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Original Research

Perception of public health midwives on adolescent and youth friendly health service: Sri Lankan experience

PVS Chiranthika Vithana[1*], RIW Nilaweera[2], AJM Basnayaka[2], Chamanthi J Jayasundera[1], HMI Handagiripathira[2], ANJ Barnasuriya[1], BMND Batugedara[1]

[1] Family Health Bureau, Ministry of Health, Sri Lanka; [2] Ministry of Health, Sri Lanka

*Correspondence: chiranthikav@gmail.com https://orcid.org/ 0000-0002-0359-8058

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Abstract

Introduction: One fourth of the Sri Lankan population consists of adolescents and youth. Public health midwife (PHM) is the grassroot level key health care provider in the field for adolescents.

Objectives: To explore PHMs' perceptions on their role and the need of improving adolescent and youth friendly health services (AYFHS) in Sri Lanka

Methods: Four focus group discussions (FGDs) were conducted among 38 PHMs in Gampaha District with 9-10 midwives for each discussion. Two experts conducted the FGDs ensuring privacy and confidentiality after obtaining informed verbal consent using FGD guide. Discussions were audio-recorded and non-verbal responses were noted down. Each session lasted 60-90 minutes. Recordings of FGDs were transcribed. Thematic analysis was conducted by coding and identifying categories and themes with constant comparison. Results were presented in a narrative form.

Results: All PHMs identified the need for providing AYFHS in the field ensuring easy accessibility. However, opinion on their role on AYFHS was substandard. Domiciliary care provided by PHM was identified as a major strength. Perceived workload of PHM, inadequate training, lack of supportive supervision, insufficient facilities in centres, poor health seeking behaviours and lack of awareness on available services among adolescents were identified as challenges. Reducing of PHM workload, capacity building on AYFHS, centres with improved facilities, a better monitoring mechanism with supportive supervisions and inter-sectoral coordination were recommended.

Conclusions & Recommendations: Interventions focused on supporting PHMs on AYFHS and strengthening quality AYFHS in the field with increased client demand were identified as priorities.

***Key words**:* adolescent health, public health midwives, strengths, barriers, adolescent and youth friendly health services

Introduction

The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) and Global Accelerated Action for the Health of Adolescents (AA-HA) identified several evidence-based interventions to improve the health and wellbeing of the adolescents (1-2). Globally, out of approximately 1.8 billion young people, over 90% belong to developing countries (3-4).

In Sri Lanka, nearly 25% of the population of the 20.4 million are young persons (5). Adolescent and youth mortality rates are 66 and 166 per 100,000 respectively, while adolescent fertility rate is rising from 28 to 36 per 1000 from 2006 to 2012 (6). Further, Sri Lanka has a well-established public health system in which each health division is headed by a medical officer of health (MOH). In each MOH area, there are around 15-30 PHMs and around 6250 PHM areas island wide. Each PHM is assigned a population of 3000 in the field (7). Recommendations of Ministry of Health, Sri Lanka state that each MOH area should establish at least one AYFHS clinic per area (8) to provide services for adolescents and youth. The AYFHS was established in the country in 2005, however only nine centres were functioning by 2014. Therefore, in 2015, it was decided to revamp AYFHS and strengthen service provision through field health services (9). Public health midwife as a key health care provider in AYFHS at grass root level, registers adolescents during home visits, refers high risk adolescents to AYFHS clinic at MOH office or in the hospital and follows them up in the field (10). Therefore, it is important to assess PHMs' perception of the need of AYFHS in the field and her role in it. This is essential in identifying the gaps and challenges of AYFHS to strengthen it. So far, no study was conducted in Sri Lanka on this aspect. Present study explored the PHMs' perception of the need of AYFHS and their role for better care provision in view of strengthening AYFHS at the field level.

Methods

Present study was conducted in Gampaha District, Sri Lanka in 2018. It had 0.6 million adolescents and youth with 15 MOH areas and 483 PHMs to provide services. Four focus group discussions (FGDs) were conducted among 38 PHMs representing all MOH areas in Gampaha District. PHMs were selected purposively with 9-10 PHMs in each FGD and an alpha numeric code was used to identify the FGD session and individual participant. E.g., A1- PHM A in FGD 1. Discussions were conducted by a moderator and a data recorder using an FGD guide after obtaining informed verbal consent.

