



To define the essential package of health services to be provided to adolescents and youth at service delivery points



To standardize the provision of quality AYFHS at all levels



To increase access to comprehensive and integrated sexual and reproductive health information and services among adolescents and youth



To strengthen collection and utilization of age and sex-disaggregated data on sexual and reproductive health among adolescents and youth

1.6 Intended Audiences and Targeted Beneficiaries

Intended Audiences

These service guidelines are intended to be used by health care providers to expand and improve the quality of adolescent SRH services everywhere in the country. These groups include:

- Program Managers
- Nursing students
- Policy Makers at all level
- Service Providers
- NGO and Faith-based Organizations
- Adolescent and Young People
- Teachers
- Community members including RHMs
- Parents

Targeted Beneficiaries

These guidelines are developed for the benefit of all adolescents and youth in Eswatini. All adolescent males or females irrespective of their social standing are eligible for ASRH information and services. These groups are aged 10 – 19 years who live in rural/urban areas; in or out of school; working or not working; in higher education; youth enclosed settings; married or not; OVCs, gay; lesbian or transgender; living with HIV; with or without children; youth with disability; young people in humanitarian/emergency settings.

1.7 Guiding Principles

The implementation of the ASRH Guidelines shall be guided by the following principles:

Table 2: ASRH Guiding Principles

1. Adolescent Sexual and Reproductive Health Rights
Adolescents have the right to have adequate information and have accessibility to services that will enable them to make informed decisions on their sexuality and reproductive health.
2. Privacy and Confidentiality
Adolescents receiving services shall be accorded privacy and confidentiality at all costs. Information will not be shared with any significant other unless otherwise the client consents. Where shared confidentiality will be necessary, the respective adolescent will be alerted.
3. Gender and Culture dimension
Gender equality and cultural dimension will be of focus during interaction and service delivery for adolescents. Services offered shall be adapted to suit the adolescent cultural beliefs, values, and perceptions if these are not detrimental to the services or information offered.
4. Universal access to comprehensive SRH services
There will be a provision of relevant education and information to in and out of school adolescents for them to make appropriate decisions regarding SRH issues. The guideline also emphasizes that care should be taken to consider the provision of services and information to the more disadvantaged groups in terms of low social-economic standing such as poverty, disability, geographical location, education, age, sex, gender
5. Social participation
Social partners such as government, non-governmental organizations, faith-based organizations, and churches shall be involved at all levels from planning through evaluation of activities. Social actors (adolescent boys and girls) will be engaged to popularize mobilization.

6. Communication

Clear and effective communication is the starting point in helping the adolescent to develop appropriately transition accordingly to adulthood. The provider/counselor should be able to communicate appropriately to understand the perspective of the adolescent and respond accordingly to create a positive and effective service experience. Positive provider-client interaction shall benefit the adolescent because s/he will feel more comfortable expressing her/his concerns or problems, thereby enabling the provider to effectively serve the adolescent's needs.

1.8 Sexual and Reproductive Health Rights

The United Nations (UN)(Year of production) defined sexual and reproductive health rights as matters relating to multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination. Member states of the UN have obligations to respect, protect, and fulfill rights related to sexual and reproductive health. Sexual and reproductive rights are enshrined in the Constitution of Eswatini. The country has reinforced its commitment to guaranteeing these rights through being a signatory member of several international agreements and treaties.

Quality of SRH services can lead to increased demand for and acceptability of services, therefore the quality of services should be regarded as the right of the client and everyone who seeks SRH services. The needs of service providers are equally as important in ascertaining SRH rights. Providers relate to clients as human beings and have attitudes and skills that are influenced by the working environment.

Table 3: Elements of Client Rights

Right to Life - This should not be put at risk by pregnancy and childbirth, gender, or lack of access to health information and services. This also includes the right to have a satisfying, safe, and pleasurable sex life.
Right to liberty and Security - No woman should be subjected to forced pregnancy, forced sterilization, or forced abortion.
Right to Equality , and to be free from all forms of discrimination - This includes, among other things, freedom from discrimination because of one's race, poverty, sex or sexual orientation, marital status, religious or political opinion.
Right to Privacy - All sexual and reproductive health care services should be confidential in terms of physical set-up, the information is given or shared by the clients, and access to records or reports.
Right to Information and Education - Everyone has the right to access full information and education on benefits, risks, and effectiveness of all methods of fertility regulation, to make decisions based on full, free and informed consent. In addition to this, is the right to know about the benefits and availability of SRH services.
Right to Choose Whether or Not to Marry and to Plan, a Family - This includes the right of persons to protection against a requirement to marry without his/her consent. It also includes the right of individuals to choose to remain single without discrimination and coercion.
Right to Decide Whether or When to Have Children - This covers the right to decide freely and responsibly the number and spacing of their children and to have access to related information and education.
Right to Health Care and Health Protection - This entails the right of clients to the highest possible quality of health care, and the right to be free from harmful traditional health practices.

Right to Access Technologies that have the potential to improve health outcomes. This includes the right of sexual and reproductive health service providers to avail the new reproductive health technologies that are safe, effective, and acceptable to clients.
Right to Freedom of Assembly and Political Participation - This includes the right of all persons to seek to influence communities and governments to prioritize sexual and reproductive health and rights.
Right to Development - All individuals have the right to access development opportunities and benefits, especially in decision-making processes that affect his/her life.
Right to be Free from Torture and Ill-Treatment - All women, men, and young people have a right to protection from violence, sexual exploitation, and abuse.

Provider Needs

1. Need for appropriate training and regular updates on new ASRH information to access knowledge and skills that will lead to the efficient performance of designated tasks.
2. Need for information relating to how they can complete their duties in attending to ASRH needs (clear job description).
3. Need for infrastructure that is appropriate for the provision of acceptable quality of care and observance of client rights to privacy and comfort.
4. Need for adequate supplies to ensure quality and continuity of care.
5. Need for supportive supervision to reinforce their knowledge and skills for delivering high-quality care.
6. Need for back-up whenever there is a need for referrals for consultation.
7. Need for positive and constructive feedback on services delivered.

8. Need for continuous encouragement to enhance and stimulate creativity and autonomy commensurate with their capabilities.
9. Need for self-expression regardless of the level of facility in which they are deployed.

CHAPTER 2: ADOLESCENT GROWTH AND DEVELOPMENT

2.1 Developmental Characteristics of Adolescents

Adolescence is a stressful period of life as the transition between childhood and adulthood occurs and it is characterized by discernible physical, mental, social, **and behavioral changes**. It is important to note that girls experience adolescence differently from boys and each girl may progress differently throughout adolescence.

Body changes in Girls (Physical and emotional, social)

Table 4: Body changes in girls

Physical changes	Emotional changes	Social changes
Breasts grow bigger	Mood swings occur	Peer Pressure
Hips become round		Friends matter more than they used to
Hair begins to grow in the private parts	Attachments to friends	Partying
Menstruation begins	Issues of Identity	Experimentation and curiosity
Develop pimples	Become sensitive	Social disorder
	Conflicting thoughts	Concern about body image
	Sexual feelings begin to occur	Sense of belonging
	Become aware of their bodies	Self-centered

Body changes in Boys (Physical and emotional, social)

Table 5: Body changes in boys

Physical changes	Emotional changes	Social changes
Shoulders grow bigger	Mood swings occur	Peer Pressure
Voice becomes deeper	Feelings of superiority begins to occur	Friends matter more than they used to
Hair begins to grow in the private parts	Attachments to friends	Partying
Wet dreams begin	Become aware of their bodies	Social disorder
Muscles Develop	Feeling sensitive	Concern about body image
	Issues of Identity	
	Conflicting thoughts	
	Sexual feelings begin to occur	

Dealing with changes associated with puberty

Adolescents need information about how to comfortably and realistically manage the physical changes in their body during puberty:

- Acne or oily skin: The face should be clean to reduce facial oil and prevent or reduce pimples and acne.
- Body odor in both boys and girls: Wash every day with warm water and soap to keep the body clean and smelling good. Youth can use deodorant and make sure to wash clothes regularly.
- Menstruation for girls: Girls can use products like sanitary pads. Girls may want to carry such items in their bags, so they are prepared for when their period starts, no matter where and when it happens.

2.2 Delaying Sexual Debut

What is delaying sexual debut?

A process whereby your first sexual encounter is postponed or delayed until a certain period – it can apply to both boys and girls. Sex is a normal, natural part of life, however as human beings, we have been given a long period to prepare our minds, bodies, and hearts for the beauty of a positive sexual experience.

Why Delay Sexual Debut?

- To reduce the prevalence of HIV: The second SHIMS 2017 findings reported that among adults (defined as those aged 15 years and older), HIV prevalence was higher in those with early sexual debut (37.2%) compared to those with sexual debut at ages 25 years and older (23.7%). Among those who reported early sexual debut, 18.7% of males and 50.6% of females were HIV-positive.
- To reduce the rate of unintended teenage pregnancies: Eswatini has experienced 83,393 teenage pregnancies in the past seventeen years (2001 – 2017). On average 5,100 teenage pregnancies are experienced on an annual basis in Eswatini.¹
- To reduce the incidences of sexually transmitted infections and complications highly likely to occur when sexual debut started early.

¹ N. Dlamini. (2019). The Implication of Teenage Pregnancies in Eswatini: A Trend and Spatial Analysis. Eswatini Economic Policy Analysis and Research Centre.

