**Original article**

# Factors Influence in Provision of Adolescent Friendly Health Services by Outreach Workers

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## Abstract

**Background:** Adolescence is a crucial transition phase of development in life. Globally, adolescents constitute a major portion of the communities, particularly in developing countries. In this phase, they are more likely to seek to a friendly health service without being ashamed of their condition.

**Methods:** A multi-center based cross-sectional study was conducted to determine the factors that influence in provision of adolescent friendly health services (AFHS) by outreach workers in the selected Government supported and private based health settings.

**Results:** The mean age of the outreach workers in both settings, the significant age difference was constructed (21.1±4.2 and 45.5±11.4 years). No adolescent was designated as outreach worker, even any participation of adolescent was not depicted from the community in the provision of AFHSs in the Govt. settings. In the case of provision of services in the communities, Govt. supported health facilities affiliated workers were striving with more components than private settings. Factors affecting AFHSs, private settings workers get more training, and had sound knowledge and practices on referral system and assistance in referral; controversially, they had inadequate medicine supply and no investigation facilities.

**Conclusion:** To strengthen the quality of AFHSs outreach workers need more training, human resources, promotional materials and well equipped health facilities with adequate medicine supplies. For making the services available and easily accessible needs to expand adolescent friendly health corners (AFHCs) in both of type settings by the intrgrated approach of both government, policymakers and stakeholders.

**Keywords: Adolescents, adolescent friendly health services, outreach workers, Bangladesh.**
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## Introduction

Young age groups of 10-19 years are denominated as adolescents.[1] Adolescence is a transitional period for human development. It is categorized by physical, psychosocial and emotional changes which transform them from childhood to adulthood. In this phase, central health situations like growth, development, sexual maturity, morbidity and mortality of adolescents are determined.[2-5] Globally, 1.2 billion are adolescents which is consists a fifth of the world's population and four-fifth of them are resides in developing countries.[6] In Bangladesh, about 36 million are adolescents which entail more than one-fouth of the total population.[7,8]

Access of adolescent health services is constrained by particular challenges such as fear, stigma, shame and lack of information as major barriers to accessibility and utilization of AFHS.[9] They also face a sort of barriers to accessing sexual and reproductive health (SRH) services, mental health services, adolescent pregnancy including provider's reluctant services which may develop a fear of confidentiality and mistreatment.[10]

Bangladesh has scarce experience in the implementation and provision of AFHSs. A few NGO based health

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facilities are providing these services for adolescents. AFHC is a new initiative in Bangladesh by the Goverrntment. In the country context, limited evaluations had been conducted for AFHS. To inflate AFHS in every part of the country need to extend SRH services to adolescents in precisely, the Maternal, Neonatal, Child and Adolescent Health (MNC&AH)) services unit of the Directorate General of Family Planning (DGFP) in collaboration with development partners has started establishing AFHCs at the selected government facilities at district and union levels.[11]

## Methods

### Study design and settings

This is a multi-center descriptive cross-sectional study carried out to determine the factors influencing in provision of AFHS by outreach workers. The study was conducted from January to December, 2019 in purposively selected two NGO based health facilities located in Mirpur, Dhaka and two Government supported health facilities located in Gazipur, Bangladesh. According to the WHO recommended sample frame[12], all outreach workers (total 12 persons, 8 persons from NGO based health facilities and 4 persons from government supported health facilities) were interviewed with informed written consent from the selected four health facilities. Outreach workers were community mobilizers, peer educators, family welfare visitors (FWV) and medical technologist for EPI (MT-EPI), designation differs from center to center. An interviewer-administered pretested semi-structured questionnaire was used to collect data through face to face interviews. The questionnaire was developed using WHO recommended 'Quality Assessment Guidebook'.[12] Data were collected on sociodemographic outlines, responsibilities of the outreach workers, AFHSs in the communities, factors influencing the provision of AFHS and opinions to improve AFHSs in the health settings. The collected data were analyzed by using IBM SPSS v23 software. The quantitative data were analyzed descriptively and presented in tables and bar diagram.

