ASSESSING APPLICATION OF WHO GLOBAL STANDARDS FOR ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN FIVE WEST AFRICAN COUNTRIES

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BACKGROUND

IntraHealth International recognizes the right of all people to sexual and reproductive health. To manifest this right, we focus on building the capacity of health workers, health systems, and communities to scale-up and sustain provision of evidence-based sexual and reproductive health programs. Investing in adolescent sexual and reproductive health (ASRH) is critical. Yet, social norms often dissuade adolescents from accessing ASRH information and services that could help them prevent unintended pregnancy and sexually transmitted infections, including HIV.

Why Adolescent Sexual and Reproductive Health?

There is an urgent need to improve access to youth-friendly ASRH services. Adolescent pregnancy, whether intended or unintended, is associated with poor maternal and infant health outcomes[1]. Worldwide, complications in pregnancy and childbirth are the leading cause of death among women aged 15-19 years, and infants born to young mothers are more susceptible to life-threatening complications[1,2]. Girls and young women with children are often denied opportunities to attend school and earn an income[3]. In turn, they, their families, and their communities are more likely to live in poverty. There is a particularly critical need to improve ASRH services in West Africa, where adolescent girls have

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the lowest contraceptive prevalence—34% among non-married sexually active adolescents and 20% among married adolescents—and the highest maternal mortality rates in Africa[4].

Despite the clear imperative to improve youth-friendly services, discomfort surrounding adolescent sexuality commonly results in barriers to essential health care. Social norms may cause adolescents to fear stigma, discrimination, or lack of respect when accessing services. They may also lead health workers to impose unnecessary restrictions on adolescents; for example, refusing to offer long-acting contraceptive methods[5,6]. Related obstacles faced by adolescents include poor knowledge about service availability, the cost of receiving services, and lack of confidentiality[7]. Even where adolescents can and do access sexual and reproductive health services, they are often poorly coordinated and of low-quality.

CS4FP Plus: Improving ASRH Services in West Africa

IntraHealth implemented the Strengthening Civil Society for Family Planning Plus (CS4FP Plus) project in West Africa, funded by the William and Flora Hewlett Foundation and the Dutch Embassy. CS4FP Plus advanced partnerships between governments and civil society organizations (CSOs) to promote the benefits of family planning, hold governments accountable to their family planning commitments, and advocate for technical support and the resources required to enable countries to meet their family planning goals.

As one of its primary aims, CS4FP Plus supported partnerships between governments and the private sector to standardize and expand access to ASRH services that align with the World Health Organization (WHO)/UNAIDS Global Standards for Quality Health Care Services for Adolescents[8]. These standards, outlined in Table 1, have been adopted by

Table 1. WHO/UNAIDS Global Standards for Quality Health Care Services for Adolescents

Adolescents' health literacy: The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Community support: The health facility implements systems to ensure that parents, guardians, and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.
Appropriate package of services: The health facility provides a package of information, counseling, diagnostic, treatment and care services that fulfills the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.
Providers' competencies: Health care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health care providers and support staff respect, protect, and fulfill adolescents' rights to information, privacy, confidentiality, nondiscrimination, nonjudgmental attitude, and respect
Facility characteristics: The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies, and technology needed to ensure effective service provision to adolescents.
Equity and nondiscrimination: The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation, or other characteristics.
Data and quality improvement: The health facility collects, analyzes, and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.
Adolescents' participation: Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

more than 25 countries and define minimum levels of quality in eight critical service delivery areas. To advance implementation of the standards, CS4FP Plus conducted a study in 2019 in partnership with governments and CSOs in Côte d'Ivoire, Guinea, Mali, Mauritania, and Niger to examine the degree to which ASRH service delivery in those countries aligns with the global standards. The objectives of the study were to:

- Determine the percentage of facilities offering services according to the global standards
- Determine the degree to which adolescent-friendly services are offered within facilities
- Identify barriers to the provision of ASRH services
- Formulate recommendations for improving accessibility and quality of ASRH services.

METHODOLOGY

In each country, the Ministry of Health, in close collaboration with its respective gynecology and obstetrics society and coalition of CSOs, selected a maximum of 20 facilities for participation in the study. Eligible facilities were located within a 25-kilometer radius of the capital city and offering ASRH services. In total, 100 public and private facilities participated in the study (Table 2). Trained researchers conducted interviews with one manager within each facility to collect information about ASRH service delivery, and used structured observation to verify processes, procedures, and conditions related to service delivery.

