Module 3: Evidence based approaches to health service provision to adolescents - Adolescent health and development with a particular focus on sexual and reproductive health - Assignment

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Perception of the reality in Uganda

Definition of a clinical service as 'The provision of a clinical service, which often includes the provision of information, advice & counselling aimed at preventing health problems, or detecting and treating them", is too restrictive.

I agree that by and large, access to services by adolescents is not available. In Uganda there are more services available in urban areas such as the capital, Kampala, largely used by the well to do or the educated. Services are inadequately and unevenly distributed, and are often funded by donors. The north of the country is poorly served when compared to the south. The adolescent environment is often not supportive towards the delivery or uptake of services: for instance, there are negative parental, religious, community attitudes towards unmarried youths seeking reproductive health (RH) services, which is a barrier to access. Special needs groups such as the disabled, refugees and adolescents in child headed households, or teenage adolescent mothers are not well catered for.

Regarding the acceptability of services, service providers are often moralistic and opinionated, can ask embarrassing questions, and are not 'youth friendly'. The opening hours are often not convenient.

Equitable: community services are better accessed by males than females, while clinic services are largely used by females. In many instances, youth, especially males, do not go for adolescent reproductive health services in hospitals or clinics, under the perception that they 'are not sick, so do not have a need to go to hospitals or clinics'.

Given the fact that there is an acute staff shortage in most health facilities, youth services are not prioritized. Some initiatives in Uganda try to reach the inaccessible youth through different innovative practices, and service providers refer to such youth as 'hard to reach', but the youth also say service providers are the ones, 'that are hard to be reached'.

Current initiatives to reach the youth include peer-to-peer education clinics, outreaches, community agents, through radio and radio talk shows, print media, and places of entertainment but few youths are reached through pharmacies. The youth centers available tend to discriminate against younger youth, for instance, the 10-14 age categories (who at the same time are often of school going age), and are not attuned to their needs and preferences. Some centres are of debatable proven value. My personal experience is that if not properly managed, youth centres can become places to hang out, especially by older youth, some of whom prolong their stay. For example, in Mbarara youth centre there has been the accusation that, 'some youth are too old'.

In some instances, there is no structural segmentation of different needs of the different categories, and assume one size fits all. The quality of instruction given is uneven. Some well-known youth centres such as the Naguru Teenage Centre in Kampala, tend to be donor

supported, and therefore prone to disruption and discontinuity when the donor taps are turned off.

Comments on the potential utility and comments on its potential feasibility of the WHO's approach

My main comment on the potential utility of WHO's approach to make services accessible, available and equitable, is that it is good, with the overall approach of building on already existing structures, or setting up new service delivery points. This intervention model has the potential to reach some underserved segments of the community.

Regarding the feasibility of WHO's approach that includes standardization, issues such as training, time, space, convenience, mental attitudes of the providers, and more importantly, the potential for large scale roll out remains debatable, especially in Uganda's complex setting. There is potential for a phased roll out. Adolescents are not a monolithic homogeneous group. They have different needs and aspirations, come from different backgrounds. The magnitude of the task is large, the complexity and logistical challenges daunting, resources required are huge. Need to obtain common, optimum space. Sustainability issues are at the forefront, and supervision and follow-up could be difficult. To mitigate this there could be need for other less traditional allies e.g. traditional, cultural and religious partners, harness the ingenuity and dynamism of the private sector.

Regarding the systematic process of rollout, in Uganda, youth activities are by definition led by the Ministry of Gender, Labor and Social Development, and not the Ministry of Health, though service delivery is primarily by the Ministry of Health, so the actual intervention has to take stock of this reality. This introduces complexity in that the Gender ministry does not yet possess the skills and resources to promote wide scale community youth interventions in this direction. Regarding standardization, there is need to establish different standards for different places and situations, e.g. clinic services verses outreach or workplace based services.

Case study: Mozambique: The Geração Biz Programme

I selected this case study because Mozambique, like Uganda, is in Sub Saharan Africa, and has a population distribution and demographic social economic parameters not unlike Uganda's, such as a high illiteracy, great imbalances in gender parameters, extremely low contraceptive use among adolescents, and a high level of unsafe abortion.

- The Mozambique model demonstrates that scale up is possible, but there is need for clear goals and objectives as well as guiding principles, coordinated, focused and patient planning and a phased approach that learns and modifies its interventions based on the successes and challenges of the past. Clear implementation structures that are standardized over different regions and levels facilitated help to coordinate and ensure smoother scale up. Initial advocacy with important stakeholders such as government or the community is vital, especially in the initial stages to obtain support and buy-in.

- A multisectoral approach promises the best chances of success, as it addresses the heterogeneity of adolescents, who are not a monolithic identical group. It demonstrates the need for a diverse group of actors such as government departments such as health, education and sports. It also stressed the importance of other actors such as NGOs. It also stresses the need for programme activities to be integrated in the overall plans of the respective sectors or ministries, so that they do not become stand-alone interventions. This boosts their chances of sustainability. Linkages between the three key intervention modes, namely, the in-school, the out-of-school and the clinical YFHS component is vital. (However, it would have been instructive to also understand the cost of the intervention vis-à-vis the government contribution to get an idea of the scope, potential of sustainability upon the waning of donor support. Perhaps I need to read the other case studies, which could have rather different approaches!)
- Adolescent health facilities need to be equipped or renovated to ensure that they function optimally. There is need for a standardized health package, definition and requirements for a quality Youth friendly facility, including skills of providers, convenience, services available. In all the intervention areas, youth participation is important (this was mainly described, but not demonstrated in the document, which to me has been a bit disappointing).

Assignment documents

1. WHO Department of Child and Adolescent Health and Development. Improving the quality and expanding the coverage of health services for adolescents. WHO's approach. Paper presented at: Training Course in Sexual and Reproductive Health Research; 2010 Sep 11; Geneva.
2. WHO Department of Child and Adolescent Health and Development. The evidence base for our approach to improve the quality and expand the coverage of health services for adolescents. Paper presented at: Training Course in Sexual and Reproductive Health Research; 2010 Sep 11; Geneva.
3. WHO, Pathfinder International. From inception to large scale: the Geração Biz Programme in Mozambique. Geneva: WHO; 2009.