The FGDs were audio-recorded, and notes were taken while non-verbal responses were noted down. Each discussion lasted about 80-90 minutes and saturation point was reached by the fourth FGD. Data analysis was conducted following thematic analysis. Transcripts of audiotapes and written notes were used as primary data. After indexing and sorting data, they were coded and organized as concepts. These concepts were categorized as dominant categories and themes by two independent experts independently and later consensus was achieved. After each session, codes, concepts, and categories were compared for further expansion of categories. Results were presented in a narrative form with direct quotes of the participants.

Results

Out of 38 PHMs participated in the four FGDs, 82.1% (n=32) were currently married with sample mean age of 44.7 years (SD=7.7; range=27-56 years). Study yielded five themes: 1). Necessity of services of field health professionals for adolescents and youth 2). Commitment and responsibility of PHMs in AYFHS 3). Acceptability of PHM as the health care provider for adolescents and youth by families 4). Present workload and other barriers encountered by PHMs in providing AYFHS and 5). Initiatives for Improving availability, accessibility, and acceptability of AYFHS (Table 1).

Table 1: Summary of themes and categories identified by the focus group discussions among public health midwives on Adolescent and Youth Friendly Health Services

Theme	Main categories of each theme
Theme 1 – Necessity of services of field health professionals for adolescents and youth	• Realization of the need of AYFHS** • Easily accessible AYFHS**preferably in the field • Acceptable to adolescents and youth • Having follow-up in the field
Theme 2 – Commitment & responsibility of PHMs* in AYFHS**	• Priority Status of their Role in AYFHS** • Not perceiving their role due to present workload
Theme 3 – Acceptability of PHM* as the healthcare provider for adolescents and youth by family	• PHM* conducting domiciliary visits to the families • PHM's provision of services for adolescents from birth
Theme 4 – Present workload and other barriers encountered by PHMs* in providing AYFHS**	• Increased workload of PHM* • Lack of training • Not seen circulars & guidelines • Inadequate facilities • Poor accessibility • Poor coverage at AYFHS clinic • Issues in referral system • Lack of supervision • Lack of monitoring of the compliance of clients • Barriers from law implementers in provision of sexual reproductive health • Poor health seeking behaviour among adolescents • Lack of awareness among adolescents
Themes 5 – Initiatives for improving availability, accessibility and acceptability of AYFHS**	• Review of the PHM* workload • Training on AYFHS**-Training of all categories of staff, hands on training on counselling, inclusion for training curricula, training at basic training, in service training • Increase availability guidelines in- In local languages, making them freely available • Improving facilities at AYFHS**clinic- Making more attractive, with new technology, as for adolescent expectations, recreational facilities • Increasing accessibility, Providing services then & there • Increasing coverage at AYFHS clinic- Mobile clinics, youth camps, holiday clinics • Strengthen referrals mechanism- Need to raise awareness on AYFHS** among curative sector • Increasing supportive supervision • Monitoring the compliance of clients • Improving inter-sectoral coordination including sensitizing law implementers • Increasing awareness of AYFHS** using multimedia, SMS system, parental awareness, trough youth clubs, newspaper articles, through schools, teacher training on AYFHS**, through youth training centres

*Public health midwife; **Adolescent and Youth Friendly Health Services

Theme 1 – Necessity of services of field health professionals for adolescents and youth

Participants identified the need of AYFHS very well and all of them recognised AYFHS should be easily accessible to adolescents and youth to improve their health seeking behaviour. Hence, they distinguished field level service provision as the best way to attend the issues among adolescents without losing their trust in assurance of confidentiality.

"They know us for a long time as we visit their families. If we take a decent effort at field, they will come for our services." (D1, A3, C5)

They had a clear understanding of the need of providing AYFHS in the field which is acceptable to adolescents and youth and recognised the necessity of follow up in the field.

"If we become closer to them, they believe us. Otherwise they will not open up. Our service should meet their other needs such as guidance for future carriers, etc." (C4, A2, D7)

"There is a need for follow up for sustainable provision of services for youth." (C2, B6, D8)

Theme 2 – Commitment and responsibility of PHMs in AYFHS

Perception on PHMs' role in providing AYFHS and their commitment were found to be substandard as they did not perceive their role in AYFHS as a priority. The PHMs attributed several reasons for that; they had to prioritize their responsibilities with work overburden and recognised providing services to pregnant women and young children as their priority service provision.

"We have to attend for mothers and babies first. That is our foremost responsibility." (D3, D7, C8) "We understand the need for providing AYFHS. Yet, with present work overload we cannot go for targets." (B1)

Theme 3 – Acceptability of PHM as the health care provider for adolescents and youth by families

All participants identified their role in providing domiciliary visits for families in the field as a major strength for provision of AYFHS. They accepted provision of their services to target population would be easy as they visit their households since birth. Hence, communication with them would be unanticipated and service provision would be entrusted.