Table 2. Study facilities by type and number of interviews conducted per country

Country	Facility ownership		Interviews
	Public	Private	
Côte d'Ivoire	17	3	20
Guinea	13	7	19
Mali	13	7	21
Mauritania	16	1	20
Niger	20	0	20
Total	**79**	**18**	**100**

RESULTS

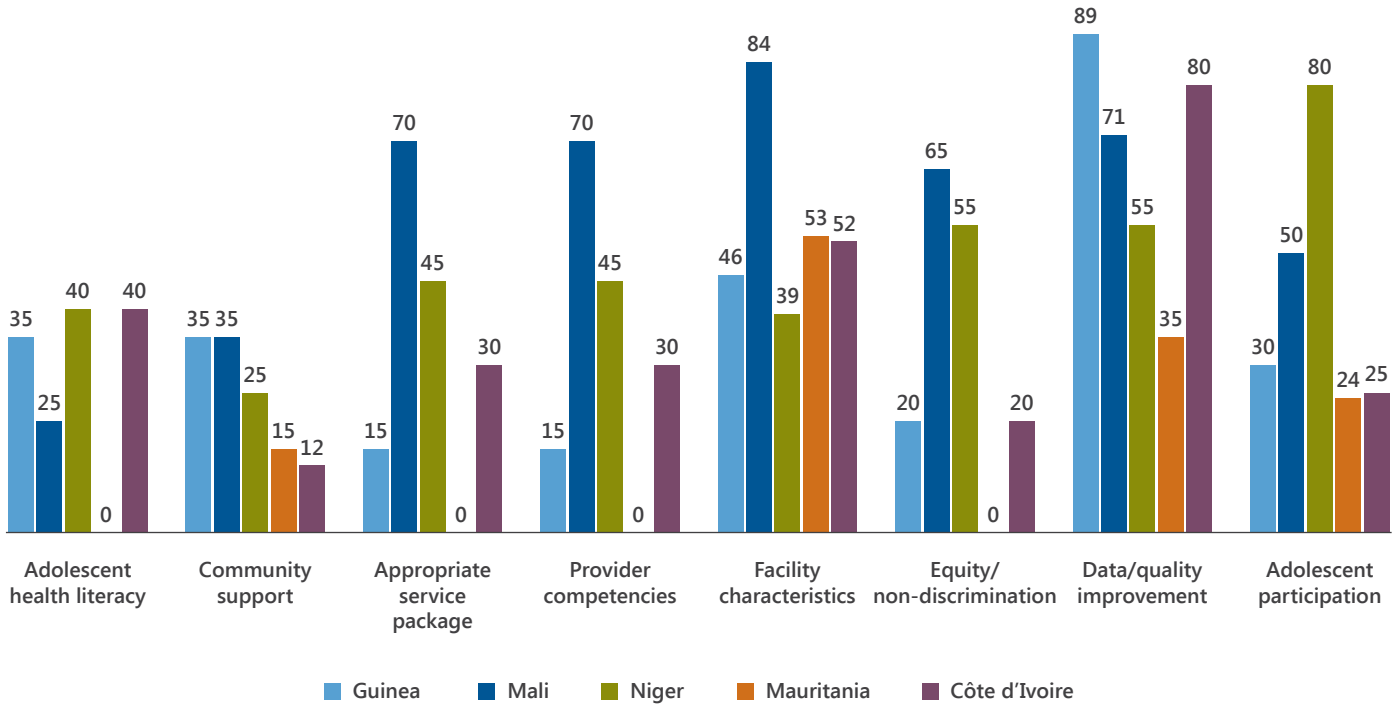
Health facilities do not consistently implement the WHO/UNAIDS global standards. As shown in Figure 1 (next page), implementation of each of the eight standards varied greatly across the five countries in the assessment. No health facility in our sample applied all of the global standards.

Providers lack guidance on youth-friendly service delivery. Of the 4,206 individuals working in the sample of health facilities, most (56%) were doctors, nurses, or midwives; 18% were community health workers, 7% were HIV/AIDS counselors, and 19% were support staff (nurse managers, orderlies, auxiliaries, clinical technicians, and guards). The majority of these health workers, ranging from 67% in Mali to 98% in Mauritania, lacked a job description that included information specific to ASRH. Health workers should be guided by national standards and procedures that specify which and how SRH services should be provided to adolescents. However, such standards are not widely available; guidelines were present in 70% of the participating facilities in Mali, 49% in Niger, 23% in Guinea, 14% in Côte d'Ivoire, and 0% in Mauritania. Additionally, very few facilities, ranging from 4% in Mauritania to 31% in Mali, had a documented plan to inform clients and communities about the availability of ASRH services.

ASRH training and supportive supervision for health workers is insufficient to ensure the provision of high-quality services. Few facilities, ranging from 6% in Mauritania to 25% in Mali and Niger, reported availability of financial resources for ASRH training for providers. Not surprisingly, few health workers (6.8%) had received any training in ASRH. Supportive supervision for ASRH providers is also lacking. While 55% of health facilities in Mali reported receiving regular supervision visits, no facilities in Mauritania reported regular visits. Facility self-assessments designed to improve services for adolescents are similarly infrequent.

