

## ASSESSMENT OF FUNCTIONING OF ADOLESCENT FRIENDLY HEALTH CLINICS (AFHC) IN NORTH COASTAL DISTRICT OF ANDHRA PRADESH.

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### Abstract

**Background:** With 253 million adolescents, India has the world's largest adolescent population, accounting for over 21% of the country's total population. The Adolescent friendly health clinics (AFHC) were introduced under the Rashtriya Kishor Swasthya Karyakram (RKSK) in 2014, to address adolescent health concerns, raise awareness, and improve preventative care. This study was intended to assess the functioning of AFHCs in Visakhapatnam district of Andhra Pradesh. **Materials and Methods:** An explanatory mixed method design in which quantitative phase (Survey) followed by qualitative phase (Focus group discussion) was done at fifty percent of total PHCs, CHCs and Area Hospitals of Visakhapatnam district. Supportive Supervision Checklist for AFHC available in the MOHFW manual was used to assess the facilities. **Results:** Adolescent friendly health clinics (AFHCs) were operational in all health facilities. Lack of dedicated space, IEC material and dedicated manpower at some health facilities were the gaps in implementation. The challenges faced by the MPHWF were mainly work overload, lack of awareness/stigma among adolescents. **Conclusion:** AFHCs were operational in secondary level health facilities (CHCs & AH) where dedicated counsellors are present. The challenges include inadequate infrastructure, non-availability of dedicated manpower, poor awareness and misconceptions among the community, workload of MPHWF, accessibility. Allocating a dedicated team for adolescent health services, training of health staff and supportive supervision would help in effective implementation of the program.

## INTRODUCTION

Adolescence is the phase of life between childhood and adulthood, from ages 10 to 19.<sup>[1]</sup> It is a distinct stage of human development during which they go through physical, cognitive, and psychosocial development.<sup>[2]</sup> These individuals are exposed to considerable health hazards and require education, counselling, and support to ensure their development into healthy adults.<sup>[3,4]</sup> They are at risk for a number of preventable and treatable health issues, including early and unintended pregnancy, unsafe sex, which can lead to STIs/HIV/AIDS, nutritional disorders such as malnutrition, anaemia, and obesity, alcohol, tobacco, and drug abuse, mental health issues, injuries, and violence.<sup>[4]</sup> India has 253 million adolescents, the world's highest adolescent population, accounting for 21% of the country's total population.<sup>[5]</sup> To address adolescent health needs, the Government of India

implemented the ARSH-Adolescent Reproductive and Sexual Health strategy between 2005 to 2013, and then launched the Rashtriya Kishor Swasthya Karyakram (RKSK) in 2014 to reach out to all adolescents.<sup>[5]</sup> Andhra Pradesh also implemented the program in 2014 to serve its nine million adolescents.

Visakhapatnam is one of the north coastal districts of the state with an unique urban-rural-tribal division. In the peri-urban, rural, and tribal areas, there are a total of 90 primary health care centres (PHCs), 13 community health centres (CHCs), and two sub-district (Area) hospitals. Because of the vastness of the rural and tribal areas, it is necessary to comprehend the adolescent's needs and access to the services under this programme. The objective of the study was to assess the functioning of AFHCs in Visakhapatnam district and to identify the barriers and challenges in implementation.

## MATERIALS AND METHODS

The present study was carried out in the Visakhapatnam district during the year 2020 – 2021. An explanatory mixed method design in which quantitative phase (Survey) followed by qualitative phase (Focus group discussion) was adopted to achieve the objective. Facilities were selected based on random sampling method. Firstly, list of PHCs/CHCs/Area hospitals were obtained from the DMHO Office and were categorised into two categories as per the geographical distribution a) Peri-urban and rural b) Tribal. Fifty percent of Health facilities were selected in each category by systematic random sampling. With a sampling interval of two, every 2nd health facility listed was chosen for the study. A total of 53 facilities were included in the study.

Supportive Supervision Checklist for AFHC available in the Ministry of Health and Family Welfare (MOHFW) manual was used to assess the facilities.<sup>[6]</sup> Perceptions of Multipurpose health workers, females {MPHW(F)} regarding the challenges and solutions was explored through focus group discussions. FGDs were conducted at primary health centre as preferred by the MPHW(F) using a FGD guide by the Principal Investigator who is trained in Qualitative Research.

IEC and other permissions: Approval was obtained from the Institutional Ethics Committee (IEC) of Andhra Medical College. Permissions were obtained from the District Medical and Health Officer (DMHO) of Visakhapatnam District. Informed consent was obtained from all the participants before administering the checklist.