Table 6: Dangers of early sexual debut and benefits of delaying sex

Dangers of Early Sexual Debut	Benefits/ Rewards of delaying sex
• Teen pregnancy - • Sexually transmitted infections (STIs) • HIV infection • Emotional stress • Regret and self-recrimination • Guilt • Abortion • Loss of self-esteem and self-respect • Loss of pride • Lack of trust • Depression and suicide • Damaged or ruined relationships • Stunted Personal Development • Negative effects on marriage	• Increased self-respect • Teaches you to respect other people • Takes-pressure off you • Free from STI and /HIV infection • better sexual relationship in marriage • Body develops and graces well • More satisfying and stable relationship later. • Reduced chances of death. • Less or no experience of sexual abuse.

2.3 Comprehensive Sexuality Education/Life Skills Education

Sexual and reproductive health and rights (SRHR) are based on the right and the ability of all individuals to decide over their bodies and to live healthy and productive lives. Addressing SRHR remains key to ensuring sustainable development and prioritizing SRHR as part of its health, gender, human rights, and sustainable development work. Comprehensive sexuality education (CSE) / Life Skills Education is part of the overall efforts within SRHR and is integrated into schools' curriculums and in policies on different levels of education.

Definition of Comprehensive Sexuality Education (CSE)

Comprehensive sexuality education (CSE) is defined as a “rights-based and gender-focused approach to sexuality education, whether in school or out of school”. By embracing a holistic vision of sexuality and sexual behavior, not only focusing on the prevention of pregnancy and sexually transmitted infections (STIs), CSE enables adolescents and young people to:

- Acquire accurate information about sexuality, sexual and reproductive health, and human rights.
- Explore and nurture positive values and attitudes towards their sexual and reproductive health, and develop self-esteem, respect for human rights, and gender equality.
- Develop life skills that encourage critical thinking.
- communication and negotiation, decision-making, and assertiveness.

Objectives of Comprehensive Sexuality Education

- Promotes positive attitudes towards life e.g., safe sex vs. abstinence.
- Helps an adolescent and young person to recognize, identify, and accept self as a human being.
- Promotes self-knowledge as a factor of self-esteem and health care.
- Promotes responsible decisions to assure responsible behavior.

To date, sexuality education is still largely delivered in schools by teachers, peer educators/ community health facilitators in communities sometimes in collaboration with health workers. Comprehensive sexuality education should not be confined to young people only and still needs to be better developed and expanded to meet the needs of those who are not in school, including adult men and women.

2.4 Menstrual Health Management

Following the UN declaration on menstrual health management (MHM) in 2014, there has been limited investment and programs on MHM in Eswatini on various fronts and levels. The invisibility of MHM in policies, strategies, and guidelines has negative impacts on the health, wellbeing, and rights of girls and women in their reproductive years. Safe and decent MHM is severely compromised or threatened by a combination of issues that are of social infrastructural and economic nature.

Good MHM involves having access to materials and sanitation, other, less obvious aspects are just as important in MHM. These aspects include:

- Access to a private space to change and clean during menstruation.
- Access to safe water.
- A social environment that does not stigmatize and silence women on menstruation matters.
- Accurate education on menstruation and menstrual sanitation; and knowledge about puberty and the relationship between menstruation and Sexual and Reproductive Health Rights (SRHR).

CHAPTER 3: ADOLESCENT FRIENDLY SERVICES

3.1 Definitions

Adolescent friendly services are means to provide access to SRH services observing privacy, confidentiality, non-judgmental, and timely among adolescents. Adolescent friendly services are commonly referred to as youth-friendly services (YFS).

According to the Standard Implementation Assessment baseline report (2019)², there are currently fewer facilities, about 52 percent providing adolescent and youth-friendly services according. Structures within government facilities that were re-designed to offer such services were used for other services such as Prevention of mother-to-child transmission (PMTCT). In addition, health workers have been trained on AYFS, others on site whilst others were trained offsite. While numerous in-service training workshops have been conducted in the past it did not cater for pre-service. The MOH with support from UNFPA has developed an in-service adolescent Sexual Reproductive Health module for tertiary institutions (2018). There is also limited linkage between health facilities, school, and communities to enhance referrals and information education.

3.2 Situation of Adolescent Friendly Services in Eswatini

National standards for adolescents and youth-friendly health services (AYHFS) were developed in 2017. The development of these standards was in line with the SRH strategic plan 2014 – 2018, and it is the Ministry's demonstration of the ESA Ministerial commitment to be responsive to young people's SRH. The development of these standards is also responsive to the numerous adolescent sexual and reproductive health issues that generally affect the Swazi youth such as high teenage pregnancy rates, GBV, alcohol and substance use, poverty, unemployment, etc. (MOYSC,

2 Ministry of Health. 2019. Eswatini National Adolescent and Youth-Friendly Health Services. Standard Implementation Assessment. Baseline Report.

2015). These standards will serve as a benchmark for measuring quality in the provision of adolescent and youth SRH services.

In 2015, the MoH assessed if health facilities were providing adolescents and youth-friendly health services. The study found that adolescent and youth friendliness varied across regions. Generally, the study showed that adolescents were satisfied with the privacy they were afforded but were discontented with the waiting time. Only 14 percent of the facilities had Information, Education, and Communication (IEC) materials targeting young people, and about 14 percent of HCPs used visual aids during their education or counseling sessions.

In detail, there were 277 HFs assessed on AYHFS, and 1,440 young clients, as well as 271 HCPs, were interviewed. Of the nine standards assessed, standard 2 was the best-performing standard, achieving an overall score of 77 percent, followed by standard 4 with a score of 72 percent. Standard 6 had the lowest performance with an overall score of 31 percent, while standard 8 had the second-lowest performance with an overall score of 31 percent.

The standards on HF characteristics and the protection of ASRH complete the list of four standards that achieved scores above 50 percent, with 66 percent and 54 percent, respectively. Lubombo region presented a consistent high-performance level compared with the other regions in all standards, while the Hhohho and Shiselweni region presented a consistently poor performance across all standards, with a few exceptions. The Lubombo region achieved an overall performance level of 62.1 percent; 51.8 percent; 45.6 percent and 50.9 percent for the Manzini, Hhohho, and Shiselweni region, respectively.

Furthermore, most adolescents (25%) get SRH information from not so reliable sources such as peers (MoH 2016). Other than the cost implications, young adolescents' preference for private facilities for maternal, STI, and FP services (MoH 2016) is of concern and creates

questions in terms of how this group has been received and treated in the mainstream primary health care.

3.3 Adolescent Services Provided

The range of adolescent services provided by Adolescent and Youth Friendly Health facilities should be in line with the MoH Essential Health Care Package (2017) and these consists of the following services:



Figure 1: Components of ASRH Services

3.4 Who is Eligible for ASRH Information and Services?

Different target groups of adolescent and youth are eligible for ASRH information and services as indicated below:

• Adolescent living in urban and rural areas • In- and out-of-school adolescent • Employed and unemployed adolescent • Married and unmarried adolescent • Adolescent mothers and fathers • Adolescent living with HIV • Orphaned and Vulnerable adolescent • Adolescent battling with substance abuse • Adolescent incarceration (juvenile or prison)	• Adolescent involved in sex work • Adolescent without homes (street children) • Adolescent living in poverty • Adolescent with abortion and reproductive health complications • Adolescent in Humanitarian settings (refugees) • Adolescent men having sex with men • LGBTIs
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NOTE: It is important that parents, guardians, teachers, community leaders, employers, and the public are sensitized on ASRH and their support lobbied for.

3.5 Who Are the Providers of ASRH Services?

Adolescent people shall access ASRH services from health facilities including clinics, health centers, and hospitals; mobile clinics; non-governmental organizations (NGOs); faith-based Organizations (FBOs).

3.6 Where Is ASRH Provided?

ASRH shall be provided at all levels of the health care system in both public and private, non-governmental and faith-based organizations; educational institutions; correctional facilities; entertainment and recreation places; youth centers, clubs and groups; and other community structures.

3.7 How Are ASRH Services Provided?

The MoH has put in place the following strategies for the provision of ASRH services:

- Providing an enabling environment and resources for the provision of ASRH services
- Collaborating with other government ministries to advocate for the provision of sexuality education, ASRH information, and services at all levels.
- Strengthening integrated adolescent and youth-friendly services at health facilities
- Strengthening service providers skills and competencies in the provision of quality integrated capacity for the provision of ASRH services
- Promoting comprehensive SRH knowledge to adolescent through IEC material with emphasis on behavior change communication.
- Increasing the availability of ASRH commodities by working on the supply chain, quantification, procurement, and through collaboration across departments and programs
- Enhancing Life Skills for Adolescents
- Promoting gender equity in ASRH including strengthening provision of male-tailored services
- Strengthening research in ASRH

3.8 Characteristics of ASRH Services

a) Health Care Workers

All health workers should be trained on the provision of ASRH however, if impossible at least one health worker should be trained in AFS provision in each facility. Adolescent friendly health workers will be identifiable by the following:

- Ensure confidentiality and privacy (however, explain that shared confidentiality may arise if an adolescent is referred for other services to other health care workers or other institutions).

- Respect views and beliefs of adolescent if they are non-detrimental.
- Have enough time to interact with adolescents.
- Have the ability to communicate correct information with adolescents and keep the message simple.
- Use open communication and allow reflection on issues.
- Be able to use interactive approaches.
- Regularly train service providers on emerging issues

b) Health facility

Facilities that are adolescent-friendly will have the following qualities:

- Convenient location
- Clear signpost about ASRH services provided.
- Convenient opening times to adolescents (after school hours and weekend)
- Privacy in the examination, consultation, waiting rooms, and in the entrance/exit.
- Referral links to a peer educator and vice versa
- Information, education and communication material available (e.g., leaflets, posters, etc.)
- Where possible ensure audio and visual education at the waiting area
- Availability of suggestion box or hotline.
- Youth representation in monthly/ quarterly meetings (Quality of Care Committee in place).
- Conduct regular client satisfaction surveys.
- Conduct regular feedback and planning meetings.
- Availability of trained peer educators

c) Youth-friendly programs/services include

- welcoming registration/retrieval procedures to all adolescents and youth irrespective of geographical location and sex
- drop-in clients with or without prior appointments
- short waiting times

- affordable and flexible terms of payment
- signage, posters, and booklets informing and reassuring youth about services provided.
- wide range of services
- Proper Data Management system.

d) Adolescent and youth participation

Adolescent and youth participants will be achieved if they have:

- formation of the facility-based youth advisory committee
- youth involvement in planning, implementation, and evaluation of quality services
- well informed on available services and their utilization
- training of Community based youth on key SRH strategies, policies, and laws
- participate in SRHR and CSE advocacy interventions.