"We do meet adolescents more than others. Visiting families make us close to them." (D2)

"These children know us for long time. They do believe us to a certain level more than hospital doctors. If we talk to them, they tell their concerns. Parents will not have any objection on adolescents getting services from us". (C1)

All agreed on it verbally as well as non-verbally.

Theme 4 – Present workload and other barriers encountered by PHMs in providing AYFHS

Public health midwives were concerned about present workload, lack of training on provision of AYFHS especially on providing counselling services to adolescents as a special target group.

"Our population is so big; we do not have enough time for providing good quality services for adolescents. We do cover up in vacant midwife areas too." (A3)

"We did not have adequate training on demand creation and communicating with adolescents to make them believe us." (A1, B2, C1, D4)

Moreover, majority expressed that they were not informed about circulars on AYFHS by the Ministry of Health. Inadequate awareness on AYFHS guidelines as well as lack of supportive supervision of AYFHS activities were identified as barriers to service provision.

"We have not seen any circulars or guideline on adolescent health." (B5)

"Nobody is correcting us in this field in providing AYFHS." (A2, C7, D4)

Some participants highlighted availability of poor facilities in the AYFHS clinics, while some others highlighted the need of strengthening services for unmarried cohabiting adolescents. They also pointed out issues in law enforcement regarding service provision to unmarried teenagers. "We do not have a separate place for AYFHS. These children do not like to come to a place without their expected level of privacy." (A4).

They emphasized the importance of providing family planning services to unmarried cohabiting adolescents as well (B1, B2 C3 and D1).

"There are instances where we were questioned by the law implementers, for provision of reproductive health services for girls under 16 years living with a partner." (C3)

The PHMs also indicated some problems related to poor coverage of AYFHS due to health system failures such as poor accessibility to service centres, confidentiality issues due to inappropriate behaviours of healthcare providers in referral centres and lack of monitoring the compliance of youth.

"We conduct AYFHS clinic on the same day with other clinics. Adolescents do not come to our clinic when adults are there." (C7)

"We do not meet adolescents in daytime when we visit families." (C6)

"When we send clients to hospital, clinicians do not consider it as important. The remarks they make reduce the confidence that our clients are having on us." (A4, B5, D7)

"Even though adolescents are referred, we do not have time to follow up whether they went for care." (A1, B5, C6)

On the other hand, many had concerns about changing the behaviour of adolescents in the community, and lack of awareness on AYFHS considered them as major barriers to service provision.

"They do not believe that adults could help them. They do believe that health care providers will not keep their information confidential." (D4)

"Adolescents are not concerned about their health. They are more occupied with their pleasure and technology." (A2)

"Though we provide AYFHS, majority of adolescents, parents and teachers do not know the services we provide for adolescents." (C4).

Theme 5 – Initiatives for improving availability, accessibility and acceptability of AYFHS

Participants highlighted the need of reviewing workload of PHM, inclusion of training on AYFHS at basic, post-basic and in-service training program and developing guidelines in local languages and make them freely available for their use.

"It is essential to reduce population we serve in order to have more time with adolescents. Otherwise, we cannot go ahead from registering them." (A5)

"Same should be followed for curriculums for teacher trainees and on the job trainings for teachers and youth training instructors." (C2)

Almost all suggested improving facilities and accessibility to AYFHS clinics. As most of the adolescents and youth are attending schools or educational institutions during weekdays and AYFHS clinics are unavailable during weekends and public holidays, they are unable to attend these clinics. There were suggestions to have clinics on public holidays, however participants were mainly concerned of shortage of staff and instead, they proposed to conduct health camps to attract adolescents and parents.

"We have to make our service points and services more attractive for them. Equipping our clinics with more technology, etc." (D1)

They emphasized the need for strengthening collaborations between clinical and preventive sectors by raising awareness among the curative sector on field health component of AYFHS. The PHMs requested for strengthening supportive supervision to guide them in the provision of services and recognized the need for back referral from field or curative sectors to follow-up adolescents at the field level. One of their imperative concerns was to sensitize law enforcing agencies on SRH services for adolescent cohabiting couples. All participants agreed to this concern verbally as well as non-verbally.

