

Adolescent Friendly Health Centres: A Review from North India

Ashfaq A. Bhat¹, Yasmeeen Jan², Rifat Jan³, Beenish Mushtaq⁴,
Sameena Yousuf⁵

¹. Associate Professor, Community Medicine, SKIMS Medical College & Hospital, Bemina

². Assistant Professor, Community Medicine, SKIMS Medical College & Hospital, Bemina

³. Lecturer, Community Medicine, Government Medical College, Srinagar

⁴. Lecturer, Community Medicine, SKIMS Medical College & Hospital, Bemina

⁵. Tutor/Demonstrator, Community Medicine, SKIMS Medical College & Hospital, Bemina

Corresponding Author: Dr. Sameena Yousuf

Abstract: Introduction: 20% of India's population is comprised of the adolescent age group. Adolescents present a distinct array of reproductive, sexual, psychological and nutritional health problems. The situation is further compounded by an increasing incidence of RTAs, substance use and violence. Adolescents comprise one of the most neglected sections of society and it is with the aim of addressing these issues that AFHCs were established and further strengthened under RKSK. This study was conducted to assess the functioning of AFHCs across Kashmir Valley. **Methods:** The study was carried out in Kashmir and Ladakh Divisions (a single division at the time of the study) over one year in all District and sub-district hospitals. The AFHC Evaluation Questionnaire available at the NHM Portal was utilized to assess the facilities in terms of infrastructure, equipment, commodities and services. Ethical approval was obtained from the Institutional Ethics Committee and permission was sought from the concerned authorities. **Results:** IEC material was available at 83.3% of RKSK and only 14.4% of non-RKSK facilities. 100% RKSK and 442.9% of non-RKSK facilities were functional all days of the week. These differences were statistically significant. Even though both RKSK and non-RKSK facilities were lacking in equipment, commodities and service delivery fronts, these differences were not significant. **Conclusion:** Even though RKSK was introduced to fill in the lacunae of AFHCs, it is still far behind the envisaged outcome. Much needs to be done to achieve the goal of a one-stop approach to address adolescent health needs under one roof.

Keywords: Adolescent, AFHCs, RKSK

Date of Submission: 22-07-2019

Date of Acceptance: 07-08-2019

I. Introduction

The etymology of "adolescence" is the Latin word "ADOLESCERE" translating into "TO GROW" or "TO MATURE" ^[1]. Adolescent as per the WHO is a person between 10-19 years of age ^[2]. About 20% of India's population is in the adolescent age group of 10–19 years. It is estimated that there are almost 236 million adolescents in India ^[3]. Despite being the most dynamic, creative, productive and enthusiastic group of population, adolescents are one of the most overlooked groups by our society and policy makers ^[4]. The adolescent presents a prominently distinct array of reproductive and sexual health problems which gives rise to an "unmet need" for reproductive and sexual healthcare. According to NFHS-4 reports, 8% of adolescents aged between 15 – 19 years have started child bearing. Of these 5% had already experienced a live birth and 3% were pregnant with their first child. These figures were 2.1% and 0.8 % respectively for the state of Jammu and Kashmir ^[6]. Contraceptive use among adolescents is as low as 7% in India ^[7]. As per NFHS-4, percentage of women aged 15-24 years who use hygienic methods of protection, i.e., locally prepared napkins, sanitary napkins or tampons during their menstrual period was 57.6% ^[6]. Moreover, public sector reproductive health services are more focussed towards adult married women, while unmarried adolescents hesitate to seek health services due to apprehensions of non-confidentiality, inability to bear expenses, requirement of parents' consent and antipathetic attitude of health providers ^[8]. Even married adolescent girls are reluctant to seek healthcare due to sheer mortification and the taboo associated with reproductive and sexual health problems ^[9]. Approximately a third of adolescents have chronic energy malnutrition. In Indian adolescents, the prevalence of under nutrition is 53.1% among males and 39.5% among females. Stunting has been observed in about 39% of adolescents ^[11]. The anemia prevalence in adolescent girls is around 90.1% of whom 7% have severe anemia ^[13]. As per the country profile for India of the Global Nutrition Report 2017, 11% of adolescents are overweight and 2 % are obese ^[14]. Depression is one of the major causes of illness and disability among adolescents and suicide is the third leading cause of death ^[16]. At least 1 in 10 younger adolescents (aged 13 to 15) uses tobacco

