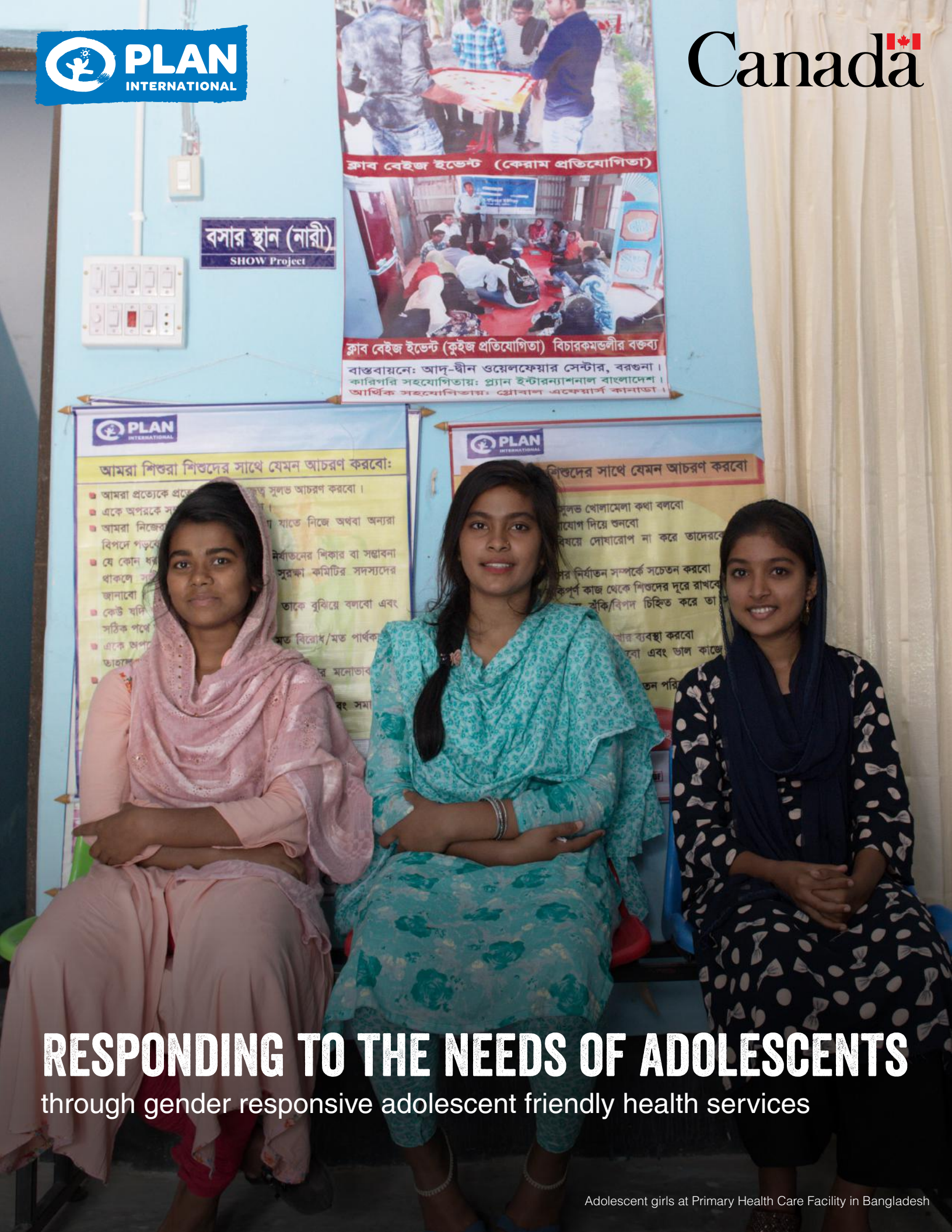


RESPONDING TO THE NEEDS OF ADOLESCENTS

through gender responsive adolescent friendly health services

Adolescent girls at Primary Health Care Facility in Bangladesh

Introduction: Adolescent Sexual and Reproductive Health

Adolescence is a major time of change in a young person's life. Starting around the age of 10, the transition between childhood and adulthood is associated with physical and psychological changes[1] related to puberty, as well as social interactions and relationships. It is not only the beginning of an individual's sexual and reproductive life, but it is also a time when gendered roles and expectations related to adulthood intensify.[2] As adolescents prepare for adulthood, socially and culturally conventional gender norms are reinforced, and their health needs enter an important stage.

Strengthening Health Outcomes for Women and Children (SHOW) is a 4.5-year multi-country gender transformative project funded by Global Affairs Canada and Plan International Canada. Its objective is to reduce maternal and child mortality amongst vulnerable women and children in targeted regions of Bangladesh, Ghana, Haiti, Nigeria and Senegal, catering to the unique needs of 331,000 and 339,00 adolescent girls and boys (ages 15– 19),[3] respectively. The project has focused on improving the quality, availability, utilization and accountability of essential MNCH/SRH services in all five countries. Three intersecting gender-transformative strategies have been employed to improve the condition and position of women and girls in their environments; one of these strategies caters to gender-responsive and adolescent friendly service provision through the broader health delivery systems offered within the country. For girls like Akhimoni in Bangladesh, who is 13 years old, this means having the ability to visit a health facility near her home and to carry out a private confidential discussion with a health professional on issues related to menstrual hygiene management. For 19-year-old Selorn Gli in Ghana, this means being comfortable walking into a facility to learn about sexual health issues important to him in a relaxed environment where he knows he will not be judged. In short, improving the provision of these adolescent health services is about making access for adolescents easier and more user-friendly in order to protect and improve their health and well-being, including their sexual and reproductive health.

[1] World Health Organization. (1993). The Health of young people: a challenge and a promise. World Health Organization. https://apps.who.int/iris/handle/10665/37353

[2] Hill JP, Lynch ME. (1983) The intensification of gender-related role expectations during early adolescence. In: Brooks-Gunn J, Petersen A, editors. Girls at puberty: Biological and psychosocial perspectives. New York: Plenum; pp. 201–228.

[3] SHOW interventions mostly reached 15-19 yes age groups.

Adolescents: health risks and their ability to protect themselves

In addition to biological and social changes, for some, the onset of adolescence is fraught with new vulnerabilities related to sexuality, early and forced marriage and risks of early childbearing. As pregnancy and childbirth are among the main contributors to disease and disability for adolescents,[4] the availability and access to MNCH/SRHR information and gender responsive and adolescent friendly health services is essential for mitigating morbidity and mortality. Despite this, many adolescents still experience difficulties finding both information and services that are focused on their health issues

Adolescents are confronted with various SRHR health issues that affect boys and girls, in all their diversity, differently. Most adolescents become sexually active by the time they reach the age of eighteen.[5] This is a normal and healthy part of life, but it also exposes adolescents to the risk of unsafe sexual behavior that could result in health problems, such as unwanted pregnancies, sexually transmitted infections (STIs), as well as HIV and AIDS. Girls experience disproportionately higher risks related to SRHR because of the vulnerabilities and gendered health care disparities created by their unequal economic, cultural and social status, compromising her ability to protect her sexual health through informed decision making and, if available, accessing the health services and information she needs.[6]

Child, early and forced marriage (CEFM) is another obstacle that jeopardizes the health status of adolescents Consequences of CEFM are primarily borne by girls who are forced into unwanted sex or marriage, resulting in a greater susceptibility towards unwanted pregnancies, unsafe abortions, STIs including HIV, as well as dangerous childbirth.[7] CEFM not only negatively influences a girl's ability to access knowledge, information and services available but this human rights violation curtails their education, limits their autonomy and exposes them to an increased risk of health problems as well as violence[8]. This harmful practice results in higher than average maternal morbidity and mortality.[9]

Finally, an adolescent's marital status can also impact their ability to make informed and independent decisions, including accessing basic and lifesaving health services. While both married and unmarried adolescents face difficulties in accessing specific information and health services in many parts of the world, unmarried adolescents can be at a disadvantage due to fear of getting in trouble with their parents, lack of available financial resources to pay for contraception or transport to and from facilities, being judged by health care providers, as well as being denied care in the context of SRH.[10] Furthermore, they may face barriers in accessing contraception due to restrictive laws and policies based on age or marital status.[11]

[4] Kiani MA, Ghazanfarpour M, Saeidi M. (2019). Adolescent Pregnancy: A Health Challenge. Int J Pediatr; 7(7): 9749-52.