Health facilities need improved health information and supply management systems. Facilities require information about adolescent clients, and they must be able to keep this information confidential. Less than half (45%) of facilities in Mali and Niger collected information to improve adolescent health care while 30% of facilities

Figure 1. Percentage of health facilities implementing WHO/UNAIDS Global Standards for Quality Health Care Services for Adolescents, by country



in Guinea did. Collection of information about adolescents is almost nonexistent in Mauritania. Additionally, facilities must have sufficient materials, equipment, and drugs that are acceptable and safe for adolescents to use. Seventy percent of facilities in Mali and Niger had systems for purchasing and managing stocks of drugs and supplies to provide the required package of services to adolescents. This dropped to approximately 40% in Côte d'Ivoire and Guinea and 6% in Mauritania. Only half of the facilities in four of the five countries had the basic materials and equipment recommended by the WHO; Mali was the exception at 84% of facilities. Similarly, many facilities did not have the minimum required stock of drugs: 86% of facilities in Mali followed by Guinea (69%), Niger (57%), Mauritania (55%), and Côte d'Ivoire (50%).

CONCLUSIONS AND RECOMMENDATIONS

The governments of Côte d'Ivoire, Guinea, Mali, Mauritania, and Niger have made commitments to, and strides toward, improving ASRH services to align with the WHO/UNAIDS Global Standards for Quality Health Care Services for Adolescents. The results of this study can help policymakers and program planners in these five countries prioritize efforts to improve accessibility and quality of facility-based youth-friendly services. Results show ASRH services are offered to some extent in the majority of health facilities, albeit with marked differences within as well as across countries. The limited application of the global standards likely reflects health system constraints as well as sociocultural norms that are unfavorable to adolescent utilization of ASRH services. Our results also highlight that the application of national ASRH standards and guidelines is limited, as is facility supervision and evaluation. Insufficient resources exist for ASRH training; consequently, few providers have been trained in ASRH. Based on the inconsistent implementation of the global standards, IntraHealth offers the following recommendations to governments in the five countries included in this assessment—and other countries in the region with similar contexts—to improve adherence:

1. Update national guidelines and standards to strengthen their focus on ASRH in accordance with the global standards and disseminate them to all facilities offering ASRH services.

2. Update the training curriculum for qualified health providers to align with the global standards.

3. Establish initial and continuing training on modern contraceptive technology for qualified health workers.
4. Ensure future training prioritizes privacy and confidentiality, clinical case management, policies and procedures to ensure provision of free and affordable care, and data use to improve service quality.
5. Strengthen technical capacities of health facilities using continuous quality improvement approaches, regular supervision, and facility self-assessments.
6. Develop a national communication plan for the promotion of adolescent health.
7. Organize advocacy days with technical and financial partners to mobilize resources.
8. Strengthen public-private partnerships to improve the quality of ASRH services in all health establishments.
9. Involve CSOs in the implementation of national programs to improve the reproductive health of adolescents and young people.
10. Promote a certification process for facilities offering ASRH services according to global standards.
11. Strengthen community engagement approaches to improve provision of ASRH services.

IntraHealth will continue to work in partnership with governments and civil society to strengthen ASRH services so that adolescents can access the information and services that they need to make healthy, empowered decisions for their futures.

REFERENCES

1. Ganchimeg T, Ota E, Morisaki N, Laopaiboon M, Lumbiganon P, Zhang J et al. 2014. "Pregnancy and childbirth outcomes among adolescent mothers: a World Health Organization multicountry study." *BJOG: An International Journal of Obstetrics and Gynaecology* 121 Suppl 1:40-8.
2. World Health Organization. 2016. Causes of death among adolescents. Geneva: WHO **https://www.who.int/maternal_child_adolescent/data/causes-death-adolescents/en/**.
3. McCleary-Sills J, Hanmer L, Parsons J, Klugman J. 2015. "Child marriage: a critical barrier to girls' schooling and gender equality in education." *The Review of Faith & International Affairs* 13(3):69-80.
4. Melesse DY, Mutua MK, Choudhury A, Wado YD, Faye CM, Neal S, et al. 2020. "Adolescent sexual and reproductive health in sub-Saharan Africa: who is left behind?" *BMJ Global Health* 5(1).
5. Solo J, Festin M. 2019. "Provider Bias in Family Planning Services: A Review of Its Meaning and Manifestations." *Global Health: Science and Practice* 7(3):371-85.
6. Chandra-Mouli V, McCarraher DR, Phillips SJ, Williamson NE, Hainsworth G. 2014. "Contraception for adolescents in low and middle income countries: needs, barriers, and access." *Reproductive Health* 11(1):1-8.
7. Family Planning High Impact Practices. Adolescent-Friendly Contraceptive Services: Mainstreaming Adolescent-Friendly Elements Into Existing Contraceptive Services **https://www.fphighimpactpractices.org/briefs/adolescent-friendly-contraceptive-services/**.
8. WHO/UNAIDS. 2015. 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. Geneva: WHO.

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