globally. Road traffic injuries are the leading cause of death among adolescents ^[16]. Sexual abuse is another significant, though usually invisible, cause of injuries among adolescents ^[17, 18].

The Pan American Health Organization and a WHO consultation in Africa in October 2000 recommended provision of the following package of services at an Adolescent Friendly Health Centre ^[20]:

- Monitoring of growth and development
- Management of behavioural problems
- Offer information and counselling on developmental changes, personal care and ways of seeking help;
- Reproductive health including contraceptives, STI treatment, pregnancy care and post abortion management.
- Voluntary counselling and testing for HIV
- Management of sexual violence
- Mental health services including management of substance abuse.

India has gradually witnessed an emergence of AFHCs run by governmental and private health agencies and voluntary organizations.

Despite existing programs and policies directed towards improvement of adolescent reproductive health, there is a paucity of Adolescent Friendly Health Services (AFHS), the expansion of which is still in the nascent stage. Moreover, programs have mostly been unable to differentiate between the special reproductive health needs of married and unmarried adolescents ^[22]. Establishment and operation of AFHS facilities in accordance with programme guidelines would assuredly ensure delivery of a holistic package of services to the target population in a suitable atmosphere of privacy, confidentiality, understanding and friendliness. However, functioning of these facilities requires to be monitored to identify and address shortcomings, if any, and to build on the strengths and experiences. There is, however, a dearth of research pertaining to this topic and to the best of our knowledge, no study to evaluate AFHCs has been carried out in this part of the country. The study was, therefore, carried out with the aim of assessing AFHS implementation in designated facilities in all districts of Kashmir Division with regard to infrastructure, equipment, commodities and service provision.

II. Materials And Methods

Study Area: At the time of the study, Kashmir Division comprised of Kashmir and Ladakh regions. Kashmir region has been divided into 3 zones on the basis of geographical demarcation: North, South and Central with a total of 10 districts. Ladakh region consists of 2 districts of Leh and Kargil. All districts where Adolescent Friendly Health Services have been implemented were included in the study with the exclusion Kulgam and Shopian consequent to inimical circumstances during the period of turmoil.

Study Design: A descriptive, cross-sectional study design was adopted for the purpose of the study.

Study Period: The study was conducted over a period of one year.

Study Sample: All district and sub-district hospitals were included in the study as AFHCs at these facilities are required to be operational throughout the week. RKSK as well as non-RKSK domain facilities were included in the study.

The list of facilities visited is as follows:

- A) Kashmir Region:
 - 1) Central Zone
 - a) District Budgam-
 - i) District Hospital, Budgam
 - b) District Ganderbal-
 - i) District Hospital, Ganderbal
 - c) District Srinagar-
 - i) LalDed Hospital
 - ii) JLN Hospital
 - 2) North Zone
 - a) District Bandipora-
 - i) District Hospital, Bandipora
 - b) District Baramulla-
 - i) District Hospital, Baramulla
 - ii) SDH, Kreeri
 - iii) SDH, Sopore
 - iv) SDH, Pattan
 - c) District Kupwara-
 - i) District Hospital, Handwara
 - ii) SDH, Kupwara
 - 3) South Zone
 - a) District Anantnag-

- i) District Hospital, Anantnag
- ii) SDH, Bijbehara
- iii) SDH, Kokernag
- b) District Pulwama-
- i) District Hospital, Pulwama
- B) Ladakh Region:
- a) District Kargil-
- i) District Hospital, Kargil
- b) District Leh-
- i) District Hospital, Leh
- ii) SDH, Diskit
- iii) SDH, Khaltsi

Exclusion Criteria:

Primary health care level facilities were not included in the studies as AFHCs at these establishments are required to be functional only once a week and would, therefore, pose time constraints.