[5] Guttmacher Institute.

[6] UNAIDS. (2019). Women and HIV: A spotlight on adolescent girls and young women. https://www.unaids.org/sites/default/files/media_asset/2019_women-and-hiv_en.pdf

[7] Shah, I.H., and E. Åhman. (2012). "Unsafe abortion differentials in 2008 by age and developing country region: High burden among young women." Reproductive Health Matters, 20, 169–173.

[8] Plan International. (2017). Submission to the report of the UN Secretary-General on progress towards ending child, early and forced marriage world-wide.

[9] Nour N. M. (2006). Health consequences of child marriage in Africa. Emerging infectious diseases, 12(11), 1644–1649.

[10] Govender, V. & Penn-Kekana, L. (2007). Gender Biases and Discrimination: a review of health care interpersonal interactions. Paper commissioned by the Women and Gender Equity Knowledge Network.

[11] de Vargas Nunes Coll, C., Ewerling, F., Hellwig, F., & de Barros, A. (2019). Contraception in adolescence: the influence of parity and marital status on contraceptive use in 73 low-and middle-income countries. Reproductive health, 16(1), 21.

Barriers to adolescent MNCH/ ASRH health care

Barriers that adolescents, both married and unmarried, encounter when trying to make informed decisions and seeking health services for their ASRH needs can be grouped as those at the individual, socio-cultural, and structural or institutional levels.

At the *individual level*, the lack of knowledge and awareness about their sexual health and rights, the low mobility of girls to access services independently, the lack of affordability of services in addition to lack of confidentiality on the part of health care providers, can all dissuade adolescents from seeking services. Plan International Canada's program data suggests that many adolescents are unaware of the services available to them, and why they should be accessing them. For example, in Bangladesh, adolescent mothers were "not aware or don't feel the necessity of health care after giving birth". This is primarily due to a cultural norm of prioritizing the newborn baby's health following childbirth and neglecting the health of the mother. One interviewed adolescent mother stated that she "did not pay attention to (herself) despite feeling sick, feverish, dizzy and unable to walk". With regards to barriers to accessing SRHR services, midterm data of the SHOW project that the perception of adolescent girls and boys is that unmarried adolescent girls experience more resistance and disapproval than married adolescent girls in terms of assessing SRHR services due to religious cultural settings and stigma. The same trend is seen with unmarried and married adolescent boys. The key reasons behind such resistance or disapproval were religious reasons and stigma.

At the *socio-cultural* level, cultural norms often dictate the behavior and sexuality of adolescents, the stigma and shame surrounding sexually active adolescents as well as parents feeling ill-informed and un-prepared to provide guidance around sexuality and reproductive health. Plan International Canada's data across a number of countries found that cultural norms at the community level greatly impeded girls' access to health facilities. For example, the gender norms in many of the SHOW communities dictate that a man's involvement and support is vital for the provision of adequate health services for their spouses as they require their permission and financial support to access MNCH/ASRH services. Similarly, for unmarried adolescents, gender norms play a critical role in an adolescent girls' ability to access health facilities. In many SHOW communities, censuring unmarried pregnancies is common. If the male partner denies his responsibilities as a father, girls may choose to leave the community to have their baby, compromising their access to family support and potentially MNCH/ASRH care. World Health Organization data suggests a high rate of these pregnancies are terminated clandestinely or by unskilled providers conducting unsafe abortions.[12] Considering the regional trends in Africa, 25% of all unsafe abortions are among adolescents aged 15 to 19 with around 8% incidence in Asia.[13]

[12] World Health Organization (WHO) Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008. Geneva: WHO; 2011.

[13] Unsafe Abortion: Global and Regional Incidence, Trends, Consequences, and Challenges Iqbal Shah, PhD, Elisabeth Åhman, MA, Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization, Geneva, Switzerland.

At the *structural* or *institutional* levels, there are challenges related to fee for service, restrictive laws and policies surrounding available health services, judgmental attitudes of health care providers and a lack of technical capacity for gender responsive and adolescent friendly MNCH/ASRH provision.[14] The completion of a health facility assessment (HFA) for the SHOW project in 2016 found a mix of policies and practice across the five countries. While Ministries of Health (MoH) are working hard towards alleviating differences, Plan International Canada's Health Facility Assessment data (Fig 3 & 4); backed by WHO and other sources, suggests that major gaps exist towards providing adequate services to this age group. For example, in Nigeria, there exists a national policy for youth friendly health service provision but this has never been institutionalized at the state level within the primary health care centers. Plan International, in close consultation with the state MOH & federal MoH, and other relevant stakeholders developed a state guideline for standard criteria and minimum standard package into primary health care services, aligned with a gender transformative approach. The state government endorsed guidelines aims to improve quality, access and utilization to expand coverage of health care services among adolescents while adding contextual clarity for the state's unique needs.

Gender Responsive and Adolescent Friendly Health Service Delivery

As a heterogenous group, adolescents have different perceptions on a service considered "gender responsive and adolescent friendly". However, at its core, these services are expected to be confidential, accessible, non-judgmental, available at their convenience, affordable or free and conducted by competent staff following appropriate protocols. Furthermore, the health facilities themselves need to be equipped with the appropriate drugs, supplies and equipment as well as be appealing and "friendly" through the addition relevant infrastructure; the WHO has defined such structures as adolescent corners, breastfeeding corners and privacy screens as those which provide adolescents with the appropriate services under these criteria.[15]

The fact is that adolescents have SRHR needs that are distinct from adults.[16] For example, in Nigeria, adolescent girls interviewed during SHOW assessments suggested that their greatest barriers to health services were costs and being treated by male staff; as a result, for them gender responsive and adolescent friendly meant better quality and more affordable treatment from health providers who were female. In Senegal, pregnant unmarried adolescent girls interviewed reported feeling constrained by the stigma and shame experienced during health center visits.

When compared to married women, one unmarried adolescent girl's experience was as follows:

> **"There is a difference. Because as soon as the doctor knows you're not married he can have prejudices against you and change his behavior and not receive you in the same fashion as married women. Once the doctor told me to go sit down. That made me feel bad.**
>
> – Unmarried adolescent girl, Nigeria

For these adolescents, adolescent friendly services means quality services provided by health staff that are non-judgmental.