Special Considerations on ASRH Youth Friendly Services

Quality Assessment on AYSRH Services

- Conduct baseline and periodic assessments to determine the extent to which characteristics of the providers, structure, and design of the program meet the needs of adolescents.
- The assessment should be conducted in collaboration with young people using the Quality Improvement package.

Involvement of Male Adolescents

Adolescent and youth-friendly programs/services can be more male-friendly if they are:

- having more male clinic staff or counselors
- offering free condom supplies
- training health care workers on young men's SRH needs including men having sex with men.
- treating male clients more respectfully and sensitively
- Identifying young males as SRH champions.

Adolescence Friendly Centers and Clubs

- Where there are youth centers, they shall be used to integrate ASRH initiatives
- The Adolescent friendly clubs shall be administered by Peer Educators, as per the convenience of adolescents,
- with support from ASRHs and any local Youth NGO to support interactive information and education.
- They should provide a package of informative entertainment materials, including information on reproductive and sexual health, contraceptives, education, and career planning.
- Books and magazines, sporting, entertainment, and game equipment should be made available where possible.
- Adolescent friendly clubs should be established in clusters, with one club for every community.
- Adolescent Friendly Clubs should be organized at sub-centers, schools, and local assemblies, the clubs can also hold events. Activities also include sessions on life skills education facilitated by Peer Educators.

CHAPTER 4: CONTRACEPTION

For purposes of this guideline the use of contraception will be used interchangeably to mean family planning. Contraception counseling and services are provided to adolescents for their benefit. All contraception services provided should be in consideration to the prevention of STIs/ HIV, and unplanned pregnancies. Thus, the reason for the promotion of abstinence (delayed sexual debut) and dual protection for those adolescents who are already sexually active.

4.1 Definitions

Contraception is the intentional prevention of conception through the use of various methods entailing devices, sexual practices, chemicals, drugs and surgical procedures. There are several types of contraceptives that have been officially labeled as such because they have shown reliability in preventing conception from occurring (WHO).

Contraception information and services shall enable adolescent people to postpone childbearing and to space births which are key to healthier families when they start having their own families. Contraception is not only a matter of human rights; it is also central to adolescents' empowerment, reducing poverty, and achieving sustainable development. In addition, delaying sexual debut can ensure late and healthier start to childbearing. The Eswatini Government is, therefore, fully committed to supporting the provision of contraception services for adolescents to benefit the health and welfare of individuals, especially young women, and to improve the socio-economic status of the country.

Reasons for the provision of contraception services to adolescent are:

- Prevent early sexual debut and teenage pregnancy (16.7% MICS 2014)
- Early marriages

- To reduce unsafe abortion and its effects
- To reduce maternal and neonatal deaths
- For PMTCT reasons
- Contribute to the growth of the economy (keeping girls at schools)
- Promote girl empowerment

4.2 Offering Youth-Friendly Contraception Services

- Facilitate access, especially for adolescents to all types of services dealing with SRH concerns, and specifically, pregnancy prevention.
- Ensure that consent of spouses, parents, guardians, or relatives does not restrict access to services. Spousal/guardian counseling, however, is strongly recommended.
- Give special concern to the counseling of adolescents who do not want to involve parents or guardians, to ensure that they understand what is involved in their decision along with its possible consequences.

4.3 Contraception Commodities Available in Eswatini

As a country, we promote the use of modern methods of pregnancy prevention. However, natural methods are also a form of contraception which accommodates religion/spiritual beliefs.

Table 7: Available natural method of Contraception

Method	Description
Abstinence	Intentionally choosing not to have sexual intercourse (primary and secondary) for moral, health, religious, ethical, or birth control reasons. NB: Abstinence is mostly recommended for adolescents as an effective way of preventing HIV, STIs, and unplanned / unwanted pregnancies.

Lactational Amenorrhea Method (LAM)	A temporary pregnancy prevention/contraception method based on the natural effect of breastfeeding on fertility. NB: The adolescent should meet all three criterion The 3 criteria are: • The mother has not resumed menses since delivery • The baby should be exclusive breastfeed (breastfed of demand) • The baby is less than 6 months old
Fertility Awareness Method (FAM)	Contraceptive methods based on an awareness of the start and end of the fertile period of a woman's menstrual cycle. NB: The adolescent should meet all three criterion • Regular menses • Cycles monitored for 3 consecutive months • Adolescent should be able to monitor her ovulation dates
Coitus Interruptus (withdrawal)	It's a method in which the man completely removes the penis from the vagina and away from the external genitalia of the female partner before ejaculation. NB: • mostly effective in the first round of sexual intercourse. • There is need for serious collaboration, cooperation and communication

Table 8: Modern method of Prevention

Types	Protection Period	Common Side Effects	Special Consideration
Progesterone Only Pills (POP)	24hrs	• Amenorrhea • Breast tenderness • Headache • Weight gain	• Effective if used correctly and consistently during breastfeeding. • Change to other option after 6 months post-partum

Combined Oral Contraceptives (COC)	24hrs	• Amenorrhea • Breast tenderness • Headache • Weight gain	Not given to breastfeeding women less than 6 months post-delivery.
Progesterone only injectables (POI)	• 8 weeks (NET-EN/ NST) • 12 weeks (DMPA/ Depo-provera)	• Amenorrhea • Breast tenderness • Headache • Weight gain	DMPA possess a risk of reducing bone marrow density, give a 6 month break every after 2 years
Combined Injectable Contraceptives (CIC)	4 weeks (Norigynon)	• Amenorrhea • Breast tenderness • Headache • Weight gain	No given to breastfeeding women less than 6 month post-delivery
Progesterone Only Implants	• 3 years (Implanon NXT) • 5 years (Jadelle)	• Spotting and bleeding • headache	Due to Drug to Drug interactions with ARVs and other drugs the years of protection are reduced.
Intra-Uterine Contraceptive Device (IUCD) • Non-hormonal • Hormonal	• Up to 10 years • 3-7 years	• Spotting and prolonged menstrual bleeding • Abdominal cramps and pain • Women may develop PID • Pregnancy with IUCD	Not recommended for adolescents who are still virgins

Condoms (Female and Males)	As the condom is used and not teared	• Irritation • Spillage or breakage of the condom	• As a country, we promote condom use with every FP method to achieve dual protection • Encourage consistency and correct use of a condom with every sexual encounter.
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**Dual protection- the use of any FP method with a condom to ensure the prevention of HIV, STIs, and unplanned pregnancy.*

4.4 Where Shall Contraception Services Be Provided?

Contraception information and services shall be provided at all levels of care to every adolescent and youth for them to make informed choices. Condoms can be accessed at a community level through traditional outlets, shops, mobile clinics, and other distribution points.

4.5 Who Shall Provide Contraception Services?

Table 9: Providers of Contraception Services

Level of services	Type of method	Health care provider
Hospital	• Surgical • All prevention methods	Doctors and Nurses
Health center	• Surgical • All prevention methods	Doctors and Nurses
Public Health Unit	• All prevention methods except surgical	Nurses
Primary health care (Clinic)	• All prevention methods except surgical	Nurses

Community	• Condoms	All health care workers including community carder
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**The country promotes the use of Long-Acting Reversible Contraceptives (LARC), which are provided by competent nurses and doctors.*

4.6 Medical Eligibility for Contraception Services

All sexually active adolescents and youth in need of contraception are eligible for pregnancy prevention/contraception services provided they have been given information for them to make informed choices. It is highly recommended that the nurse/ doctor should conduct a comprehensive clinical assessment to ascertain medical eligibility for the prevention method of choice.

4.7 Essential Steps Before Prescribing Medical Contraception Methods

Young people deserve nonjudgmental and respectful care no matter how young they are. Criticism or unwelcoming attitudes will keep young people away from the care they need. Services providers can make services friendly to youth through;

- Showing respect and positive attitudes
- Counseling them in private areas where you cannot be seen or overheard.
- Ensuring confidentiality and assuring the clients of confidentiality
- Listening carefully and asking open-ended questions
- Using simple language, the client can understand and avoid the use of complex medical terms
- Welcoming partners and including them in counseling if the client desires
- Trying to make sure that a young woman's choices are her own and are not pressured by her partner or her family
- Avoiding criticism even if you do not approve of what the young persons is strongly recommended
- Giving special concern to the counseling of adolescents and

young adults under 16 years of age who do not want to involve parents or guardians, to ensure that they understand what is involved in their decision along with its possible consequences

CHAPTER 5: GENDER ISSUES IN ADOLESCENTS SEXUAL AND REPRODUCTIVE HEALTH

This chapter provides a guide on the Health Sector's response to gender and gender-based violence. This section should be used in conjunction with the National Guidelines - GBV Multisector Response in Eswatini (2018).