"Problems results due to others not knowing the importance of what we are doing for adolescents. Need exists in sensitizing the law implementers on the role we are doing on provision of reproductive health services for adolescents." (A1)

To increase the awareness on AYFHS among the target population, they suggested peer adolescent and youth group involvement, use of mass media, social media, short message services, through school health clubs and youth clubs, vocational training centre and parental awareness.

"Details about available AYFHS services should be added to teacher training as well." (B4)

Discussion

In the present study, PHMs identified their role in providing domiciliary visits for families as a major strength in the provision of AYFHS. Identified barriers were workload of PHMs, inadequate training, unavailability of guidelines to them, lack of facilities at service delivery points, issues pertaining to referrals, lack of supportive supervision and legal issues encountered when providing SRH, poor health seeking behaviour of adolescents and their lack of awareness of the quality and availability of AYFHS.

FGDs were identified as ideal to obtain perspectives and attitudes of people about issues, seek explanations for behaviours, and generation of hypotheses (11). Thematic analysis is identified for getting rich in-depth data with a detailed account of it analysed (12). The study being confined to one district, it limits the generalizability, however Gampaha District having the second highest population in the country makes the findings more reflective.

Global and National Standards for AYFHS identified the need for easy accessibility and acceptability for quality AYFHS services (9, 13), which was perceived by study participants too. Despite the Family Health Bureau (FHB) publishing several guidelines, circulars, protocols on AYFHS such standards on AYFHS (9), protocol for AYFHS clinic (14) and circular for provision of AYFHS (10), this study revealed that majority of the PHMs are unaware of these documents. This highlights the need for strengthening the mechanism of dissemination of all guidelines and circulars to the grassroot level, the inclusion of AYFHS in PHM curriculum with and streamlining supportive supervision as some current priorities.

Barriers identified such as unawareness of youth friendly nature of services, limited facilities in the AYFHS clinics, poor logistic management and lack of accessibility highlighted that there is a necessity for ensuring quality of AYFHS. A systematic review conducted by Chilinda et al (2014) revealed that unprofessional attitude of health care providers and lack of youth friendly nature inhibited adolescents from coming to SRH services in developing countries (15). The present study also recommended to provide services in a more youth friendly manner to improve attendance to AYFHS.

Participants of the study suggested that using modern techniques and equipment for AYFHS (e.g. computers, mobile phones, internet, short message service, social media) has been already highlighted in the national standards of AYFHS (9). They perceived the need for capacity building on AYFHS among health workers in curative sector and strengthening referral system with providing priority and due recognition for the youth referred from the field to hospital.

Similar to the present study, the need for proper training to prevent breaches of confidentiality in

AYFHS was highlighted in a study conducted in South Africa (3). Recommendation of present study was to include it into the basic curriculum of health workers and to have regular in-service training on AYFHS. Recently, AYFHS training has been included in the PHM basic curriculum, while AYFHS training of trainers (ToT) programmes for district health teams were conducted by the FHB during past few years. Yet, this study shows the training gap at grass root level.

Study participants perceived the lack of support from law enforcing agencies in providing SRH services to under-aged adolescent girls (<18 years). Legal clearance was obtained by the Ministry of Health for health workers to provide services for the best interest of the child (16). Nevertheless, there were some instances where health staff was questioned by law enforcing agents on such service provision without informing health authorities. Hence, PHMs show lack of confidence in providing SRH services to under aged adolescent girls.

Conclusions & Recommendations

Present workload of PHM, inadequate capacity building and the guidance of supervisory officers have been perceived as challenges for study participants to provide AYFHS. Hence, they did not recognize their role in AYFHS sufficiently.

Present study focused PHMS, future studies on implementing evidence-based interventions to improve quality of AYFHS and to improve health seeking behaviour of adolescents are priorities.

Authors Declarations

Competing interests: None of the authors are having any conflict of interest.

Ethics approval and consent to participate*:* Ethical approval was obtained from the Ethic Committee of the Medical Research Institute. Informed verbal consent was taken from the participants prior to the commencement of each focus group discussion.

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Public Health Implications

- Recruiting new PHMs for vacancies, revisiting the duties of PHMs with capacity building, and monitoring and evaluation of the outcomes of training of trainer programmes at grass root level, are recommended to improve perception on PHMs' role in AYFHS. Expanding service points with adequate facilities and improved accessibility and regular advocacy for law enforcing agents are strongly recommended to overcome the barriers in service provision.
- Accreditation system and service appraisal system would be beneficial in the process of strengthening the quality of AYFHS services. These findings and recommendations were forwarded to relevant stakeholders for necessary corrective action to enable it through field health components in the country.

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