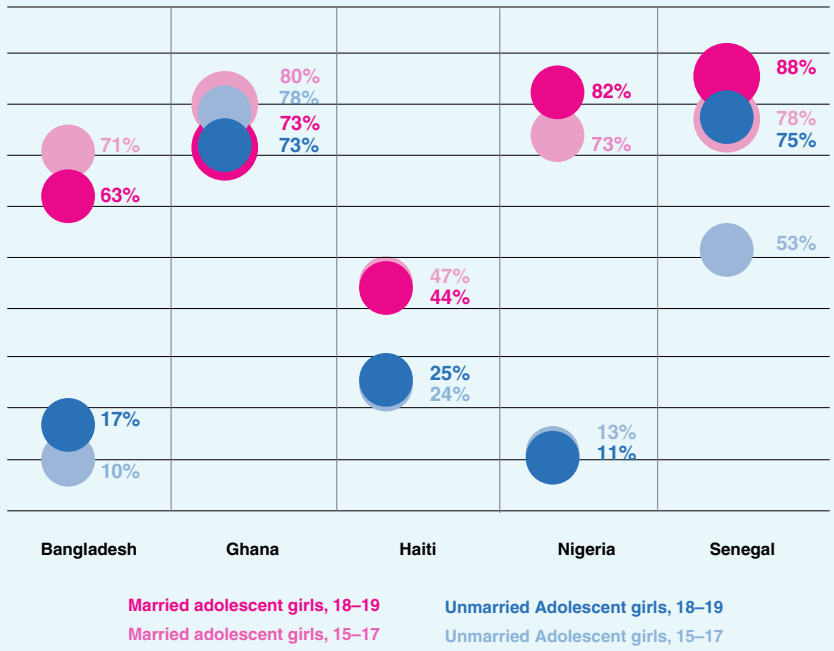
[14] Plan International. Adolescent/Responsive-Friendly, Maternal, Newborn (Child) Health/Sexual Reproductive Health MNCH/SRH Services. Guide for Health Facility Staff & Supervisors/Managers.

[15] WHO (2012) Making health services adolescent friendly. Developing national quality standards for adolescent-friendly health services. Department of Maternal, Newborn, Child and Adolescent Health.

[16] Young Adult Health and Well-Being: A Position Statement of the Society for Adolescent Health and Medicine Journal of Adolescent Health, (2017) Volume 60, Issue 6, 758–759.

Figure 1 further illustrates the discrepancies between the provision of care based on marital status. It shows that adolescent girls, especially unmarried, are vulnerable when it comes to accessing modern contraceptives compared with their married peer group. In all five countries, adolescents felt it was easier for married adolescents to access modern contraceptives in comparison to unmarried adolescent girls.

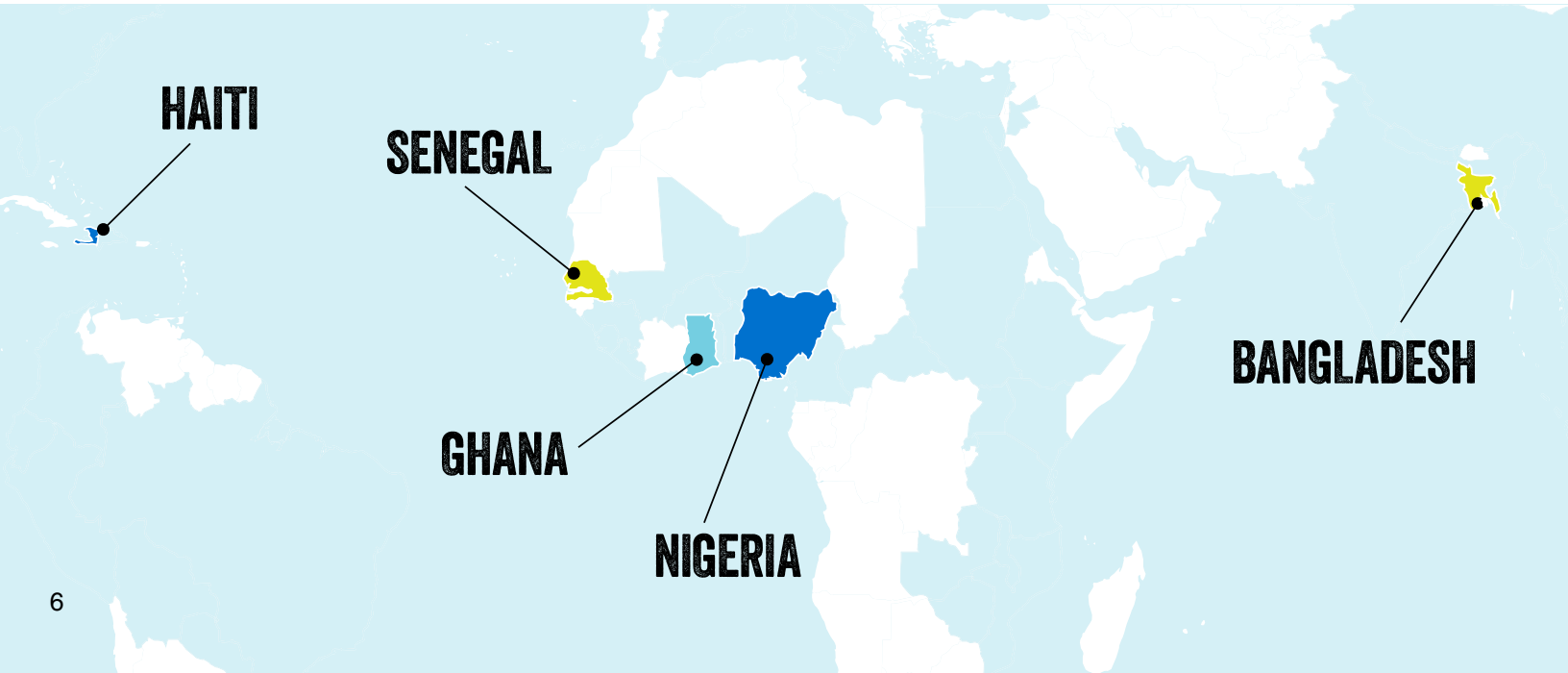
Figure 1: Percentage of adolescent girls who feel that unmarried adolescent and married adolescent girls have access to modern contraceptives, disaggregated by age of respondents



Plan International Canada's SHOW Model: How to get started for the improvement of adolescent health services

At the commencement of the SHOW project, the integration of gender responsive and adolescent friendly MNCH/SRH services into core health service delivery was prioritized.

But provision alone was insufficient without corresponding actions to improve service utilization. As a result, adolescent girls and boys were mobilized as active stakeholders and beneficiaries of ASRH service provision for the improvement of adolescent *utilization* of the essential health services. ASRH related topics were embedded within different community groups' (e.g, adolescent peer to peer groups, male engagement groups, influential women groups, support groups) with related discussions and meetings as a means of sensitizing community members and creating an enabling environment to encourage adolescents to access and utilize health services.