5.1 Definitions

WHO defines gender as the characteristics of women, men, girls, and boys that are socially constructed. This includes norms, behaviors, and roles associated with a woman, man, girl, or boy, as well as relationships with each other. As a social construct, gender varies from society to society and can change over time (WHO, 2020). Gender interacts is different from sex, which refers to the different biological and physiological characteristics of females, males, and intersex persons, such as chromosomes, hormones, and reproductive organs. Gender and sex are related to but different from gender identity.

5.2 Gender-Based Violence (GBV)

Gender-based violence refers to violence that is directed at an individual based on his/her biological sex, gender identity or perceived adherence to socially defined norms of masculinity and femininity. Reporting GBV is key to enable survivors to access much-needed services.

Types of GBV

- **Sexual Violence** – And sexual act or attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic men, women or children for sexual purposes using coercing, threats harm or physical force, financial deprivation by any person regardless of relationship to the victim. This may occur

anywhere, and not limited to work or home.

- **Sexual Abuse** - a process where a person, who exercises a form of power and uses it to force another person into sexual activity (or activities) against his/her will.
- **Emotional abuse** - any behavior that is designed to control and subjugate another through the use of fear, humiliation, intimidation, guilt, coercion, manipulation, etc. (e.g. Bullying)
- **Financial/Economic abuse** - is when the abuser has control to or over the victim's/survivor using money and other resources.
- **Neglect** - any act or failure to act on the part of a parent, partner, or caregiver, which results in starvation, ailed wellbeing, starvation and malnutrition, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm or death.
- **Physical abuse** - means any act or threat of physical violence towards another person. This may include pushing, slapping, assaulting with fist or kicks etc.
- **Victim** – A person harmed or injured or killed as a result of abuse, crime, accident, or other event or action.
- **Mandatory Reporting** – Refers to legislation passed in the country statutes such as the Constitution 2005, Children Protection and Welfare Act 2012, Sexual Offences and Domestic Violence Act 2018 etc, that requires individuals or designated individuals including health care providers to reporting any incident of actual or suspected violence against children.

Gender-Based Violence amongst adolescents

Violence against children is prevalent as children endure violence on a routine basis, in everyday settings within their families, at home, and in school. Experiencing violence during childhood increases adolescents' risk of HIV or other sexually transmitted infections by nearly four times compared to girls who have never experienced sexual violence. Sexual violence in childhood also impacts significantly on teenage pregnancy,

alcohol use, suicide, and health issues, or self-destructive behaviours. The most prevalent forms of violence against children include violent discipline which includes both physical punishment and psychological aggression (88%), followed by sexual violence (38%), bullying (32%), physical violence (31%), and emotional violence (28.5%). Findings further show that experiencing one type of violence puts children at an increased risk of experiencing other types of violence (UNICEF, 2016). Tibi Tendlu *creates a cycle of violence that is reinforced by institutional and community-level drivers such as lack of confidential reporting mechanisms for both adults and children as well as community reluctance to get involved in family matters.

Consequences of GBV

GBV is a violation of human rights and a form of violence that results in, or likely to result in, physical, sexual, psychological, or economic harm or suffering of another person whether in public or private life. Violence can have a serious impact on the health and wellbeing of survivors, both in the short and long-term. The survivor may suffer physical, behavioral, and psychological symptoms which are not limited as follows:

a) Physical signs

- Visible Injuries such as bruising, cuts, burns, choke marks, black or swollen eyelids.
- Any injuries, with no or reasonable explanation(s) as to how they occurred.
- Unattended injuries may be apparent such as old untreated fractures.
- Serious bleeding injuries, especially to the face, head, and internal organs.
- Gynecological problems-sexually transmitted infections, bleeding, and infections from tears or cuts.
 - Shock; feel cold, faint, become mentally confused (disorientated), tremble, feels nauseous and sometimes vomits.

- Throat irritations and/or soreness due to forced oral sex.
- Headaches, sleep disturbances and eating disturbances.

b) Behavioral signs

- Survivor is tense, fearful, and apprehensive.
- A survivor looks to a companion (parent, caregiver, and partner) for direction.
- Difficulty concentrating at work or school etc.
- Being restless, agitated, irritable and unable to relax or feeling listless and unmotivated or cries more than usual.
- Socially withdrawn or not wanting to be alone.
- Stuttering or stammering especially in children that was violated from childhood
- Avoiding anything that reminds them of the abuse or violence.
- Being more easily frightened or startled than usual.
- Fear of sex, loss of interest in sex or loss of sexual pleasure or increased sexual behavior.
- New or increased substance abuse behavior as coping mechanism.
- Suicide attempts and other self-destructive behaviours
- Survivor is overly concerned about the perpetrator and/or family and has little or no concern for his/her own health needs.

c) Psychological signs

- Severe crying spells or feelings of isolation or inability to cope.
- Depression, at times, is accompanied by suicidal thoughts.
- Increased or acute anxiety attacks.
- Experience shock, disoriented, become mentally disturbed.
- The intermittent or continual presence of stress reactions such as tension, hyperactivity, headaches, insomnia, and pain in the back, chest, or stomach often has no clear physiological cause.
- The intermittent or continual presence of fear, anxiety, depression, and hopelessness.

- Inconsistency between cognitive and emotional levels.
- Self-blame and guilt.
- Helplessness, no longer feeling in control of his or her life.
- Humiliation and shame and lowering of esteem
- Feeling dirty or contaminated by the abuse (physical, sexual, emotional, financial control, controlling behavior)
- Losing hope in the future or emotional numbness.
- Confusion and anger
- Loss of memory.
- Constantly thinking about the abuse.

5.3 Sexual Offenses and Domestic Violence

In 2018, the Government of Eswatini took its first action towards the commitment in fighting against sexual offenses and domestic violence through enacting a Sexual Offences and Domestic Violence Act, 2018. This commitment was fulfilling constitutional provisions on children, and complementing the Children Protection and Welfare Act 2012. This also aligns with international ratification on Convention in the Children Rights Charter.

5.4 Common Types and Manifestations of Gender-Based Violence

Gender-based violence can occur in multiple forms and may cause imminent harm to the safety, health, and well-being of a person and these include:

- Oppression and intimidation
- Controlling behaviors
- Sexual violence (incest, rape, coerced sex, sexual harassment)
- Emotional/verbal and psychological abuse
- Domestic violence (spouse battering)
- Harmful cultural practices
- Early marriages

5.5 Who Are at Higher Risk of Gender-Based Violence?

- Men, Girls and women and Children
- Girls and women
- Persons with disabilities (mental, cognitive, or physical)
- Women with mental health problems
- Key Population (LGBTs, Commercial Sex workers, bus conductor etc.)
- Minority population (OVC, neglected children, household helper etc.) Commercial sex workers

5.6 The Health Sector response to GBV

Health care providers have a legal and ethical obligation to provide comprehensive services to survivors of GBV. Health Services in GBV cases include but not limited to the following;

- Provide all relevant clinical services for clients for all active and cold cases presenting at a health facility. Such as
 - Comprehensive history taking
 - Physical examinations
 - Clinical Management
 - Stabilizing the survivor
 - Prevention package
 - Administering of comprehensive PEP (See GBV Guidelines)
- Support in medico-legal examinations,
 - Conduct a forensic examination
 - Documentation
 - Court preparation
- Refer and link to other key critical services required or requested by the client outside the health sector:

5.7 Health Services for GBV survivors

- Medical Emergency Management (includes all prophylactic measures as defined in the health sector guidelines)
- Provision of short to/ or long-term service such as psychological management needs to both client and family/ those closely affected.
- General examination (Physical/ Biometric/ Laboratory investigation)
- Medico-legal examination and medical certificate delivery
- Facilitating the reporting of the incident to relevant service providers outside the health sector as determined by survivor and in accordance with sector guidelines.

5.8 Why Use Health as A Critical Service for GBV?

Health providers have a critical role in supporting those affected or exposed to GBV regardless of sex, age, and economic status to minimize the impact of GBV in the health of the individual by preventing complications that may arise such as :

- HIV and STIs
- Unwanted pregnancy
- Mental health issues
- Delay in accessing Justice

5.9 What Services Can Be Provided to Survivors of Gender-Based Violence?

- a) Response Management
 - Counseling and rehabilitation.
 - Medical treatment of presenting symptoms.
 - Screening for STI/HIV/AIDS among those affected including IPV.
 - Post Exposure Prophylaxis (PEP).
 - Emergency Contraception in case of sexual violence

- A referral is as necessary.

5.10 Gaps and Challenges in the Existing Health Facilities in Managing Gender-Based Violence

Some problems that exist in the health facilities are:

- Inadequate knowledge/skills among health services providers.
- Limited data and statistics on the gender-based violence.
- Inadequate counseling services and follow up.
- Inadequate agencies involved in the referral and linkages after health services have been provided for gender-based violence.
- Absence of male user-friendly services.

5.11 What More Should the Health Sector Do to Curb Gender Disparity in SRH?

- Orient health system to respond to the prevention and management of gender-based violence, sexual reproductive health issues, advocating for promotion of cultural change, and improved legal protection of survivors.
- Train health workers to be gender-sensitive in providing health services.
- Increasing men's and women's access throughout the life cycle to appropriate, affordable, and quality health care, information, and related services (by improving knowledge, attitudes, and skills of health workers). That includes creating community awareness on the impact of GBV on the health of those affected.
- Undertake gender-sensitive initiatives to address sexual reproductive health issues including gender-based violence.
- Promote gender-based operations research.
- Strengthen gender-sensitive MIS rehabilitation.
- Develop appropriate treatment programs for survivors of violence and rehabilitation for perpetrators.

- Promote gender based SRH issues into pre-service and in-service training.
- Establish a referral and linkage mechanism between the health system, communities, social welfare, law enforcement, and legal systems. Health facilities should be equipped with laboratory facilities for Pregnancy/STI/HIV/AIDS screening. Develop gender-sensitive BCC and IEC materials.
- Strengthen and improve multi-disciplinary referral and linkage mechanism in the health system.