Data analysis: The quantitative data was entered in MS Excel worksheet and expressed using proportions. The data from FGDs was recorded as a transcript, each transcript along with the field summary notes were coded manually by Principal investigator. And were then checked by other investigators, then thematic analysis was conducted. Analysis indicated the challenges and solutions for effective implementation of programme.

### Definitions

“Operational” facility as per the checklist is defined as facility with dedicated space and ensures privacy, availability of IEC material, dedicated manpower which includes MOs and specialist doctors, ANM, LHV, AH & ICTC Counsellors and average monthly footfalls should not be less than 10 for PHC, 20 for CHC/SDH 30 for DH, and 40 for Medical Colleges.<sup>[7]</sup>

## RESULTS

AFHCs were established at all the health facilities in the district including PHCs, CHCs and Area hospitals.

Out of the 8 secondary level facilities AFHCs were operational at 62.5% of facilities i.e., 4 CHCs and 1

Area Hospital. These clinics were functioning all 6 days/week and the timings were from 9 am to 4 pm. Reports were submitted to district once in a month. In all the 45 Primary level facilities, AFHC Services were provided through regular outpatient rather than through separate clinics. Although the facility was not in accordance with the definition of “Operational” as per the checklist, all the services were provided, and reports were submitted timely. Based on the criteria of dedicated space, 19% of the facilities had dedicated space. IEC material related to adolescent clinics were available at 10% of the health facilities i.e., at the secondary level facilities which were “operational” according to definition.

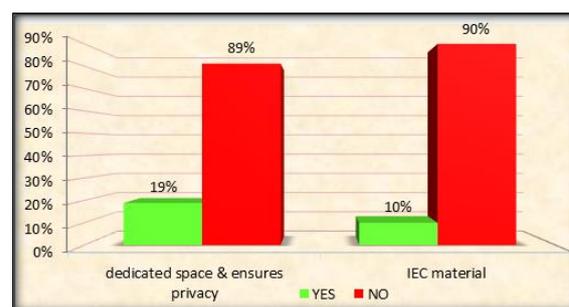


Figure 1: Facility Check for AFHC

Staff pattern recommended for operationalizing AFHS clinics are Medical Officer, MPHW (F) and Counsellor. Client visit was quantified in terms of number of beneficiaries attending the clinics. More than 15 adolescents were availing services per day in 5 out of 8 secondary level facilities (62.5%), these are the centres where dedicated counsellors were available.

In rest of the health facilities less than 15 adolescents were attending the clinic per day. Outreach services are conducted every thursday by the dedicated counsellors or ANMs in the schools. In all the 45 PHCs selected for the study, MPHW(F) (ANM) were available and received informal training during monthly meetings. Counselling services are taken up by these ANMs and peer educators.

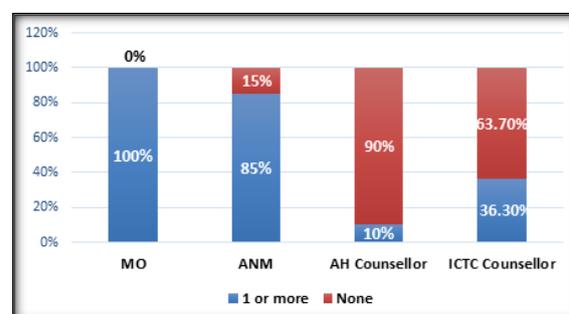


Figure 2: Availability of Human Resource at AFHC

[Figure 2] shows that Medical Officers were present and trained at all the health facilities included in the study. Dedicated AFHS Counsellors were present

in 5 out of 8 secondary level facilities and all were trained. Apart from these, ICTC Counsellors were present in 8 out of 22 health care facilities (36.3%).

### Qualitative Data Analysis

Two themes were evolved after manual coding of transcripts from Focus Group discussions.

#### 1. Challenges faced by Multi-Purpose Female Health Workers [MPHW(F)]:

- As the health workers were involved in many other health programme activities, lack of time and increased workload were two main challenges.
- In tribal areas, as the distance between the villages was far, it was difficult for health workers to commute and perform field activities actively. Response from ANM 2 from tribal area when asked about motivation/awareness of parents,

“Due to distance and transport problem, we are unable to do outreach activity in villages and by the time we go, some parents already leave for work so unavailable for motivating or educating them”

- Health workers perceived that many of the adolescents were unaware of the clinics and there is a stigma among the parents to send their children to clinics for availing services. When asked about AFHCs, one of the ANMs - ANM 4 from rural area responded as,

“Parents usually say that - my child is healthy; then why do I need to send my child to clinic? If I send, neighbours will think that my child is ill.”

- Accessibility was found to be another challenge, as the clinics are located far from schools/home. At few places it was difficult for the school children to come to clinics alone due to lack of transport and also due to overlap of school timings with clinic timings.