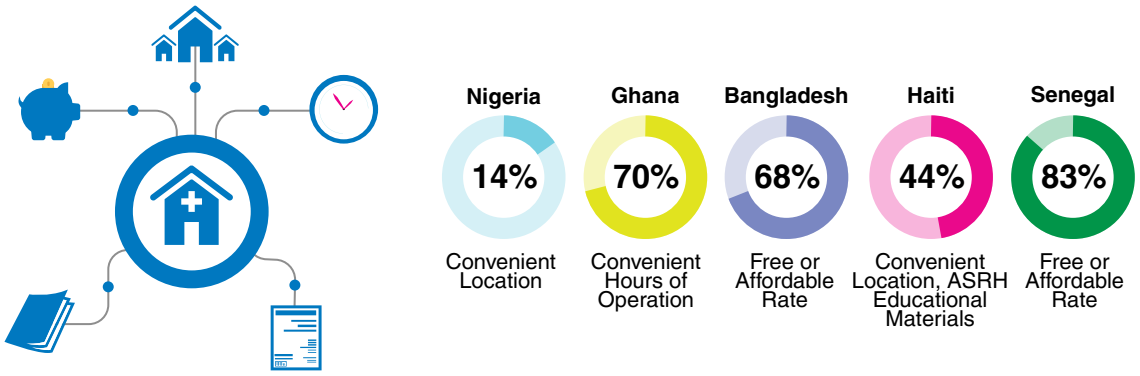


Figure 2: The percentage of health facilities with one of the selected five (5) criteria for adolescents

To improve the *delivery* of quality essential health services, the current state of the health facility, especially as it pertained to ASRH service provision, was assessed using Health Facility Assessments (HFA).[17] The HFA generated reliable information on service delivery (such as the availability of key human and infrastructure resources), the availability of basic equipment, basic amenities, essential medicines, diagnostic capacities, and the basic healthcare interventions related to gender responsive and adolescent friendly service provision such as family planning, basic and comprehensive emergency obstetric care (BEmONC), and immunization etc.

The HFA assessed five important criteria: 1) convenient location; 2) having convenient hours of operation; 3) offering services at free or affordable rates; 4) presence of written guidelines; and 5) ASRH educational materials. **Figure 2** highlights some of the HFA findings based on these criteria: Bangladesh and Senegal (had a 68% and 83% of facilities offering free or affordable rates while Ghana had 70% of facilities with convenient hours of operation. On the flipside, Haiti and Nigeria had a lower percentage of health facilities with a convenient location and/or available ASRH educational materials at 44% and 14% respectively. These results then formed the basis of Plan International's response plan for facilities. It recognized that while country Ministries of Health (MoHs) had already made notable strides in the provision of adolescent care, there remained weaknesses within health facilities still needing improvements in terms of delivering gender responsive and adolescent friendly services.

Furthermore, the HFA noted that MoHs offer mixed packages of ASRH health services in each country. The following package of services was assessed at the individual health facilities using the HFA: SRH education and counseling, family planning (FP) services, pregnancy care and delivery, voluntary counselling and testing (VCT) for HIV and STI treatment. With reference to the latter, **Figure 3** shows that the health ministries in some countries had made some notable strides in implementing STI treatment for adolescents at the majority of their health facilities; in Bangladesh (76%), Senegal (99%) and Ghana (92%) these services covered the majority of facilities.

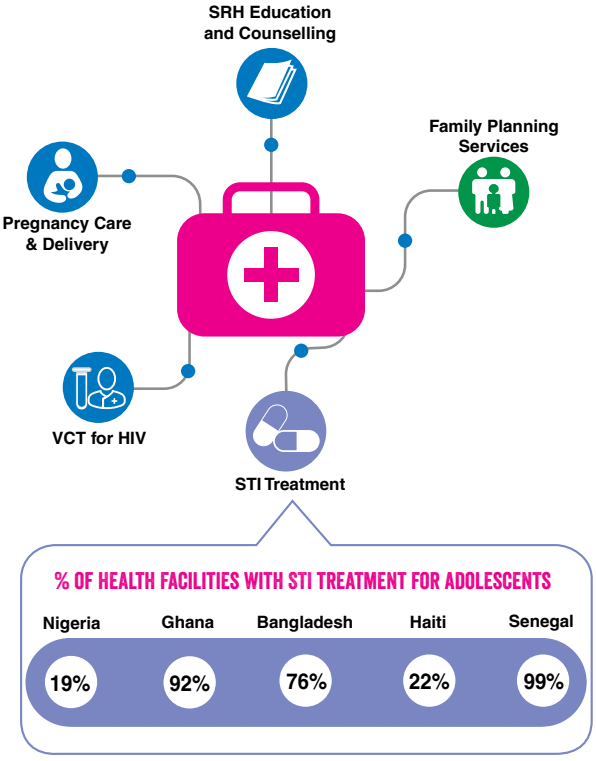


Figure 3: The percentage of health facilities with STI treatment for adolescents

[17] HFA was mainly a quantitative survey tool consisting of 17 sections, adapting WHO criteria for service availability and service readiness.

However, on the same indicator, further efforts to implement STI treatment was identified as a requirement in Haiti (22%) and Nigeria (19%) due to the low prevalence of health facilities offering this service. Once again, the HFA provided the roadmap for Plan's intervention in supporting ASRH service provision.

Plan's SHOW Model: Interventions strengthening health systems for quality adolescent health care

In recognition of the barriers and needs identified, each SHOW project country employed a set of five initiatives implemented in conjunction with the global standards for ASRH care.[18] These interventions aimed to strengthen the gender responsive and adolescent friendly dimensions to improve access to health services by adolescents. They included: 1) Health staff capacity building; 2) Advocating for improved policies; 3) Revitalizing and Strengthening Community Health Committees (CHCs); 4) Strengthening referral systems; and; 5) Improving quality assurance mechanisms.

In each country, SHOW developed health facility investment plans (HFIPs) with the ministries of health MoH and other relevant stakeholders to ensure coordinated efforts for inputs at the health facility including refurbishments and other support. These HFIPs included small-scale refurbishment, and provision of basic MNCH/SRH equipment and supplies to the targeted health facilities.

1. Health Staff Capacity Building

The effectiveness of health services for adolescents is best achieved if the health care providers have the required competencies in working with adolescents in general, in the 'adolescent-specific' aspects of providing health promotion, preventive, curative and rehabilitative services, as well as in interpersonal relations and communication. In SHOW, Plan International Canada worked alongside partners including MoH with over 2,826 service providers, particularly at

[18] WHO and UNAIDS. (2015). Global standards for quality health-care services for adolescents. Volume 1: Standards and Criteria. https://apps.who.int/iris/bitstream/handle/10665/183935/9789241549332_vol1_eng.pdf?sequence=1

the primary health care facility level in some of the most far reaching parts of the countries. Plan invested in capacity building of the health care staff through the provision of training on the clinical components of MNCH/ASRH service provision as well as their ability to respond to adolescents with empathy and sensitivity to contribute to the development of good communication and mutual respect, with a pronounced focus on gender responsive needs of girls and boys, in all their diversity. The training content for the health care providers was based on protocols and guidelines that are technically sound and of proven useful, adapted to the requirements of the national/ subnational situation and approved by the relevant authorities. The training structure comprised of competency-based sessions to build knowledge as well as skills base through clinical and hands on practice on areas such as education and counseling on gender responsive and adolescent friendly MNCH/ASRH services as a key aspect of quality of care, sexual health, pregnancy care and delivery, STI treatment and counseling and Voluntary Counseling and Testing (VCT) for HIV.

The gender responsive and adolescent training content was based on either newly developed or adapted content, depending on country curriculum endowments, and included topics such as: 1) how to make health services responsive to adolescents; 2) how the interplay of gender inequality and the social determinants of health has an impact on health outcomes; and, 3) how to consider contextually relevant measures to ensure health services are gender responsive and adolescent friendly and providing age appropriate effective health services. In the end, complementary guidelines were written and used as guidance tools for practices such as needs-based staffing, the provision of female health providers for maternal and reproductive health, as well as dedicated staff to address ASRH issues with adolescent girls and boys. This is especially important for environments with conservative cultural norms.