5.12 What Shall SRH Providers Be Aware of?

The health sector must ensure that gender is mainstreamed in all health programs. This perspective needs to recognize that GBV is a social issue with serious impact on public health . As it:

- Affects women and men differently
 - Have risk factors that are different for women or groups of women thus need different interventions for women and men
 - Men tend to under-utilize these services as it tends to bias attention to women
- Is more prevalent in women and children

HEALTH CARE PACKAGE FOR SEXUAL VIOLENCE MANAGEMENT

Include immediate and follow up care

- Triaging
- History taking
- Clinical services
 - Management of injuries
 - Mental health (PFA and Debriefings, including management)
 - HIV/STI management
 - Pregnancy prevention
 - Immunization against Tetanus and Hepatitis B
- Physical assessment (medical and forensic)
- Documentation
- Court preparation

CHAPTER 6: MATERNAL AND NEWBORN CARE

6.1 Pre-conception Care

Pre-conception care is the health care information and services given to an individual or couple before biologically fathering or mothering a child. It consists of the following services:

- Physical assessment and risk screening
- Information on contraceptives, nutrition, responsible parenthood
- STI/HIV/AIDS prevention
- Advice on balanced diet and initiate on iron supplements and another nutritional supplementation where necessary
- Provision of Pregnancy prevention/contraception method depending on assessment if there is a need to delay.
- Screening for STI including HIV/AIDS, anaemia, blood grouping
- Referral where necessary

6.1.1 Where Shall These Services Be Provided?

- Government health facilities
 - National and Regional Referral hospitals
 - Health Centers
 - Clinics with/without maternity
 - Public Health Units
 - Health posts/mobile stops
- Private sector
 - Hospital
 - Private practitioners
 - Private institutions
- Mission/faith-based hospitals/ clinics

6.1.2 Who Is Eligible for The Services?

Everyone of child-bearing age that is anticipating conception.

6.2 Antenatal Care

Antenatal care is information and service provided by healthcare providers during pregnancy. It consists of the following ANC services:

- History taking
- Maternal assessment
- Foetal assessment
- Point of care tests as outlined in ANC guidelines
- Preventive measures: Td vaccine, anemia, intestinal worms
- Counselling on PMTCT program and provision of antiviral drugs and enhanced prophylaxis for HIV-positive women.
- Referral of high-risk cases
- Referral of high-risk cases
- Health Information and education.: danger signs, birth preparedness, signs of true labour, baby layette

6.2.1 Where Shall Antenatal Care Be Provided?

Table 10: Providers of ANC

Public Sector	Private sector	Mission/faith-based
• National and Regional Referral hospitals • Clinics with/without maternity • Public Health Units • Health posts/mobile stops	• Hospitals • Private practitioners	• Hospitals • Clinics • Health posts/mobile stops

6.2.2 Who Can Provide Antenatal Care?

- Obstetricians/Gynecologists
- Medical Officers
- Midwives

6.2.3 When Shall ANC Be Provided?

- ANC shall start as soon as pregnancy is confirmed
- Low risk women will be monitored as stipulated in the ANC guidelines
- High risk women shall be referred to higher level care and seen as is required

6.3 Labour and Delivery (Intra partum) Care

It is monitoring interventions and care given to women during labour in order to ensure safety and well-being of the mother and the baby. It consists of the following services:

- Review of history and ANC record
- Evaluation of presenting complaints
- General physical examination
- Specific examination to assess the three (3) "Ps"
- Observation and tests
- Monitoring of maternal and foetal well-being and progress of labour through correct use of the partograph
- Counselling and education on birth process and reassuring as labour progresses etc.
- Ensuring clean and safe delivery
- Relief of distressing symptoms e.g. pain
- Involvement of father, relatives or friends
- Counselling post-delivery in the case of adverse events e.g. FSB, MSB, ENND, congenital abnormalities

6.3.1 Where is Labour and Delivery Care Provided?

- Government health facilities
 - National and Regional Referral hospitals
 - Clinics with maternity
 - Clinics for emergency deliveries
- Private sector
 - Hospital
- Mission/fait-based hospitals/ clinics with maternity facilities

6.3.2 Who Can Provide Labour And Delivery Services?

Skilled providers such as:

- Obstetricians/gynaecologists
- Medical Officers
- Midwives
- Pediatrician (where resuscitation is anticipated)

6.3.3 When Are Labour and Delivery Services Provided?

It is a continuous 24-hour service in all designated facilities.

6.4 Postnatal Care

Postnatal care is the health care and follow-up given to a mother immediately following delivery and up to six (6) weeks after delivery.

It consists of the following:

- During hospitalization, the following shall be ensured:
 - Immediate monitoring of both mother and baby during the first 24hrs
 - Subsequent examination
 - Prevention of infection e.g. wound care in case of caesarian section, perineum care, antibiotics
 - Birth testing

- Encourage rest and provide pain relief remedies
 - Health information on nutrition, FP, 7 days PNC checkup,
 - Hygiene (mother and baby)
 - Baby immunisation and care
 - Cord care
 - breastfeeding (Attachment, benefits, feeding cues)
 - Education on danger signs (warning) for mother and baby
 - Information and education on postnatal exercises
 - * Born Before Arrival (BBA) should report to the nearest hospital within 24hrs post delivery
 - * BBAs reporting post 24hrs to be attended at the nearest clinic
 - Early Infant male circumcision
 - Birth registration
- Domiciliary care shall involve:
 - Home visit by community health volunteer within the first week after delivery.
 - Enquire on the condition of both the mother and the baby e.g. anemia, jaundice, involution of the uterus and state of lochia
 - Dietary advice.
 - Counselling, information and education on individualized personal care.
 - Psychological and emotional support particularly for mothers who had difficult deliveries and or lost their babies.
 - 7 days post-natal
 - Physical examination for both mother and baby
 - Health information on nutrition, FP,

- Hygiene (mother and baby)
 - Baby immunisation and care for missed cases (BBAs)
 - Cord care
 - breastfeeding (Attachment, benefits, feeding cues)
 - Education on danger signs (warning) for mother and baby
 - Information and education on postnatal exercises
- 6-8 weeks postnatal visit
 - Examination of the mother and baby.
 - Screening for cervical cancer.
 - Counselling on FP and provision of FP methods.
 - General health education on nutrition, hygiene, care of baby, immunisation, STI and HIV prevention and treatment for HIV positive women or couples
 - Referrals.
 - Medical report.

6.4.1 Where Can Postnatal Care Be Provided?

Table 11: Providers of PNC

Public Sector	Private sector	Mission/faith-based
• National and Regional Referral hospitals • Clinics & Public Health Units with teen mother clubs • Home	• Hospitals • Private practitioners	• Hospitals • Clinics

6.4.2 Who Can Provide Postnatal Care?

- Obstetrician/gynaecologist
- Medical officer
- Midwives
- General nurses
- Pediatrician
- Neonatologist

6.4.3 Who Is Eligible for Postnatal Care?

Any woman and baby within six weeks of delivery (couple counselling for FP and STI/HIV prevention is advisable).

6.4.4 IEC For Postnatal Clients

- All health care workers shall provide the community with information and education on the importance and composition of immediate and later postnatal care during the puerperium in regard to the mother and her baby.
- All HCW providing MNCH services shall ensure that women are given information, education and counselling regarding postnatal care and FP. The education shall include:
 - Description of component of postnatal care and services, including pregnancy prevention/contraception
 - Importance of postnatal care to mother and baby
 - Where and how to obtain the services
 - When after delivery to go for the services.
- Each postnatal client shall be given a return date for postpartum examination at 6 -8 weeks period.

6.5 Emergency Obstetric Care (EmONC)

Emergency obstetric care refers to urgent life-saving care provided to pregnant women and newborn in response to problems arising during pregnancy, labour, delivery and puerperium. It includes ensuring availability of care to all who develop complications in order to reduce maternal mortality. Table 12 shows the list of common obstetric emergencies

Table 12: Common Obstetric Emergencies

During Pregnancy	During Labour and delivery	During Puerperium
• Ectopic pregnancy • Abortions • pre-eclampsia and eclampsia and HELLP syndrome • hyperglycemia/hypoglycemia • anemia in pregnancy • Premature rupture of membranes • Congestive cardiac failure (CCF) • Ante-partum hemorrhage (APH)	• Hemorrhage • severe pre-eclampsia, eclampsia and HELLP syndrome • Obstructed labour • Pre-term labour • Delayed 2nd stage of labour • Birth asphyxia • Ruptured uterus • Malpresentations • Shoulder dystocia • Retained placenta • Cervical/extensive tears • Anaesthetic complications	• Pre-eclampsia and eclampsia • Puerperal sepsis • Post-partum hemorrhage

6.5.1 What Common Activities Are Undertaken in EmONC?

The table below provides the current component definition of these terms which together make up 10 signal functions.