Study Tools: The AFHC Evaluation Questionnaire available at the NHM portal was utilized for the study. Facilities were assessed regarding AFHS Implementation Guidelines in terms of infrastructure, equipment, commodities and service provision.

Strategy: Permission to carry out the study was obtained from Director Health Services, Kashmir Division. CMOs of the respective districts were contacted and their approval and cooperation for conducting the study in the facilities within their jurisdiction was sought. A single visit was made to each facility where the investigators administered the study instrument and interacted with the concerned personnel.

Ethical Considerations: Ethical clearance was obtained from the Institutional Ethics Committee at SKIMS Medical College and Hospital, Bemina.

Data Analysis: The data thus generated was tabulated and analyzed using SPSS version 20 software. Appropriate statistical methods were applied as per requirement. Chi-squared tests were used for categorical variables, and Fishers exact tests were used in place of χ^2 for independence when one or more cells in a table had an expected count of less than 5 whenever required. P value < 0.05 was taken as significant.

III. Results

Under RKSK, 4 districts of Kashmir Division have been taken up wherein facility is available in 50% of CHCs comprising 8 sub-district hospitals in addition to one Tertiary Care Hospital. In non-RKSK districts, AFHC facility is available predominantly at district level only and one AFHC at SDH Kupwara under (Menstrual Hygiene Services Scheme) in all other 6 districts visited.

Table 1: General Facility Check

Parameter		Type of AFHC				P Value
		RKSK		Non-RKSK		
		N	%	N	%	
Isolated location of clinic	Yes	7	58.3	6	85.7	.333
	No	5	41.7	1	14.3	
Dedicated space for clinic	Yes	9	75	6	85.7	1.000
	No	3	25	1	14.3	
Consultation room ensures privacy	Yes	9	75	4	57.1	.617
	No	3	25	3	42.9	
IEC material available	Yes	10	83.3	1	14.3	.006
	No	2	16.7	6	85.7	
Signboard indicating location & timing	Yes	3	25	0	0	.393
	No	5	41.7	3	42.9	
	Only timing	4	33.3	4	57.1	
Functional days per week	All days	12	100	3	42.9	.009
	>50% days	0	0	3	42.9	
	Not functional	0	0	1	14.3	
10 to 4 timing	Yes	12	100	6	85.7	.368
	No	0	0	1	14.3	
Mention of clinic in citizen charter	Yes	4	33.3	4	57.1	.377
	No	8	66.7	3	42.9	
Total		12	100	7	100	

Table 1 demonstrates the findings of the general facility check. Isolated location of clinic was present in 85.7% of non-RKSK AFHCs compared to 58.3% of RKSK AFHCs. Similarly, 85.7% of non-RKSK AFHC had a

dedicated space for clinic as compared to 75% of RKSK AFHCs. In 75% of RKSK AFHCs, consultation room ensured privacy in contrast to 57.1% of non-RKSK AFHCs. IEC material was available in only 14.3% of non-RKSK AFHCs as opposed to 83.3% of RKSK AFHCs. Signboard indicating both location and timing was seen in only 25% of RKSK AFHCs and none of non-RKSK AFHCs. Only timing was displayed in 57.1% of non-RKSK AFHCs. 100% of RKSK AFHCs were functional all days of the week in contrast to 42.9% of non-RKSK AFHCs. 57% of the non-RKSK AFHCs were functional for less than 4 days a week. Of all functional AFHCs, 100% of RKSK facilities and 85.7% of non-RKSK facilities were working from 10am to 4pm. 57.1% of non-RKSK AFHCs had been mentioned in the citizen's charter of the health facility in comparison to 33.3% of RKSK AFHCs.