For health providers, these trainings were critical for honing their skills as well as contextualizing gender relations into their work. For example, in Nigeria, one health provider said: "…this is an eye opener, we never thought that these things matter, now we know, and we will make sure we step down this knowledge to other colleagues at our facilities who were not able to benefit from the training". Another participant added, "I actually thought there is nothing wrong with denying adolescent girls contraceptives, I felt I was helping them to be good girls but now I know better". In Haiti, the health providers, while participating in different gender responsive and adolescent friendly MNCH/ ASRH theoretical and practical trainings, credited the technical assistance as well as the subsequent coaching and supportive supervision visits as contributors to the mastery of their skill set. A health worker in Bangladesh stated the following:

I am newly recruited as an FWV (Family Welfare Visitor). The mentoring support has greatly helped me to develop my practical knowledge on different issues. As a service provider we have some knowledge gaps and lack of practical experience. The supportive supervision checklist and mentoring support showed me the indicators of quality services.

Kalo Chakma (FWV, Chengi UH&FWC, Panchari)

A notable success in all five SHOW countries was the national/federal MoH endorsement and inclusion of gender responsive and adolescent friendly content into the government health departments' documents such as clinical training manuals, modules and referral protocols. For example, in Nigeria, Plan supported the federal government in integrating gender-responsive and adolescent friendly component related to the contraception needs of adolescents in the national FP training curriculum for health care providers. In Bangladesh, the government endorsed the Union Health & Family Welfare Centre's management committee training manual and referral protocol.

Table 1 shows the facility-based health care staff in all five SHOW countries that were trained in gender responsive and adolescent friendly MNCH/SRH service provision. Senegal had the largest (1300) number of staff trained whereas Haiti had the lowest (69). In Ghana, there was almost an equal division of male and female health care service providers, but collectively there was a larger proportion of facility-based female health care staff trained (69%) than males (31%). This gender divide is important because studies have demonstrated that a gender diverse medical workforce might also translate into improved patient outcomes[19] and that different patients prefer to be treated by a specific gendered doctor and this is important for equity of access to care.[20]

2. Advocating for improved ASRH policies

In many countries existing laws, policies and financial allocations hinder the equitable provision of adolescent health services either by discriminating against adolescents in any way (e.g. marital status) or by making health care service provision unaffordable to adolescent clients. Government officials from the MoH and Women's Affairs/Gender and other relevant agencies in all five SHOW program countries were sensitized on gender responsive and adolescent friendly service provision, as well as governance and planning in Bangladesh, Ghana, Haiti and Nigeria.[21] Their orientations and meetings included trainings on the importance of equitable, accessible and acceptable service provision for improving adolescent SRH outcomes. In turn, as part of their critical role, these government officials would then be in a position over the long term to better advocate for and implement related policies to ensure the provision of an appropriate package for adolescent health care services. This includes information, counselling, diagnostics and treatment with a focus on gender related needs and priorities, including affordability and client confidentiality. They are also well positioned to advocate for female representation in trainings and their presence in health care facilities, leading to improved standards for gender responsive and adolescent friendly service provision. Finally, in situations where their role extends to decision-making forums within government spheres, they can help ensure that MNCH and ASRH remains a priority agenda item when it comes to health development planning and budget allocations. This intervention, while more difficult to attribute, is fundamental to the long-term sustainability of ASRH service delivery and gender responsive and adolescent friendly service provision. Moreover, some of the structural improvements to facilities and appropriation of training tools can be attributed, in part, to the advocacy efforts of these government officials.

Country	Total No. of Health Facilities in SHOW program	Total No. of facility-based health staff trained in GR-AF service provision	Total No. of female facility-based health staff trained in GR-AF service provision	Total No. of male facility-based health staff trained in GR-AF service provision
Bangladesh	71	541	368 (68%)	173 (32%)
Ghana	105	361	183 (51%)	178 (49%)
Haiti	11	69	52 (75%)	17 (25%)
Nigeria	244	555	334 (60%)	221 (40%)
Senegal	210	1300	1019 (78%)	281 (22%)
Total	**641**	**2826**	**1956 (69%)**	**870 (31%)**

Table 1

[19] Shannon G, Jansen M, Williams K, Cáceres C, Motta A, Odhiambo A, Eleveld A, Mannell J. (2019). Gender equality in science, medicine, and global health: where are we at and why does it matter? The Lancet; 393: 560-69

[20] Cooper-Patrick L, Gallo JJ, Gonzales JJ, et al. Race, gender, and partnership in the patient-physician relationship. JAMA 1999; 282: 583–89.

[21] This activity was not conducted in Senegal.

3. Revitalizing and Strengthening Community Health Committees (CHCs)

As part of the health facility strengthening approach in SHOW, Community Health Committees (CHCs) have been revitalized and established, corresponding to country specific situations, to oversee the general operation and management of the health facility. Plan has included training CHC's on gender responsive and adolescent friendly service delivery to improve their overall understanding of the needs of adolescents as well as develop a partnership with the facility-based health staff in bridging the gap for quality gender responsive and adolescent friendly health services, including the promotion of MNCH/SRH services for adolescent girls and boys, married and unmarried. Furthermore, the project's efforts for proportionate female as well as adolescent membership and leadership in the CHCs has provided support to community health structures in adequately responding to the varied and unique needs of often neglected community members, such as women, adolescent girls and boys. Together, these efforts have resulted in an additional layer of strengthened service delivery for adolescent girls and boys, in collaboration with the facility-based health staff.

At the SHOW program midpoint, data was collected on women's participation in the CHCs to assess progress against the percent of CHC members that are female and the percentage of CHC leadership positions held by women. **Table 2** shows that there was an improvement in female CHC membership and the level of participation of women in leadership positions across all program countries, except Senegal. With reference to female CHC membership, notable improvements were observed in Ghana, Haiti and Nigeria with increases of 20, 13 and 16 percentage points respectively compared to the baseline. With reference to the level of participation of women in leadership positions on CHCs, nominal improvements were observed in Ghana and Haiti whereas notable improvements were observed in Bangladesh and Nigeria with an increase of 7 and 10 percentage points, respectively. In terms of sustainability, these results are encouraging for a long-term shift in women's participation and decision making in community structures that directly impact health outcomes, including those of adolescents. On the other hand, Plan's engagement to get more adolescent participation within CHCs was met with some resistance at country level. With some exceptions in Bangladesh and Nigeria based CHCs, their leadership often felt that adolescent participation took young people away from their studies or constrained a more open debate on health issues. Where this was the case, Plan worked with CHCs to encourage adolescent voices in discussions, even if it meant getting views from them outside of formal meetings. When successful, it was concluded that adolescents who were trained outside of the CHC as part of other youth peer groups were most effective at advocating within CHCs.

