Original Article

Constraints in Implementing Adolescent Friendly Health Services in Bangladesh: Health System Aspects from the Service Providers

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Abstract

Background: Adolescent Friendly Health Services (AFHS) aim to provide accessible, confidential and comprehensive care to adolescents, yet service gaps and implementation challenges persist in Bangladesh.

Objective: To identify health system-related constraints in implementing AFHS from the perspective of service providers.

Methods: This multi-center cross-sectional study conducted from January to December 2018 assessed constraints in implementing Adolescent Friendly Health Services (AFHS) at four Adolescent Friendly Health Corners (AFHC) in Dhaka and Gazipur, Bangladesh, including two NGO and two government facilities. Participants included health facility managers (n=5), healthcare providers (n=8), outreach workers (n=12), and supporting staff (n=5), purposively selected. Data were collected using WHO-adapted semi-structured questionnaires on socio-demographics and service delivery.

Results: The findings revealed that HFMs oversaw administrative and clinical activities, with 80% reporting inconvenient service hours. All HFMs provided reproductive, nutritional and mental health services; however, there were gaps in HIV counseling (20%) and STI/RTI diagnosis (80%). The majority of reproductive health services were provided by healthcare providers, mostly counselors and paramedics, with only 12.5% offering STI/RTI diagnosis or 0% counseling for HIV-positive adolescents. Outreach workers and peer educators actively included adolescents in community programs, with 83-92% trained in referral procedures. Supporting staff were primarily responsible for facility operations and acknowledged discomfort with some teenage groups (20%) as well as insufficient referral training (0%). Common recommendations included increasing waiting areas, expanding educational/entertainment offerings and strengthening referral systems.

Conclusion: This study identifies gaps in HIV care, STI/RTI management, staff training, resources and privacy within AFHS. Strengthening capacity, ensuring resource availability, and engaging adolescents are essential to enhance service quality and accessibility in both NGO and government facilities in Bangladesh.

Keywords: Adolescent friendly health services, Implementation, Constraints, Bangladesh.

Introduction

Adolescence is an important transitional phase in human life which is marked by rapid physical and mental changes. Word Health Organization (WHO) has defined adolescence as a stage of life that spans from 10 to 19 years of age.[1] The second decade of life is of vital importance for an individual as it lays down the cornerstone of a healthy and productive future as an adult. In the twentieth century, rapid globalization has put teenagers in front of challenges like substance abuse, risky sexual behaviors, unwanted pregnancy, injuries, violence and numerous physical and psychological adversaries.[2,3] This makes adolescence one of the most vulnerable portions in the overall population. To accommodate the uniqueness of physical and psychological changes in adolescent period, young people need special attention and care. Moreover, adolescents account for one sixth of world population.[4] Therefore, to provide age-specific healthcare to a huge number of people, the arrangement should aim at providing a safe, confidential and friendly environment. Nonetheless, adolescent health has always not been given equal importance all around the globe. Sometimes, it is overlooked in many places due to conservative social structures and fragile economic conditions.[5,6] To raise uniform awareness worldwide and to conserve health and wellbeing of the youth, leading bodies in health and social welfare like WHO and UNICEF have taken multiple enterprises that include necessary principles, elements and guidelines.[7]

Adolescent Friendly Health Services (AFHS) is a specialized healthcare that addresses the unique and changing health needs of adolescents and therefore, AFHS are grounded on shared principles of access, acceptability, equity, effectiveness, appropriateness, respect for privacy and confidentiality.[8,9] The services should be available in a way so that no adolescent is deprived of getting care based on gender, socioeconomic status, marital status, disability, or any other factor.[10] Whereas, extensive delivery of services is needed, including AFHS guidelines focusing on ensuring involvement and sensitization in the community in a way that reduces stigma and increases awareness of adolescent health needs. The services need to be offered at the right times and in the right places to encourage