#### 2. Solutions as recommended by Multi-Purpose Female Health Workers [MPHW(F)]:

- Solutions identified were strategies like involving local community, School teachers, anganwadi workers and Village sachivalayam volunteers for creating awareness would be beneficial as they are from the same community and can act as influencers. When question raised regarding manpower involvement in tribal area, ANM 6 responded as,

“Village Sachivalayam volunteers are aware of all the adolescents in all village so they must be involved in beneficiary mobilisation.”

- Repeated health education sessions and exclusive AFHC health camps are to be conducted at schools. When question raised about mobilisation of adolescents to clinics, response by ANM 1 of Peri -Urban as,

“Due to the school timings, distance and transport problem, Adolescents are least interested for a visit

to clinics, so if medical camps are conducted at schools every week, they can be benefitted”

- Allocating a dedicated team for delivery of the adolescent services, repeated training sessions for health functionaries and provision of transport for field visits especially in tribal areas would help in better implementation of the programme. Response by ANM 4 of Rural Area when asked regarding better implementation of the programme she responded as,

“As we are overburdened with already existing works, we don't have time to involve in this adolescent programme so a dedicated team must be allocated exclusively for these adolescent activities”.

## DISCUSSION

Adolescent friendly health clinics were established at all the health facilities in the district including PHCs, CHCs and Area hospitals. RKSK program highlights the need for strengthening Adolescent Friendly Health Clinics (AFHC) under its facility based approach.<sup>[8]</sup>The ‘friendly’ component of AFHC mandates facility-based clinical and counselling services for adolescents. Adolescents often do not have the autonomy to make their own decision which affects their health-seeking behaviour. Studies have reported that less than 50% of the adolescents are aware of the health facilities and very less percentage of them are actually attending the facilities.<sup>[9]</sup>

In the current study, it is observed that in facilities where infrastructure and manpower were available more than 15 adolescents were attending the clinics per day. Benchmark for AFHC includes 1)Infrastructure- clean, bright and colourful 2) Maintains privacy and confidentiality and which 3) Can be easily accessed by the adolescents (distance and convenient working hours) along with IEC and Proper Signage.<sup>[8]</sup>In the present study, in 19% of facilities had dedicated space 10% had IEC material displayed. Beneficiary mobilizing by health workers, availability of IEC Material, adequate trained service providers - MO, ANM and Counsellors at AFHCs and training and involvement of school teachers are found to be effective in implementation of the programme.<sup>[8]</sup> These finding are similar to other studies.<sup>[10]</sup>Counsellors play a crucial role in operationalization of AFHCs. They inform, educate and counsel clients on various health issues and refer clients to health facilities, or other service delivery points such as Integrated Counselling Testing Centre (ICTC), de-addiction centre, Non Communicable Diseases clinics etc.<sup>[8]</sup> In the present study, medical officers at all the health facilities were present and trained at all the health care facilities . Presence of ANM and training of them was found in 85% of health facilities, ICTCs with trained counsellors were available at all the secondary level health facilities and 3% of primary

level health facilities. Remaining 97% of the primary level health facilities had FI ICTCs where screening process is being done and referred to ICTCs if required. Adolescent health counsellors were present and trained at 62.5% of secondary level facilities. These findings are similar to other studies.<sup>[11,12,13]</sup>As per the health care providers, the reasons for non-utilization of services were lack of awareness among beneficiaries and their parents, parents unwilling to send their children to clinics, distance and timings of the clinic overlapping with that of school. MPHWF were stressed and overburdened with other health programmes. As suggested by the MPHWFs in the FGD, allocation of dedicated team and community involvement would help in adolescent health promotion. They also suggested that involving parents/school teachers would increase utilization of services.<sup>[14]</sup>The strength of the program is its health promotion approach. It is a paradigm shift from the existing clinic-based services to promotion and prevention and reaching adolescents in their own environment, such as in schools, families, and communities. Key drivers of the program are community-based interventions like, outreach by counsellors; facility-based counselling; Social and Behaviour Change Communication; and strengthening of Adolescent Friendly Health Clinics across levels of care.<sup>[14]</sup>

## CONCLUSION

AFHCs were operational in Secondary Level Health Facilities (CHCs & DH) where dedicated counsellors are present. The challenges in service delivery include deficiencies in health infrastructure and manpower such as dedicated space and counsellors, poor awareness and misconceptions among the beneficiaries, workload of MPHWF and accessibility. Allocating a dedicated team for adolescent health services, training of health staff on communication skills and supportive supervision would help in effective implementation of the programme.

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## Conflict of interest

No conflict of interest.

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