Country	% of CHC members that are female		% of CHC leadership positions held by females	
	Baseline	Midterm Study	Baseline	Midterm Study
Bangladesh	37	38	27	34
Ghana	21	41	25	26
Haiti	35	48	48	52
Nigeria	23	39	14	24
Senegal	31	32	27	37

Table 2

4. Strengthening Referral Systems

While emphasizing an appropriate package of health care services, strengthening referral systems is also a key factor to improve ASRH services including maternal and child health. Although mothers should ideally be treated as close to their homes as possible at the primary care level with the needed expertise,[22] a referral system serves as an important "back-up function" if life-threatening complications require management and skills that are only available at higher levels of care.[23] The importance for adolescents cannot be understated – referrals may require adult consent or disclosure to parents or require accompaniment; each of these may be more difficult for those under the age of 18, particularly those unmarried, single mothers, or those hiding their condition from their parents or partner. However, if the referral system is utilized appropriately with considerations for adolescents, it can be expected to decrease maternal and newborn morbidity and mortality.[24] The SHOW project supported and strengthened gender responsive and adolescent friendly referrals to the appropriate level of care, as part of a comprehensive package of health services that fulfills the needs of all adolescents including girls, boys and women of reproductive age.

All SHOW project countries integrate safe and respectful gender responsive referrals through an enabling environment of referral systems and structures from primary to secondary health care facilities. Referral protocols have been revised, developed and used as guidelines to inform the MoH on gender responsive and adolescent friendly referral services. They have facilitated the realization of a strong referral mechanism where all adolescents and adults are managed appropriately, regardless of their sex, age or ability.

Gender responsive and adolescent friendly trainings on the referral protocols have also been conducted with facility-based health staff as well as transport operators. The have equipped health staff with the knowledge and skills on how to provide appropriate support and accommodations for patients and their accompanying person in transition through the referral process, in addition to the provision of appropriate treatment for the referred patient. The trainings for transport operators have ensured that all pregnant women and girls, as well as their accompanying attendants, are treated with dignity, respect and sensitivity along the continuum of care (inclusive of referrals). In turn, their increased capacity contributes to the establishment of a gender responsive and adolescent friendly transportation system that is affordable, timely, comfortable and safe for adolescents and adults.

Country	Total No. of facility-based health staff trained on (reviewed) referral protocols	Total No. of female facility-based health staff trained on (reviewed) referral protocols	Total No. of male facility-based health staff trained on (reviewed) referral protocols	Total No. of transport operators trained on (reviewed) referral protocols
Bangladesh	407	281 (69%)	126 (31%)	208
Ghana	3360	1073 (32%)	2287 (68%)	935
Haiti	79	45 (57%)	34 (43%)	17
Nigeria	2749	2505 (91%)	244 (9%)	488

Table 3

[22] Jahn A, De Brouwere V. Referral in pregnancy and childbirth: concepts and strategies. In: De Brouwere V, Van Lerberghe W, editors. Safe motherhood strategies: a review of the evidence. Antwerp: ITG Press; 2001. p. 229–246.

[23] WHO (1994). Mother-Baby-Package: Implementing safe motherhood in countries, Maternal Health and Safe Motherhood Programme, WHO, Geneva.

[24] Jahn A, De Brouwere V. Referral in pregnancy and childbirth: concepts and strategies. In: De Brouwere V, Van Lerberghe W, editors. Safe motherhood strategies: a review of the evidence. Antwerp: ITG Press; 2001. p. 229–246.

Table 3 shows that both female and male facility-based health staff, as well as transport operators, have been trained on the gender responsive and adolescent friendly reviewed referral protocols. Ghana had the largest number (3360) of health staff trained whereas Haiti had the lowest (79). In Bangladesh, Haiti and Nigeria, there was a greater proportion of females trained in comparison to males.

Finally, communication for referral care is facilitated by a referral form or via an ICT platform that assures gender responsive and adolescent friendly patient care and follow up; the database is then capable of analyzing the data by age group (including adolescents: 10 to 14 years old, 15 to 19 years old) for pregnant and breastfeeding women and girls. This disaggregated data provides further insight into the magnitude of the burden, adolescent health needs and barriers to services for this age group. All these initiatives are also embedded in ongoing advocacy efforts to ensure the sustainability of the gender responsive and adolescent friendly referrals in each of the five countries after the close of the program in 2020.

How can health staff make referrals gender responsive and adolescent friendly?

- *Ask whether a partner or family member can accompany them*
- *Explain the reason for the referral including information on health care provider and health facility referred to*
- *Suggest appropriate transportation methods*
- *Listen to and address, where possible, the concerns of adolescent girls and boys*
- *Fill out the appropriate forms properly and provide duplicates to the patient*
- *Treat the patient with dignity, respect, privacy and confidentiality*
- *Accommodate and involve the partner or family member*

5. Improving Quality Assurance Mechanisms

SHOW is implementing joint field monitoring as well as integrated supportive supervision (ISS) visits as part of their quality assurance mechanisms. Both type of supervisory visits paves the way for actionable feedback and the improvement of gender responsive and adolescent friendly health service delivery at the health care facilities. They are planned in advance and conducted in collaboration with stakeholders such as government officials, facility-based staff, local partners and community members.

Joint field monitoring and supervision visits were conducted in all five SHOW project countries on a regular basis. The joint visits include monitoring visits to the program sites to ensure adherence to ASRH standards. Program inputs, outputs and outcomes are reviewed as a comparative evaluation against the health facility monitoring tools such as checklists and program intervention standards, inclusive of benchmarks on gender responsive and adolescent friendly service provision.

The ISS visits also ensure the provision of feedback to health care providers as well as monitoring data collection processes for improved health care decision-making. Different tools such as ISS checklists, facility checklists and antenatal/postnatal care cards were used to facilitate this process. These tools and processes were strengthened through the project to incorporate more gender responsive and adolescent friendly indicators. In addition to joint field monitoring and ISS visits, Bangladesh and Haiti have implemented recognition initiatives for champions of gender responsive and adolescent friendly service provision as means of upholding quality assurance mechanisms. In Bangladesh, health facilities were awarded for modelling the minimum standards for gender responsive and adolescent friendly service provision across the continuum of care, whereas in Haiti, service providers honored and recognized for their gender responsive and adolescent friendly service provision. These incentives are meant to encourage other health facilities and staff to reach the improved standards.

Country	Baseline	Midterm
Bangladesh	32%	23%
Ghana	26%	89%
Haiti	0%	73%
Nigeria	28%	29%
Senegal	49%	57%
Overall Average	**27%**	**54%**