Table 13: Common Activities Undertaken in EmONC

BASIC EmONC	COMPREHENSIVE EMONC
1. Provision of Antibiotics drugs IM and IV	A Basic EmONC Plus:
2. Provision of Oxytocic drugs (IM and IV)	8. provision of Surgery (caesarean section) & Anesthesia
3. Provision of Anticonvulsants such as Magnesium Sulphate	9. provision of Blood transfusion
4. Manual removal of the placenta	10. Care of low birth weight and sick neonate
5. Removal of RPOC using MVA and D&C	
6. Assisted vaginal delivery (vacuum extraction)	
7. Performing neonatal resuscitation of newborn	

6.5.2 Where Can EmONC Be Provided?

Table 14: Providers of EmONC Services

Public Sector	Private sector	Mission/faith-based
• National and Regional Referral hospitals • Clinics & Public Health Units with maternity wards neonatal units	• Hospitals • Clinics with maternity facilities	• Hospitals • Clinics with maternity facilities

6.5.3 Who Can Provide EmONC?

- Skilled providers such as:
- Gynaecologist/obstetrician
- Medical officer
- Midwife
- Family Nurse Practitioner
- Pediatrician
- Neonatal nurse

6.5.4 Who is eligible for EmONC?

Any woman and baby with obstetric and neonatal emergency including; ectopic pregnancy, and post abortion complications.

6.5.5 Neonatal Care

Care of the baby given following delivery to 28 days. It consists of the following services:

- For immediate care within the first 24hrs:
 - Ensure good adaptation to external life e.g. clear airway, maintenance of warmth, resuscitation.
 - Carry out observations.

- Full examination of baby.
 - hygiene and cord care prevention of infection by giving tetracycline eye ointment at birth
 - Vitamin K.
 - exclusive breastfeeding
 - PMTCT protocol followed in case of a baby of HIV-positive woman.
 - Referrals where necessary
 - Prevention of hemorrhage.
- For high-risk neonatal care:
 - Resuscitation.
 - Close monitoring and observation.
 - Provision of warmth.
 - Prevention of infection.
 - Provision of appropriate care.
 - Counselling of the mother on the condition of the baby
 - Referrals.
 - Information and Education to mothers on continuity of care after discharge.
- Subsequent care for the normal and special baby:
 - Examination.
 - Management of any special condition
 - Immunizations.
 - Growth monitoring.
 - Teaching on childcare.
 - Nutrition, hygiene, etc.
 - Education on danger/warning signs, care of cord,
 - Attendance of child welfare clinic.

6.5.6 Where Is Newborn Care Provided?

Table 15: Providers of Newborn Care Services

Public Sector	Private sector	Mission/faith-based
• National and Regional Referral hospitals with specialized care • Clinics with/ without maternity wards • Mobile stops and health posts	• Hospitals • Private practitioners	• Hospitals • Clinics with/ without maternity wards • Domiciliary visits

6.5.7 Who Can Provide Newborn Care?

Skilled providers such as:

- Obstetrician
- Pediatrician
- Doctor
- Neonatal nurse
- Midwife
- Registered nurse and enrolled nurse

6.5.8 Who Is Eligible For Newborn Care?

- Every newborn irrespective of status at birth.
- High risk newborns need special attention e.g. low birth weight, large for gestational age, congenital abnormalities, asphyxia, baby whose mother dies during childbirth, dumped babies.

6.5.9 Care of Babies Born Before Arrival

Babies born before arrival should be kept in isolation for observation and necessary care. They should be given tetanus and immediate care as outlined under.

CHAPTER 7: UNINTENDED PREGNANCIES AND POST ABORTION

7.1 Definitions

Unintended pregnancies are pregnancies that are mistimed, unplanned, or unwanted at the time of conception. Sexual activity without the use of effective contraception through choice or coercion is the predominant cause of unwanted pregnancy. In Eswatini abortions are not permitted unless it is for medical or therapeutic reasons. Abortion is available under certain circumstances in Eswatini (as contained in the Constitution of the Kingdom of Eswatini, 2005), including to save the woman's life, fetal impairment; rape; incest, mental or physical health. The magnitude of complications of abortion in Eswatini is limited but it is known that abortion contributes significantly to maternal mortality especially in adolescents and where the unmet need for contraception is huge.

In a study comparing thirty African countries, unwanted pregnancies were most frequent in Eswatini (Amo-Adjei and Anamaale Tuoyire 2016; Central Statistical Office 2008). Unplanned pregnancies carry health risks both for the adolescent mother and her offspring. Women with unwanted pregnancies are less likely to receive adequate prenatal care, more likely to suffer from depression (Marston and Cleland 2003; Cheng et al. 2009; Kost and Lindberg 2015; Amo-Adjei and Anamaale Tuoyire 2016).

Post-abortion care aims at integrating with pregnancy prevention/contraception services in health care systems as a means of breaking the cycle of repeated unintended/unwanted pregnancy and the health status of women.

7.2 Underlying causes of unintended/unwanted pregnancies

The most common underlying causes of unwanted pregnancies are:

- Gender inequality
- Obstacles to human rights
- Poverty/ low socio-economic status
- Sexual violence and coercion
- Restricted access to contraception, age-appropriate sexuality education
- Lack of access to education and reproductive health services
- Underinvestment in adolescent girls' human capital
- Lack of or improper use of pregnancy prevention/contraception methods and unawareness of it

7.3 Essential Components

7.3.1 Provide Information

- Information is a necessary component of any medical care and should always be provided to adolescents considering abortion under certain circumstances.
- information about the dangers of abortion i.e., excessive bleeding and infection.
- the available options for abortion methods and pain management.
- what will be done before, during, and after the procedure, including any tests that may be performed.
- what they are likely to experience (e.g., pain and bleeding) and how long the procedure and the recovery are likely to take (vaginal bleeding for two weeks is normal after a medical abortion such bleeding can last up to 45 days in rare cases).
- how to recognize potential complications, and how and where to seek help, if required (individuals should return to the hospital or clinic if they experience increased intensity of cramping or abdominal pain, heavy vaginal bleeding, and/or fever).
- when normal activities can be resumed, including sexual intercourse (the return of fertility can occur within two weeks

- following abortion), and
- where and how to access additional services and follow-up care.

7.3.2 Management

At the clinic level, they should start the process before referral unless it's a life-threatening emergency.

Abortion may be incomplete hence there is a need to conduct uterine evacuation of the retained parts and other medical interventions including drugs if necessary. Follow standard infection prevention and control (IPC) precautions given the high risk of infection.

- Perform a pregnancy test
- Perform full blood count
- Conduct an HTC and STI screening for adolescent pair
- Ensure sensitive physical and verbal patient contact and follow-up care.

7.3.3 Counseling

Counseling is a focused, interactive process through which one voluntarily receives support, additional information, and guidance from a trained person, in an environment that is conducive to openly sharing thoughts, feelings, and perceptions. When providing counseling, it is essential to:

- Communicate information in simple language that they understand
- Maintain privacy;
- Support the individual and ensure they receive adequate information
- Responses to their questions and needs; and
- Avoid imposing personal values and beliefs (cultural or religious beliefs)

7.3.4 Additional services

Additional services may need to be provided to individuals seeking medical abortion:

- Provide iron supplements for anemia, if needed; (depending on the level of anemia)
- Provide any necessary pain medications;
- Provide emotional support, if needed; and
- Refer the adolescent to other services as determined by an assessment of their needs. these services may include counseling and testing for sexually transmitted infections (STIs, including HIV), abuse support services, psychological or social services, or other specialist health or medical services.

7.3.5 Follow-up care

Routine follow-up is not necessary following an uncomplicated surgical or medical abortion using mifepristone and misoprostol. However, optional follow-up visits 7–14 days after their procedure may be offered to provide further contraceptive counseling and services, further emotional support, or to address any medical concerns. A routine follow-up visit is recommended only in the case of medical abortion using misoprostol alone, to assess the success of the abortion.

7.4 Abortion care service providers

Adolescents can access abortion services at the following facilities as highlighted in the Essential Healthcare Package:

Table 16: Abortion Care Services Provided

Abortion Care Services	Service components offered by level of service delivery					
	Community	Clinic	PHU ³	HC ⁴	RRH ⁵	NRH ⁶
Health promotion	Yes	Yes	Yes	Yes	Yes	Yes
Vaginal bleeding (abortions, APH, PPH)	No	Yes	Yes	Yes	Yes	Yes

3 Public Health Units

4 Health Centers

5 Regional Referral Hospitals

6 National Referral Hospitals

Abortion Care Services	Service components offered by level of service delivery					
	Community	Clinic	PHU ³	HC ⁴	RRH ⁵	NRH ⁶
Provision of therapeutic abortion	No	No	No	No	Yes	Yes
Provision of post-abortion care						
Use of manual vacuum aspiration to manage incomplete abortion	No	No	No	Yes	Yes	Yes
Manage complications of abortion	No	Yes	Yes	Yes	Yes	Yes
Counseling on pregnancy prevention/contraception	Yes	Yes	Yes	Yes	Yes	Yes

7.5 Preventing unwanted pregnancies

- Encourage adolescents to prevent unwanted pregnancies and unsafe abortions
- Educate adolescents on the importance of abstinence. If failure to abstain promote condom use and contraception methods to increase contraceptive uptake and thereby help adolescents prevent unwanted pregnancy, space births, and reduce unsafe abortion
- Provide age-appropriate information, and offer health services needed by adolescents
- Educate adolescents about obstetric emergencies and appropriate care-seeking behaviors
- Link contraception to post-partum and post-abortion care, and other primary health care, education, and social and psychological support services; and

- Incorporate adolescent-friendly service delivery elements into existing contraceptive and health services.

HEALTH CARE PACKAGE FOR UNWANTED PREGNANCIES AND POST ABORTION CARE FOR ADOLESCENT

- Pregnancy test
- Full Blood count
- STI screening
- Evacuation of retained parts
- Monitoring of vital signs
- Drug management
- HTS
- Information on pregnancy prevention/contraception services
- Contraceptive supplies
- Essential drugs and supplies for managing pain, infection, and bleeding
- Counseling for both partners
- Screen for reproductive cancers
- Information on prevention of pregnancy and complications of unsafe abortions.