Table 2: Equipment and Commodities

Parameter		Type of AFHC				P Value
		RKSK		Non-RKSK		
		N	%	N	%	
Stadiometer	Yes	4	33.3	1	14.3	.603
	No	8	66.7	6	85.7	
Weighing Scale	Yes	8	66.7	3	42.9	.377
	No	4	33.3	4	57.1	
BMI Charts	Yes	2	16.7	0	0	.509
	No	10	83.3	7	100	
Contraceptives	Yes	5	41.7	2	28.6	.656
	No	7	58.3	5	71.4	
Inj. TT	Yes	1	8.3	0	0	1.000
	No	11	91.7	7	100	
IFA Tablets	Yes	8	66.7	1	14.3	.057
	No	4	33.3	6	85.7	
Albendazole Tablets	Yes	6	50	1	14.3	.173
	No	6	50	6	85.7	
Snellen's Chart	Yes	3	25	0	0	.263
	No	9	75	7	100	
Sanitary Napkins	Yes	3	25	0	0	.263
	No	9	75	7	100	
PTKs	Yes	4	33.3	0	0	.245
	No	8	66.7	7	100	
Total		12	100	7	100	

Table 2 reveals the status of facilities in terms of availability of equipment and commodities with more of RKSK AFH Clinics having supplies as compared to non-RKSK AFH Clinics. This difference, however, was not found to be statistically significant.

Table 3: Clinical Services Provision

Parameter		Type of AFHC				P Value
		RKSK		Non-RKSK		
		N	%	N	%	
Clinical services provided	Yes	0	0	0	0	1.000
	No	2	16.7	1	14.3	
	Partly provided	10	83.3	6	85.7	
Total		12	100	7	100	

Table 3 illustrates the position of facilities with respect to clinical service provision. None of the RKSK and non-RKSK AFHCs were providing clinical services, only part-time services were being provided in both type of facilities.

IV. Discussion

RKSK was launched in India by Ministry of Health & Family welfare on 7th January 2014 to strengthen the adolescent component of RMNCH+A strategy. The guidelines for operationalizing the Model AFHC is directed to remove the lacunae left in the RMNCH+A programme. RKSK envisages for infrastructure a separate room with basic amenities like sitting arrangement, clean drinking water & clean toilets. Additionally, confidentiality & privacy is to be maintained by way of screens & curtains.

Our study revealed that only 75% of the RKSK AFHCs in contrast to 85.7% non-RKSK were having the envisaged infrastructure. Similar findings were reported in the CORT study 2008 Assessment of Adolescent & Sexual Health Centers in GujratPg 13 wherein only 7 out of 12 functional centres had the infrastructure meeting the standards.

The guidelines recommend that all AFHCs have a display sign board indicating the location & timing of the clinic. The same needs to be present on the citizen charter of the facility. Our study revealed display board in only 25% of RKSK AFHC in comparison to 57% of non-RKSK AFHCs. Similarly citizen charter bearing the AFHC was seen in only 33.3% of RKSK AFHCs in contrast to 57% of non-RKSK AFHCs.

IEC material relevant to adolescent needs has to be displayed in AFHCs with provision of pocket books, pamphlets & posters for communication. This was seen more in RKSK (83.3%) than non-RKSK (4.3%) AFHCs. Similar observations were reported by a study on ARSH centers (non-RKSK) in Vadodra.

All AFHCs at DH & CHC level have to be functional on all week days from 9-4 with Medical Officer appointed for the same having OPD timings from 2 pm-4 pm. Our study revealed that all RKSK AFHCs were functional on all week days from 10 am-4 pm. Our study revealed that only one of the RKSK & none of the non-RKSK AFHCs were providing all the envisioned clinical services due to lack of MO appointed for the same. 83.3% of RKSK & 85.7% of non-RKSK AFHCs were partly providing clinical services.