### Ethical approval

Participation was voluntary and confidentiality was maintained by using an individual code number for each participant. The study was validated by the National Institute of Preventive and Social Medicine (NIPSOM), Dhaka 1212, Bangladesh. (NIPSOM/IRB/2019/111)

## Results

#### Socio-demographic outlines of the outreach workers

Table 1 outlines the socio-demographic overview of the outreach workers occupied in both Government supported and NGO based private health settings. Among the interviewed outreach workers, two-third (8,75.0%) were from private facilities designated as peer educatiors and community mobilizers with the mean age 21.1±4.2 years and their age range 16-26 years; one-third (4,25.0%) from Govt. supported facilities designated as FWVs and MT-EPI with the mean age 45.5±11.4 years with a wide age range 29-55 years. No adolescent was involved in services provision in Govt. settings. In private facilities, the male-female ratio was 1:3, above one-third (37.5%) were married, one-fourths (25.0%) were completed their graduation and three-fourth (75.0%) were working for less than 6 months with the mean 4.2±3.7 months. In the Govt. facilities, the male-female ratio was equal (1:1), three-fourths (75.0%) were married and completed their graduation, and all of them were working for more than 12 months with the mean 22.7±44.8 months.

**Table 1: Socio-demographic outlines of the outreach workers (N=12)**

| Attributes | | Private (n=8) n(%) | Govt. (n=4) n(%) |
|---|---|---|---|
| **Age groups** | 16-19 years | 4(50.0) | 0(0) |
| | 20 years and above | 4(50.0) | 4(100) |
| | Mean±SD (years) | 21.1±4.2 | 45.5±11.4 |
| | Age range (years) | 16-26 | 29-55 |
| **Sex** | Male | 4(50.0) | 1(25.0) |
| | Female | 4(50.0) | 3(75.0) |
| **Marital state** | Unmarried | 5(62.5) | 1(25.0) |
| | Married | 3(37.5) | 3(75.0) |
| **Designation** | Peer educator | 4(50.0) | 0(0) |
| | Community mobilizer | 4(50.0) | 0(0) |
| | FWV | 0(0) | 3(75.0) |
| | MT-EPI | 0(0) | 1(25.0) |
| **Education** | Secondary and below | 4(50.0) | 0(0) |
| | Higher secondary | 2(25.0) | 1(25.0) |
| | Graduation and above | 2(25.0) | 3(75.0) |
| **Working duration** | Less than 6 months | 6(75.0) | 0(0) |
| | 6-12 months | 2(25.0) | 0(0) |
| | More than 12 months | 0(0) | 4(100) |
| | Mean±SD (months) | 4.2±3.7 | 22.7±44.8 |

## Responsibilities of the outreach workers

In the private facilities, peer educators were responsible for arranging awareness programs, satellite health camps and 'uthon boithak' with adolescents in the community. They also advised adolescents to go in health facilities for any particular health problem. Community mobilizers were responsible for arranging awareness programs, satellite health camps, provision of MCH and family planning counseling and common health problems related sessions with parents and school teachers in the communities and schools. In Govt. supported facilities, FWVs and MT-EPI were also responsible same as private settings workers. In addition, FWVs also conducted normal delivery and MT-EPI supervised the EPI program to the adolescent clients.

## AFHSs in the communities

Among the respondents, all of them were responsible for providing health services to the adolescent in the community. Table 2 demonstrates that among the services, cent percent were provided information on SRH, information on nutrition and awareness on child marriage in private settings; other-sides, 75.0% of workers were provided with information on SRH and the rest components were provided by the cent percent. In addition, Govt. supported health facilities affiliated outreach workers also provided information regarding drug addiction, and TT vaccination and supply sanitary pads for the adolescent girls in the health facilities, schools and communities.

**Table 2: Outreach workers providing services in the community**

| Service components | Private (n=8) n(%) | Govt. (n=4) n(%) |
|---|---|---|
| Information on SRH | 8(100) | 3(75.0) |
| Information on nutrition | 8(100) | 4(100) |
| Information on mental health | 7(87.5) | 4(100) |
| Awareness on child marriage | 8(100) | 4(100) |
| Information on adolescent pregnancy | 6(75.0) | 4(100) |
| Information on anaemia | 5(62.5) | 4(100) |

*Multiple responses

## Factors influencing the provision of AFHS

Figure 1 illustrates the factors influencing the provision of AFHSs in the health facilities and communities by the outreach worker in both settings. In NGO based private settings, cent percent peer educators and community mobilizers were involved other adolescents from the community to provide AFHSs; and among the workers, cent percent were known the proper referral system and provided assistance during referral in selective cases, and majorities (87.5%) were received training from the health facilities. In Govt. supported settings, three-fourths (75.0%) were known the proper referral system and received training from the health facilities, but half of them (50.0%) were not provided any type of assistance during referral a client to the other center. No outreach workers involved any adolescent from the community to provide AFHSs.