Table 4

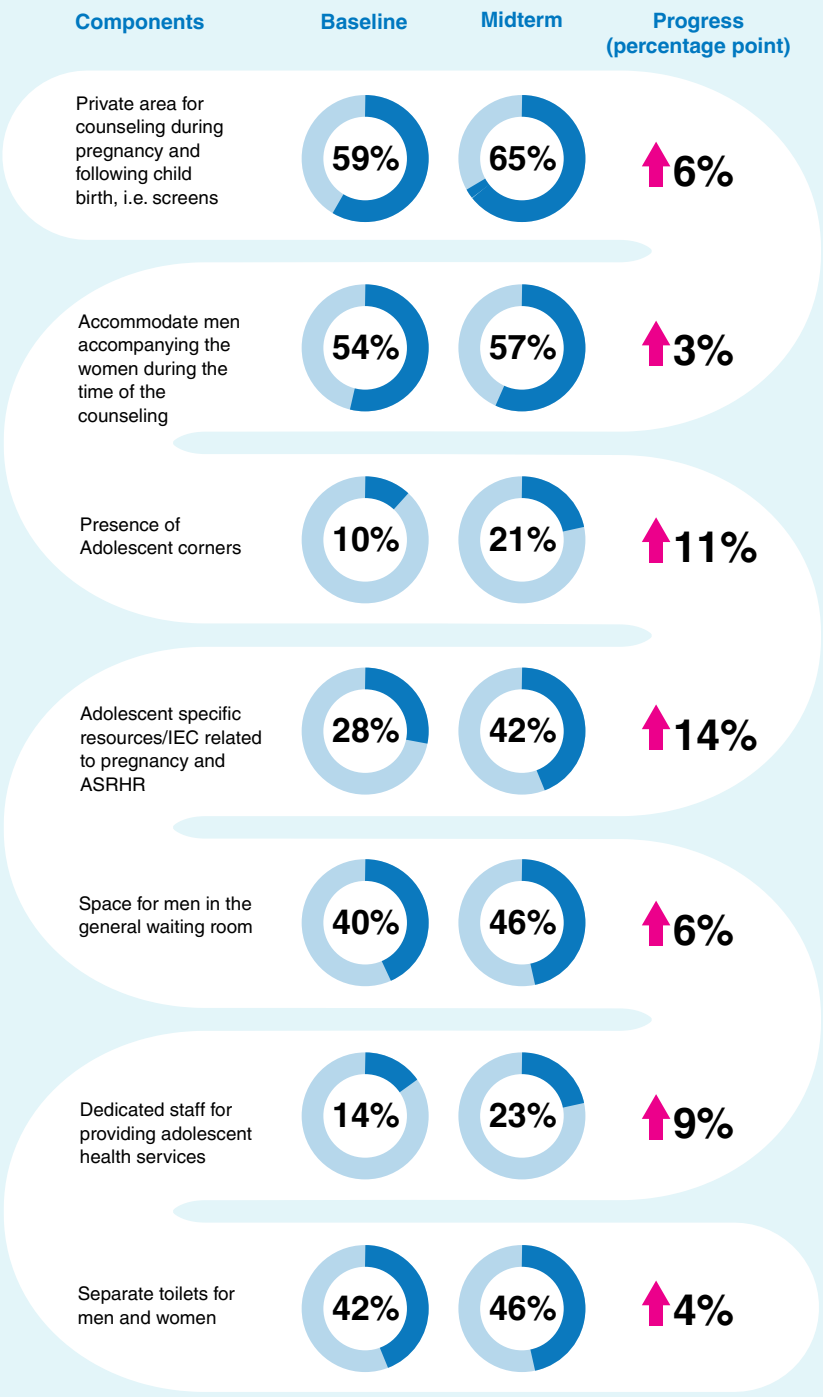
More results towards gender responsive and adolescent friendly MNCH/SRH services

As already noted, midterm surveys were conducted in all five SHOW countries between August and November 2018, in part, to assess progress in gender responsive and adolescent friendly service provision.

Table 4 shows midterm data[25] revealed four out of five SHOW countries having a greater percentage of health facilities providing gender responsive and adolescent friendly MNCH/SRH services from baseline to midterm. The percentage of health facilities providing gender responsive and adolescent friendly MNCH/SRH services increased substantially in Ghana and Haiti, whereas more moderate improvements were observed in Nigeria and Senegal. The exception was Bangladesh where there was a decrease of 9 percentage points due to the selection of the facilities measured.[26] Altogether, there was a 27 percentage point increase in health facilities in all five SHOW countries that provided gender responsive and adolescent friendly MNCH/SRH services.

[25] Due to the limitations in baseline and midterm approach in sampling of health facilities, the results are indicative and shouldn't be generalized.

[26] Upon further investigation it was noted that this decrease was due to the facility type that was measured. The Union Health and Family Welfare Centre Management Committees (UH&FWC) performed better than the community Clinics (CC) in terms of providing gender responsive and adolescent friendly services.



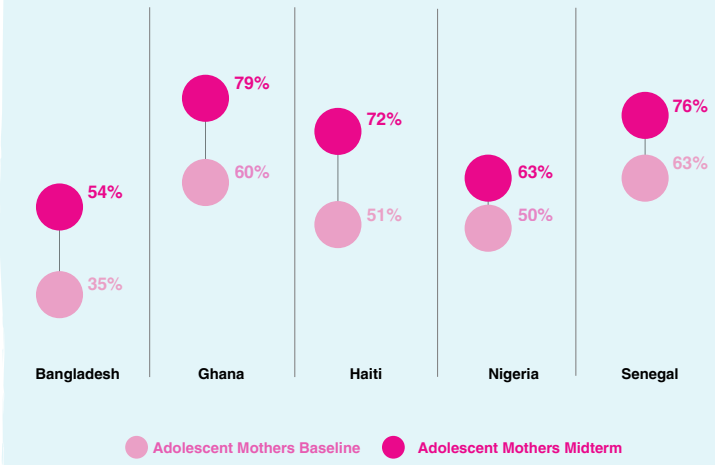
Due to limitations in the baseline and midterm approach in sampling of health facilities, the results are indicative and should not be generalized.

Figure 5

In terms of performance of health facilities, key components of gender responsive and adolescent friendly MNCH/SRH services were measured at baseline and midterm with notable improvements in a few key components (**Figure 5**). For example, in all five SHOW project countries, there were improvements from baseline to midterm in the presence of adolescent corners. This resulted in an overall 11 percentage point increase across the country portfolio. Furthermore, in Ghana, Haiti, Nigeria and Senegal, there were improvements from baseline to midterm in the presence of adolescent specific resources/IEC materials related to pregnancy and ASRHR. Despite the decline seen in Bangladesh, a 14-percentage point increase was noted in the portfolio. The other key components listed in the table below saw more modest overall improvements from baseline to midterm.

Overall, the midterm survey results demonstrated improvements in the provision of gender responsive and adolescent friendly MNCH/ASRH services in most health facilities across the five SHOW program countries. The five global standards that were implemented (in addition to small scale refurbishment programs) have shown positive impacts towards creating more conducive environments for adolescents accessing the health services that they need. Further evidence in increased service uptake for antenatal care, skilled birth attendance, post-natal care and utilization of contraceptive services by adolescent mothers (ages 15 to 19), further supports the beneficial impacts of the SHOW project.

Figure 4: Percentage of adolescent mothers who received 4 or more ANC services by a skilled provider at baseline and midterm



Antenatal Care (ANC)

The results from the midterm household survey show interesting trends with regards to MNCH/SRH service usage. The data on Antenatal Care (ANC), shows the percentage of adolescent mothers reporting to have received 4 or more ANC services has increased since the baseline study across all project countries.

Delivery Service

With regards to use of Skilled Birth Attendants (SBA) during delivery, the midterm showed an increase in usage of SBAs, across all five countries, for both adolescent and adult mothers. Adolescent mothers in **Ghana** experienced the largest increase from the baseline while the use of SBAs was highest overall in **Senegal**. **Nigeria** had the lowest rates during both the baseline and midterm. With regards to location of delivery, most women in **Haiti**, **Ghana** and **Senegal** delivered at a facility.