Commodities like IFA / Albendazole tablets, sanitary napkins, contraceptives (condoms, OCPs, ECPs), medicines such as paracetamol, anti-spasmodics and first aid, pregnancy testing kits have to be made available for adolescents through these AFHCs. Our study revealed that only 2 RKSK AFHCs & none of the non-RKSK AFHCs had the provision of these commodities. Both the AFHCs where commodities were available had limited commodities like condoms & PTK. WIFS was not available at some facilities where adult formulation of iron-folic acid was used in place of WIFS.

V. Conclusion & Recommendations

Going through the review of articles and reports on Adolescent Reproductive & Sexual health reveals that majority of the work has been done either on the KAP of adolescents or on the meta-analysis of these studies. Due to this restriction of the review, we limited our evaluation to whatever previous work had been conducted on Adolescent Reproductive & Sexual Health before the implementation of RKSK & tried to determine the effectiveness of the current AFHCs under RKSK in relation to non-RKSK centres in terms of infrastructure, manpower and services. As already discussed, there is no dramatic difference in RKSK & non-RKSK centres in these regards.

Hence, with the above findings it is clear that even though RKSK was shaped to fill in the lacunae of the AFHCs, it is still far behind the envisaged outcome. Much needs to be done and some of the recommendations include:

1. Proper infrastructure for the AFHCs to provide comfort zones for the clients.
2. Provision of requisite equipment and commodities for smooth functioning of the AFHCs.

References

- [1]. Bashir R. Prevalence of iron deficiency anemia among adolescent girls and impact of health and nutrition education programme in changing their dietary behavior. Thesis submitted to Institute of Home Science Faculty of Applied Science and Technology University of Kashmir, Srinagar. 2013.
- [2]. http://www.who.int/topics/adolescent_health/en/
- [3]. Census of India 2011. New Delhi: Office of the Registrar General.
- [4]. Kumar D., Yadav R.J., Pandey A. Evaluation of adolescent friendly health services (AFHS): clients' perspectives. *Int J Cur Res Rev.* August 2015. Vol 7; Issue 16.
- [5]. International Institute of Population Sciences and ORC Macro. National Family Health Survey - 4. International Institute of Population Sciences, Mumbai.
- [6]. WHO. Available from: www.who.int/school_youth_health/media/en/family_life.
- [7]. Mamdani M. Adolescent reproductive health: Experience of community based programmes. In: Pachauri S, editor. *Implementing a reproductive health agenda in India: The Beginning*. New York: Population Council; 1999.
- [8]. Bang R, Bang A. A community Study of Gynaecological Diseases in Indian Villages. In Zeidenstein and Moore, editors. *Learning about sexuality: A practical beginning*. New York: The Population Council; 1989.
- [9]. www.icmr.nic.in/annual/2005_06/nirrh/chapter%206.pdf.
- [10]. NNMB. Report on diet and nutritional status of adolescents, NNMB Technical report no: 20. NINICMR Hyderabad; 2000. p.1-25.
- [11]. Global Nutrition Report. Nutrition Country Profile, India. Chhatwal J, Verma M, Riar SK. Obesity among pre-adolescent and adolescents of a developing country (India). *Asia Pac J Clin Nutr* 2004;13:231-5.
- [12]. www.who.int/mediacentre/factsheet/fs345/en/updated_may2017.
- [13]. Studies on adolescent girls-An analytical review. National institute of public co-operation and child development. 2008. p.145, 81,189.
- [14]. Lal S, Adarsh, Pankaj. *Textbook of Community Medicine*. 3rd ed. New Delhi: CBS Publishers; 2013. p.155-6.
- [15]. McIntyre P. *Adolescent Friendly Health Services: An agenda for change*. Geneva: World Health Organization; 2002. p. 19.

Ashfaq A. Bhat. "Adolescent Friendly Health Centres: A Review From North India." *IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)*, vol. 18, no. 8, 2019, pp 44-48.