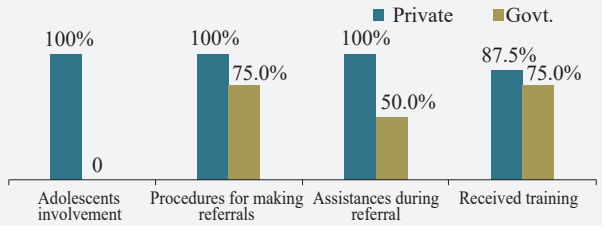


**Figure 1: Factors related to the provision of the AFHS (N=12)**

### Opinions to improve AFHSs in the health settings

In the NGO based health facilities, the some facilities provided services on selected days of the week through healthcare providers, but they didn't present at all times. Respondents suggested that the fixed time presence of paramedics and counselors in the facility and service provision throughout the week should be established. They need adequate medicines supply and baseline investigations facility to provide services properly in their center. They also said that provision of more educational and entertainment materials is needed for adolescent refreshment in the facilities. In Govt. supported facilities, respondents said that they need more waiting space and separate toilet facility for adolescents. More awareness programs and satellite health programs should be arranged in the community and schools. FWVs said that they need more pad supplies for adolescent girls. They also said that provision of more educational and entertainment materials is needed for adolescent refreshment in the facilities.

## Discussion

Bangladesh has a significant adolescent population. This significant adolescent population presents a demographic window of opportunity, which will contribute to the development of the country.[13] It is also evident that adolescence provides a second window of opportunity to adoloscents growth and cognitive development.[14]

This study demonstrates significant mean age differences within the outreach workers in the Govt. supported health facilities (21.1±4.2 years) and NGO based private health facilities (45.5±11.4 years). In private settings, adolescents were also involved in the provision of services in the communities, but there was no involvement found in Govt. settings. No significant differences were found in the marital state, educational state and responsibilities in both settings workers. In addition, they also conducted normal delivery and supervised the EPI program in Govt. settings.

To the greatest extent, outreach workers are responsible for providing AFHSs to the adolescents in the community. In the case of provision of services in the communities, Govt. supported health facilities affiliated workers were provided with more components than private settings such as information regarding drug addiction, and TT vaccination and supply sanitary pads for the adolescent girls.

Regarding factors affecting AFHSs, private settings workers get more training, and had sound knowledge and practices on referral systems than otherside workers. They also assisted in referrals in selective cases. In most of the referral cases, they refer due to unavailability of healthcare providers all day, inadequate medicine supply and no investigation facilities. In Govt. settings, they had adequate medicine supply and baseline investigation

facilities; and also indoor service facilities for critical illness. But they didn't involve any adolescents from the community to provide AFHSs. In both settings, more educational and entertainment materials are needed for refreshment adolescents in the facilities.

According to WHO guidelines, outreach efforts should more strengthened to reduce the factors related to the provision of AFHSs.[16] Investment in adolescents has an imperative stroke that can protect them against the effects of poverty, inequity and discrimination and make more productive adulthood for them.[16] To achieve the Sustainable Development Goals (SDGs), investment in adolescent's health will have a direct effect on Bangladesh's health goals.[13] In the context of rising global concern, the Government of Bangladesh's specific pledge to adolescent development is gradually manifesting policy and legislative framework like 'National Strategy for Adolescent Health 2017-2030'.[17]

## Conclusion

Depiction from outreach worker's recommendations, the study reveals that increasing access to information is a priority to increase knowledge on adolescent health topics and awareness of available health services. For available and expansion of these services needed more AFHCs with human resources alongwith adolescent involments from the community. All of the health facilities should be need well equipped and establish entertainment corner with informative booklets and storybooks for their recreation during waiting time. Government should more investment with policymakers and stakeholders for improving the quality of the AFHSs in both settings.

## Author's contributions

Conceptualization and literature review: Nurunnabi M; Methodology: Nurunnabi M and Noor IN; Data curation: Nurunnabi M; Formal analysis: Nurunnabi M; Writing draft: Nurunnabi M, Khan FA and Alam MB; Writing review and finalization: Nurunnabi, Khan FA, Noor IN, Alam MB and Begum A.