CHAPTER 8: SEXUALLY TRANSMITTED INFECTIONS (STI'S) AND HIV/AIDS

8.1 Background

According to Eswatini HIV Estimates and Projection Report, 2019, a total number of people living with HIV was estimated to be 205,700 in 2018 and projected to increase to 221,600 in 2024. Among the total number of people living with HIV, adolescents aged 10 – 19 accounted for 11,500 with the largest representation of female adolescents.

The recent (2016-2017) SHIMS report revealed that nearly one-tenth (9.1%) of young people were HIV positive. HIV prevalence in females was more than triple the HIV prevalence in males (13.9% and 4.1%, respectively). HIV prevalence was higher in the ages 20 – 24 years (4.2% in males and 20.9% females) than in ages 15 – 19 years (3.9% in males and 7.2% in females).

The Eswatini Estimates and Projection report shows that new infections are higher among females compared to males. In 2018, there were 1,300 new infections amongst adolescents aged 10 – 19, and 1,200 if those were among females compared to 30 new HIV infections among males.

STIs contribute to increased rate of infertility, prevalence, of reproductive cancers and are a major setback in reducing new HIV infections, if not early diagnosed and managed properly. Exposure to an STI can occur at any time you have sexual contact with an infected person, and it is more likely if you have more than one partner, engage in anal sex or do not use a condom. STIs affect both men and women and almost half of all STIs occur in people younger than 25 years old. The graph below illustrates

Eswatini OPD STI data of 2019:

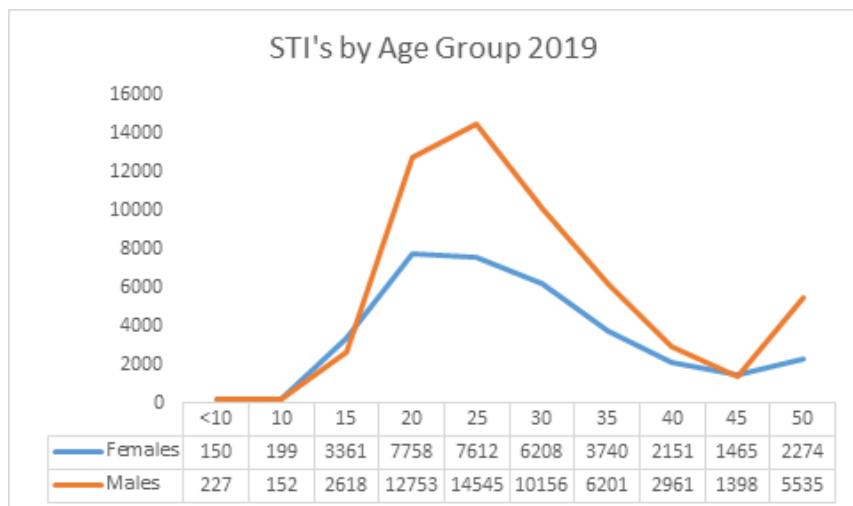


Figure 2: STI's By Age Group 2019

8.2 STIs and HIV Prevention

8.2.1 HIV Prevention Strategies

There has been a significant improvement in people knowing their HIV status through adolescents and youth have not been aggressively accessing HIV prevention services evidenced by the high prevalence and incidence among adolescents and youth especially females. The prevalence amongst females aged 20-24 years is (20.9%) and for males (4.2%), 25-29, females (37.5%) and (13.3%) for males. The incidence rate for females aged 15-24 years (1.9%) and (0.8%) for males (SHIMS, 2016).

HIV testing services (HTS) is a critical entry point to HIV prevention, care, and treatment services. Based on the test result, the client should be referred to and linked to prevention, treatment, care, and support service. Adolescents and youth should receive a same-day diagnosis, as well as same-day referrals and linkages to prevention and treatment, care and support services.

Prevention services that should be accessed by adolescents and youth are:

- Voluntary Medical Male Circumcision
- Male and female condoms including lubricants
- Pre-Exposure Prophylaxis (PrEP)
- Post Exposure Prophylaxis (PEP)
- Treatment for Prevention
- STI screening and treatment

a) Voluntary Medical Male Circumcision (VMMC)

VMMC reduces the chances of males contracting HIV by 60%. The coverage of VMMC in the country is 41% as of 2019 and a large proportion of those circumcised are in-school adolescents aged 10-19 (VMMC program data). Adolescent (15 and above) and youth boys should be encouraged to access VMMC services. The process of VMMC should include:

- a) Safe sexual behaviors
- b) HIV testing:
 - If HIV negative proceed with the VMMC process
 - If HIV positive:
 - Check for CD 4 count and if it is above 350 without underlying conditions proceed with the VMMC process
 - Refer and link for treatment and care
- c) STI screening and treatment
- d) NCD screening, referral, and linkages

b) Condom Promotion

Condoms are highly recommended as part of the dual protection package which prevents unintended pregnancies as well as transmission of STI's including HIV (SRH report, 2019).

Consistent and correct use of condoms reduces sexual transmission of

HIV, other STIs by up to 94%, and prevents unwanted pregnancies. To maximize condom use:

- All Adolescents and youth must be given male and female condoms as and when they need them in all health facilities and communities.
- All services providers should ensure accessibility of condoms to adolescents and youth at all times as they provide a triple effect for prevention of pregnancy, STI, and HIV.

c) Pre-exposure Prophylaxis (PrEP)

The country adopted the use of pre-exposure prophylaxis (PrEP) following the recommendations from WHO on the service being offered as an additional prevention choice for people at substantial risk of HIV infection especially adolescents and young people.

PrEP is the use of ARVs by HIV-negative people who are at increased risk of acquiring HIV to prevent the acquisition of HIV during periods of high risk. Service providers should offer PrEP to:

- Older adolescents and youth are eligible to access PrEP.
- Young adolescents (12 years old) under the following reasons:
 - when they have an STI, pregnant and sexually active

For more information refer to Integrated HIV Management Guidelines (2018).

d) Post-exposure Prophylaxis (PEP)

Post-exposure prophylaxis (PEP) is the use of ARVs by HIV negative people after exposure to HIV to prevent infection with HIV. Registered doctors and nurses should:

- provide PEP to all adolescents and youth who present with a history of exposure to HIV either accidentally or occupationally

or sexually or otherwise as early as 1 hour and within 72 hours to minimize the risk of acquisition of HIV and other blood-borne pathogens.

PEP should be provided to adolescents and youth under the following criteria:

- An exposed individual is HIV negative at baseline.
- PEP should be used only in emergencies. It is not meant for regular use by people who may be exposed to HIV frequently.
- Exposure occurred within the past 72 hours.

The process of providing PEP should follow:

- Risk assessment to determine the risk levels of the background to the need for PEP
- Counseling and information giving on the possible side effects in some people of the HIV medicines used for PEP. The health care worker should assure the client that the side effects of PEP can be treated and aren't life-threatening. Clients can talk to their health care provider if they have any side effects that bother them.
- HIV testing with an HIV negative result
- Prescription of PEP drugs to be taken for 28 days.

e) Treatment for Prevention

- The management of HIV/AIDS shall be integrated into sexual and reproductive health services.
- All health workers at facilities shall offer the treatment to all affected males and females, adolescents and youth irrespective of age, and other attributes.
- All health workers shall offer support to patients with HIV/AIDS.
- Management of HIV/AIDS shall follow the guidelines as prepared by the Eswatini National AIDS Program.

8.3 Sexually Transmitted Infections

STIs are spread predominantly by sexual contact, including vaginal, anal, and oral sex. Some STIs can also be spread through non-sexual means such as via blood or blood products.

Sexually transmitted infections remain a priority in the fight against HIV. Eswatini uses the syndromic approach in STI's management, which means the diagnosis is made when the patient's signs and symptoms are matched to a particular syndrome. Predominantly amongst adolescents and youth, males have more reported cases than females on STIs (SRH report, 2019).

8.4 Biological and Social factors that increase vulnerability to STI

The same biological and social factors that increase vulnerability to STIs also increases vulnerability to HIV infection.

a) Biological factors

- A mucosal tear during a sexual act
- Underdeveloped vaginal epithelium, leading to interruption in mucosal integrity which could be easily infected by aetiologies of STI and HIV.

b) Social factors

- Multiple sexual partnerships
- Transactional sex
- Poor health-seeking behavior
- Low self-esteem
- Lack of youth-friendly services
- Lack of related information on STIs

Health care workers should be cognizant of the following key issues during the management of STI in adolescents and youth:

- Adolescents and youth may have limited access to health care and may not seek care adequately. therefore, arrangements

should be made to ensure compliance and future follow up.

- Partner notification and management are often difficult; thus, the risk of re-infection exists.
- Pregnancy should be considered, and screening is pertinent in adolescent females.

For more information refer to Eswatini National STI Guidelines (2018)

8.5 Information, Education and Communication

Special Considerations

- STIs like chlamydia, gonorrhea, untreated HIV, and viral hepatitis can sometimes cause infections in the prostate gland which could result to erectile dysfunction.
- Service providers should provide information to adolescent on the consequences of untreated STIs including information on the following:
 - Provide education and counseling on sexual dysfunction; its causes, manifestations, and how it could be prevented.
 - Encourage adolescents to control body weight and prevent obesity through regular exercise and a healthy diet.
 - Avoid alcohol, smoking, and substance abuse
 - Do regular medical check-ups for early diagnosis and management of cardiovascular diseases and diabetes.
 - Inform parents that it is critical to provide ongoing psychological support. However, consent for parental involvement should be obtained from the adolescent given the sensitivity of the issue

Adolescents and youth should have information about:

- HIV Testing Services
- Prevention methods including delaying sexual debut
- Encouraging reducing number of sexual partners

- Correct and consistent use of male and female condoms
- Preventing, screening, and early treatment of STIs,
- VMMC, PrEP, and PEP
- Treatment for Prevention

CHAPTER 9: ALCOHOL, OTHER DRUGS AND SUBSTANCE ABUSE

9.1 Definitions

9.1.1 What is Addiction (drug or alcohol)?

Repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits a determination to obtain psychoactive substances by almost any means.