Figure 5: Percentage of adolescent mothers who are attended to by a skilled birth attendant during child birth

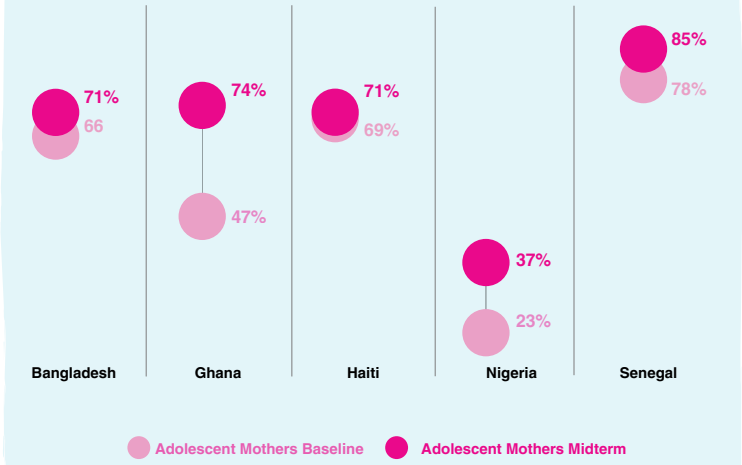
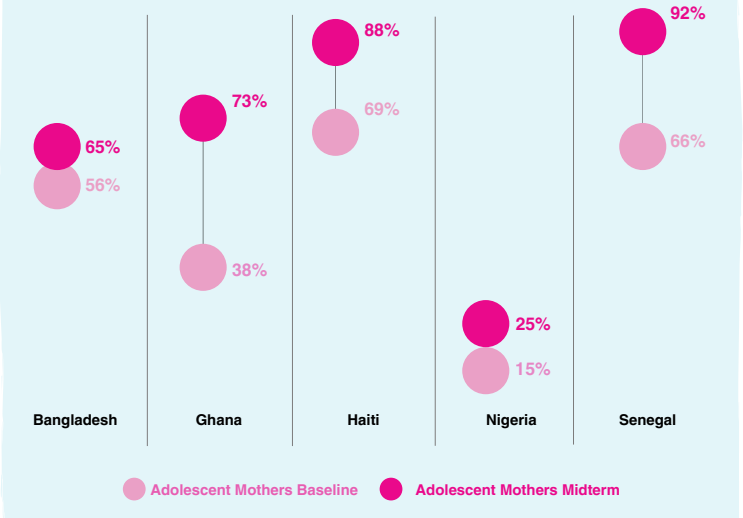


Figure 6: The percentage of adolescent mothers who receive postnatal care within two days of childbirth



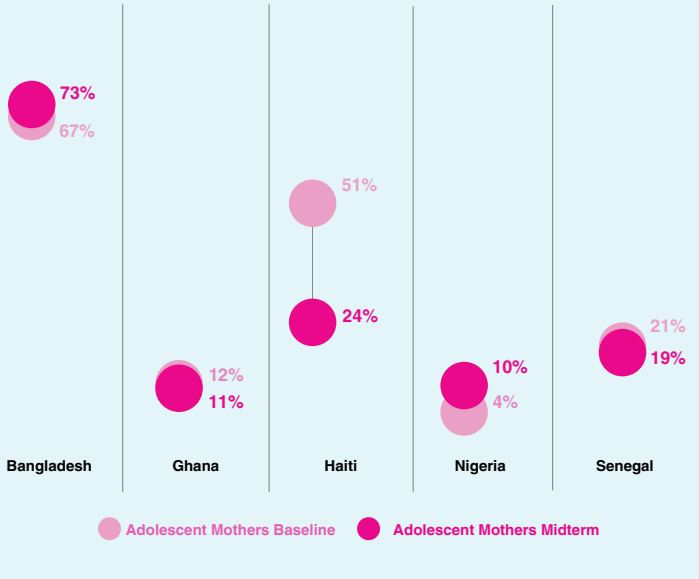
Post Natal Care (PNC)

The results from the midterm showed improvements in all five countries for Postnatal Care (PNC) within 2 days as compared to the baseline study results. The highest PNC rates were reported in **Senegal** followed by **Haiti** while **Nigeria** recorded the lowest levels of PNC use. **Ghana** on other hand has shown marked improvement in increasing PNC from 38% to 73%. For all five countries, nurses and midwives were the key service providers for PNC as per the midterm data.

Family Planning

The mid-term survey questions on family planning (FP) were asked at both baseline and midterm only of those respondents who identified as currently married or in union. Midterm survey results suggest a general increase in the proportion of WRA currently using modern contraceptive methods. However lower rates of uptake by adolescents has been observed. Bangladesh at 73% has the highest levels of adolescent mothers using any form of modern contraception method. Overall the project is slowly setting the stage to progress on this indicator considering the misperceptions; and harmful social norms within each country. Additionally, the importance of obtaining consent from in-laws and husbands of adolescent cannot be underrated. The strong societal influence on how adolescents should live their lives and how adolescents live their lives causes a lot of confusion and barriers to acceptance by the community. Furthermore, proving fertility is more common among adolescents right after they get married, besides the fear of infertility that hinders them from opting for these services, despite their availability. The interplay between gender, environment, education status and decision making capacity are all critical limitations that require behavior change and thus takes longer.

Figure 7: The percentage of adolescent mothers, who are currently using a modern method of contraception



Conclusions

In conclusion, the results and trends revealed thus far at mid-point demonstrate that adolescents are accessing improved gender responsive and adolescent friendly services as the SHOW program continues to help adolescent girls and boys grow and develop in good health.

The HFA serves as the foundational resource for the refinement and contextualization of the programmatic support planned at each health facility in the SHOW countries. It also serves as a reference for monitoring the project's progress in terms of promoting increased service availability and operational capacity of supported facilities to offer quality gender responsive, adolescent friendly MNCH/SRH services. This includes informing the scale, scope and priority of the refurbishment of the health facilities and the development of a health facility investment plan (HFIP), inclusive of small-scale facility refurbishment plans and the provision of essential MNCH/SRH medicines and equipment as well as clinical waste disposal processes and equipment. The HFA, though an intense process using the project criteria in identifying gaps and weaknesses, served as the groundwork for future support and improvement towards targeting the health facilities effectively by the MoH and other development partners as well limiting duplication of efforts.

As part of the HFA, resources and systems available/lacking/in need of strengthening were identified as well as the capacity of human resources in carrying out quality service delivery. The Projects results also showed that access to and the uptake of gender responsive and adolescent friendly sexual and reproductive health services are most effective with the

right combination of training and health facility improvement along with community acceptance on demand creation activities. The process helped the project teams in all five countries in working closely with the government both for capacity building of health care providers and refurbishing the health facilities. The consultation process, although, excellent in building ownership and sustainability was time consuming where the project faced delays in implementation whereby completing interventions in different phases. Some criterion such as flexibility in facility operating hours, ensuring increased number of female staff, availability of separate toilets for males and females and additional space for private consultations and waiting areas have been possible through targeted advocacy efforts in collaboration with MoH through the CHCs.

The training of the health care providers needs to be combined with supportive supervision to be effective. Health workers performance is perceived to improve, which can be attributed to the supportive supervision where they receive acknowledgment of good performance as well as seek guidance in address skills and knowledge that they are not capable to perform adequately. These interactions serve to continue their learning momentum following trainings and serve as reminders for their core competencies. The issue with supportive supervisions remains to be an area requiring further support by the MoH as they had received from their supervisors following the intervention. Working closely with the community and MoH has helped in bringing ASRH as priority agenda ensuring sustainability of efforts beyond the life of the project.

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Plan International Canada Inc.

National Office
245 Eglinton Avenue East
Suite 300
Toronto, ON M4P 0B3
Canada

Ottawa Office
130 Slater Street
Suite 1350
Ottawa, ON K1P 6E2
Canada

416 920-1654
1 800 387-1418
getinvolved@plancanada.ca
plancanada.ca

CRA Charity Registration Number 11892 8993 RR0001