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## References

1. Adolescents sexual and reproductive health fact sheet. [Internet]. WHO: 2013. Available from: https://resourcecentre.savethechildren.net/pdf/adol-srh-fs-13.pdf (Retrieved 2022 January 12)

2. Marrying too young- End child marriage. [Internet]. United Nations Population Fund: 2012.

   Available from: https://www.unfpa.org/sites/default/files/pub-pdf/MarryingTooYoung.pdf (Retrieved 2022 January 12)

3. The Second decade: Improving adolescent health and development. [Internet]. WHO: 2001. Available from: https://apps.who.int/iris/handle/10665/64320 (Retrieved 2022 January 12)

4. Plan of action on adolescent and youth health. [Internet]. Pan American Health Organization: 2009. Available from: https://iris.paho.org/handle/10665.2/5203 (Retrieved 2022 January 12)

5. Mehra S, Sogarwal R, Chandra M. Integrating adolescent-friendly health services into the public health system: an experience from rural India. WHO South-East Asia Journal of Public Health. 2013;23(4):165-73. Available from: URL: https://doi.org/10.4103/2224-3151.115828

6. The second decade: Improving adolescent health and development. [Internet]. WHO: 2002. Available form: https://www.who.int/maternal_child_adolescent/documents/frh_adh_98_18/en (Retrieved 2022 January 12)

7. Population Census Report 2011. [Internet]. Bangladesh Bureau of Statistics (BBS): 2011. Available form: http://bbs.portal.gov.bd/sites/default/files/files/bbs.portal.gov.bd/page/7b7b171a_731a_4854_8e0a_f8f7dede4a4a/PHC2011PreliminaryReport.pdf (Retrieved 2022 January 12)

8. National ARH strategy 2006: Bangladesh adolescent reproductive health strategy. [Internet]. Directorate General of Family Planning Bangladesh: 2007. Available form: https://dgfp.gov.bd/site/page/dd79f17e-0ee5-4aad-8619-b3b8ebdb37f0 (Retrieved 2022 January 12)

9. Anaba EA, Abuosi AA. Assessing health care quality in adolescent clinics, implications for quality improvement. International Journal of Health Governance. International Journal of Health Governance. 2018;23(4):269-80. Available from: URL: https://doi.org/10.1108/IJHG-03-2018-0012

10. Global health: Adolescent sexual and reproductive health fact sheet. [Internet]. Save the Children: 2019. Available from:https://www.savethechildren.org/content/dam/usa/reports/health/adolescent-sexual-reproductive-health-fact-sheet-2019.pdf (Retrieved 2022 January 12)

11. Adolescent Friendly Health Corners (AFHCs) in selected government health facilities in Bangladesh: An early qualitative assessment. [Internet]. Population Council Bangladesh: 2017. Available form: https://evidenceproject.popcouncil.org/wp-content/uploads/2017/05/Bangladesh-AFHC-Report_2017.pdf (Retrieved 2022 January 12)

12. Quality assessment guidebook: a guide to assessing health services for adolescent clients. [Internet]. WHO: 2009. Available from: https://apps.who.int/iris/bitstream/handle/10665/44240/9789241598859_eng.pdf (Retrieved 2022 January 12)

13. National strategy for adolescent health 2017-2030. [Internet]. Directorate General of Family Planning (DGFP), Bangladesh: 2016. Available form: https://www.unicef.org/bangladesh/sites/unicef.org.bangladesh/files/2018-10/National-Strategy-for-Adolescent-Health-2017-2030.pdf (Retrieved 2022 January 14)

14. Dahl RE, Allen NB, Wilbrecht L, Suleiman AB. Importance of investing in adolescence from a developmental science perspective. Nature. 2018;554(7693):441-50. https://doi.org/10.1038/nature25770

15. Global standards for quality health-care services for adolescents. a guide to implement a standards-driven approach to improve the quality of health-care services for adolescents. [Internet]. WHO: 2015. Available form: https://apps.who.int/iris/handle/10665/183935 (Retrieved 2022 January 14)

16. Gender and Adolescence: why understanding adolescent capabilities, change strategies and contexts matters. [Internet]. GAGE conceptual framework. London: 2017. Available from: https://www.gage.odi.org/publication/gage-conceptual-framework (Retrieved 2022 January 14)

17. Bangladesh national adolescent strategy. [Internet]. Ministry of Women and Children Affairs, Bangladesh: 2020. Available form: https://mowca.portal.gov.bd/sites/default/files/files/mowca.portal.gov.bd/npfblock//National%20Adolescent%20Strategy_15.12.2020.pdf (Retrieved 2022 January 14)