9.1.2 What is a Substance Abuse?

It is when an individual or group of people use alcohol or other preparations for other than the maintenance of normal health. Substance abuse affects all aspects of an individual; physical, emotional, psychological, social and spiritual.

9.1.3 Effects of Substance Abuse?

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime

- Homicide
- Suicide

9.1.4 Criteria for Substance Abuse Disorders



9.2 Types of Drugs Available in Eswatini

This list is not exhaustive:

- Alcohol
- Cannabis
- Tobacco
- Volatile solvents (glue, petrol, benzene)
- Heroin
- Cocaine
- Mandrax
- Ecstasy

9.3 Essential Components

9.3.1 History taking

Screen for addiction. (Check the screening and assessment tools used/ approved in Eswatini).

Apart from personal information, include what drugs or substances are used. Determine frequency and quantity, age of onset, and mode of administration to determine if there are any incidences of overdose and dependency. Screen for signs of depression – self-isolation, sleeping patterns and substance use disorders. Check the family history for the presence of addictions in the family.

10.3.2 Physical examination

- general appearance – unkempt hair, red eyes,
- head to toe examination - injection marks, black spots on figure and toe tips
- Restlessness – fidgeting, not standing still
- screen for withdrawal symptoms such as tremors, tempers, moodiness.

10.3.3 Information, education, and counseling

Discuss causes, dangers of alcohol other drugs, and substance abuse, to the adolescent such as unsafe sex resulting in the risks of STI and HIV infection; to the unborn child such as low birth weight, miscarriages, and sudden infant death syndrome

10.3.4 Management

- Provide basic counseling on drug abuse (causes, effects, withdrawal symptoms, how to quit)
- Assure the adolescent of confidentiality. Explain to them the importance of disclosure to parents or another adult for support in their recovery.
- Provide HTS

- Manage other conditions according to history and physical exam (pregnancy, STIs,)
- People who inject drugs counsel on the usage of non-sharing of needles and syringes
- Refer for further management to psychiatric care if adolescent threatens suicide
- Refer for further management if the adolescent does not respond positively to counseling
- Refer for further management to psychiatric care if the adolescent does not respond positively to counseling and threatens suicide

10.3.5 Referral

- Refer adolescents to the National Psychiatric Referral Hospital, SADAT, Teen Challenge Life Skills Centre.
- Refer PWID to National Psychiatric Referral Hospital (find out if there are rehabilitation centers.)

CHAPTER 10: MONITORING AND EVALUATION

10.1 Monitoring and Evaluation

Monitoring refers to the process of regularly measuring the status of a program by comparing the actual implementation of activities against the work plan, whereas evaluation is directed at measuring progress periodically towards the achievement of program objectives and their impact.

Monitoring and evaluation is an integral part of the Adolescent and Youth Friendly Service provision. With technical assistance from the ASRH technical working group, the Ministry of Health (MOH) Monitoring and Evaluation Unit shall provide overall strategic leadership in monitoring and evaluating the implementation of these guidelines. MOH in collaboration with other stakeholders will work in a coordinated manner to ensure effective monitoring and evaluation of the ASRH services.

Data from all existing M&E systems including routine, surveillance, evaluations, research, and population projections & estimates will be used to measure progress towards set indicators for program performance.

10.1.1 Health Management Information Systems (HMIS)

The SRH program and the Strategic Information Department – Health Management Information System (HMIS) unit will ensure that all data are available in routine information systems to address data needs for ASRH indicators, observing all the data quality elements- ensuring that data are reported timely, complete, valid, precise, reliable, and fit to serve its purpose.

The Monitoring and Evaluation (M&E) unit will ensure that all relevant quality data products are produced timeously. This entails ensuring that all indicators are in place to respond to all the ASRH programme data

needs, this will include local international data requirements, routine and ad-hoc.

10.1.2 Surveillance

Surveillance will be conducted for all necessary and emerging health conditions. These may not be adolescent-specific but for the general population e.g., STI's surveillance, ANC surveillance.

10.1.3 Research

Following the current research agenda for the country, studies will be conducted to respond to research questions. The Central statistics will provide data that is collected through the MICS and other population-based surveys.

10.1.4 Evaluation

Evaluations will be conducted to ascertain the impact of service interventions on adolescent health. Impact Evaluations are mainly based on guidelines and strategies to see if there are any changes over time, e.g., impact of adolescent-friendly services.

10.2 Levels of Implementation and Responsibilities

Regular monitoring/evaluation shall be carried out at all levels (i.e., at national, regional, and facility levels) in an integrated manner.

10.2.1 National Level

- Develop and indicate the framework to be used by all sectors involved in the monitoring and evaluation of the ASRH program.
- Assess the scope, effects, and impact of implementing the ASRH guidelines
- Collect, analyses periodically, interpret, and utilize data.

- Monitoring and evaluation shall be budgeted for annually. Therefore, the national level shall formulate budgets for the exercise.
- Conduct support visits at regular intervals to the regions
- Shall receive, compile, and utilize data from the regions.
- Provide feedback to the regions at the earliest possible time (e.g., quarterly) following the support visits and data analysis.
- Prepare and produce annual evaluation reports.

10.2.2 Regional Level

- Collect/collate information using a checklist and reports from the health facilities and community level.
- Analyze, interpret, and utilize data for the benefit of the services.
- Conduct monthly support visits to the facilities.
- Provide timely (i.e. monthly) feedback to the central and facility level.
- Hold regular meetings with the staff at the facility level to review and discuss the ASRH services implementation and key issues.
- Budget for the monitoring/evaluation activities done at the regional level.

10.2.3 Facility Level

- Service providers should collect data using existing data collection systems (CMIS, Paper-based), compile, analyze, and utilize data locally.
- Submit all paper-based reports to regional levels.
- Conduct monthly meetings to review the implementation of ASRH activities at their level.
- Identify and request support in training needs in data collection, compilation, analysis, and utilization.

Table 17: ASRH M&E Indicators

Category	Indicator	Disaggregation	Frequency	Source
Youth Friendly Services	% Service delivery points offering AYFS	Facility, Region	3 years	Program Reports
Family Planning	(%) use of any contraceptive among adolescent women (15-19 years)	Facility, Region	Quarterly, Annually	Program Reports, MICS
Maternal Health	% of Teenage pregnancy among adolescent women aged (15-19 years)	Facility, Region	Quarterly, Annually	Program Reports, MICS
Sexually Transmitted Infections and HIV/AIDS	Comprehensive knowledge about HIV among 10-14-year-olds (percent)	Region	2 years	MICS
	Knowledge of HIV prevention among adolescent girls and boys 15-19-year-olds (percent)	Region	5 years	MICS
	Percentage of adolescents who used protection at first/most recent intercourse	Region	5 years	MICS
	% of adolescents who are receive STI services	Facility, Region	Quarterly, Annually	Program Reports
	HIV incidence among 15-19-year-olds (percent)	Facility, Region	Quarterly, Annually	Program Reports, SHIMS

	% of young people (15 – 19 years) living with HIV currently receiving ART therapy	Facility, Region	Quarterly, Annually	Program Reports
Gender Issues in Sexual and Reproductive Health	SGBV among adolescent women 15-19 years (percent)	Facility, Region	Quarterly, Annually	Program Reports
Growth and Development	Age at sexual debut among 10-14 years olds	Facility, Region	5 years	MICS
Cancers of the Reproductive systems	% of adolescents diagnosed and treated for cervical cancer	Facility, Region	Quarterly, Annually	Program Reports
Community involvement and mobilization	Number of community awareness SRH (with a focus on ASRH) sessions conducted per health facility catchment area	Facility, Inkhundla, Region	Quarterly, Annually	Program Reports
Policy Environment	Existence of government policies, programs or laws favorable to adolescent reproductive health	National	5 years	MoH Policy inventory
	% of resources allocated to adolescent sexual and reproductive activities	National	Annual	National MoH Expenditure Budgets

10.2.4 How will the guidelines be monitored and evaluated

Monitoring and Evaluation of these guidelines will be integrated into the current existing health sector monitoring system. Information will be analyzed based on the adolescent strata namely 10 – 14 years and 15 – 19 years and 20-24 years with other demographics including sex and location. The data should be able to identify services sought vs services rendered and referred. Above are some of the proposed monitoring and evaluation indicators; where possible, population-based indicators should be customized to be also collected routinely.

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ANNEX 1: INTERNATIONAL AND REGIONAL COMMITMENTS AND AGREEMENTS

The government of Eswatini subscribes to or is signatory to the following international and regional instruments which underpin or inform the revised Adolescent Sexual and Reproductive Guidelines.

Table 18: International and Regional Commitments and Agreements

International	Regional
• International Conference on Population and Development (ICPD), 1994. • UN Convention on the Elimination of Discrimination against Women (CEDAW), 1979. • The Convention on the Rights of Persons with Disabilities (CRPD), 2006. • The Convention on the Rights of the Child (CRC), 1989. • UN Universal Declaration of Human Rights, 1948.	• African Union Agenda 2063 • Maputo Plan of Action 2016-2030, 2016. • SADC Revised Regional Indicative Strategic Plan 2015 – 2020. • SADC Revised Protocol on Gender and Development, 2016.

ANNEX 2: SUSTAINABLE DEVELOPMENT GOALS

SUSTAINABLE DEVELOPMENT GOALS



NOTES

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