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increased use among young people. Hence, this care should be accessible to all teenagers despite variations in individual characteristics or locations[11] which may include sexual and reproductive health, mental health, nutrition, drug prevention and general health care. Health services can earn its acceptability from its young clients by providing a non-judgmental environment, less waiting time, adequate privacy and confidentiality which in turn will ensure that they are confident, and they trust the service.[12] AFHS can be made more effective through providing the right kind of health service in an appropriate manner with the help of welcoming facilities[13] and youth-friendly information materials are used to create a positive experience. Trained and sensitized health workers who can communicate with adolescents and are sympathetic to their emotional and psychological needs; facilities that ensure privacy and confidentiality at the time of consultation are the key elements of AFHS.[14] Services should be at no cost or low cost with minimal or no bureaucratic stipulations such as parent permission for access to care.[15] WHO has set a global standard of AFHS that comprises adolescent's health literacy, community support, appropriate package of services, providers' competencies, facility characteristics, equity and non-discrimination, data and quality improvement and adolescents' participation.[8,16]

Being equipped by definitive guidelines and frameworks, AFHS may face significant challenges in implementing an effective service for the adolescents nonetheless.[17,18] Obstacles that emerge in the process of service delivery can be widely manifested by both care receivers and care providers.[19] Lack of health literacy among adolescents, less awareness about health services, family challenges, negligence from the community etc. are some of the significant barriers from the part of service receivers.[20,21] On the other hand, scarcity of human resources, lack of competencies, breach of confidentiality, infrastructural inadequacies, distance of the facilities, cost of service etc. can be seen on the service provider's side.[19,21,22] With a view to mitigating such obstacles and ensuring AFHS effectively, multilevel measures can be taken. A study from Bangladesh shows such strategies where the community approach towards AFHS encompasses school initiative and village courtyard session. Alternatively, the facility approach includes free service provision, capacity building of the service providers and arrangement of visible messages to disseminate information.[23] To put these initiatives into action, the service providers play a vital role in different health facilities. They work in different layers of the health system whereas they are involved in providing listed services which may include- counseling on adolescence, nutrition, risky sexual behavior, early marriage, menstrual hygiene, violence related information and giving treatment for sexually transmitted infection, reproductive tract disease, family planning etc.[24] AFHS is a unique kind of service as it is designed to address the diverse health needs of a specific age group. To ensure an uninterrupted and efficient AFHS, it is necessary to remove or, at least, to reduce the possible barriers and constraints present in different levels of the health system. This study is designed to find out such constraints in implementing AFHS from a health system aspect from the service providers.

Materials and Methods

During the study period of January to December 2018, this cross-sectional study evaluated the service availability, staff competence, training and infrastructural constraints in implementing AFHS at Adolescent Friendly Health Corners (AFHC) in Dhaka and Gazipur, Bangladesh, including the Adolescent Friendly Model Clinic and Pallabi Extension in Dhaka and the Upazila Health Complex, Kaliganj and Family Welfare Centre, Nagari in Gazipur.

The study population comprised health facility managers, healthcare providers, outreach workers, and supporting staff. All health facility managers (n=5) were included, while 8 healthcare providers, 12 outreach workers and 5 supporting staff were purposively selected. Eligible participants were assigned personnel at AFHCs who provided informed consent, while those unwilling to participate were excluded. Data were collected using semi-structured questionnaires and adapted from the WHO Quality Assessment Guidebook (2009)25, covering socio-demographics and service-related aspects. Pre-testing was conducted at AFHC, Mazar Road, Mirpur to refine the instruments.

Data were entered and analyzed using IBM SPSS Version 26 (New York, USA). Descriptive statistics were presented as frequencies (percentages) for categorical data and means (±SD) for continuous data. Participation was voluntary, with confidentiality ensured through individual code numbers. Informed consent was obtained after explaining the study's objectives and potential outcomes. The research adhered to the 2013 revised Declaration of Helsinki and its amendments, or comparable ethical standards. Ethical approval was granted by National Institute of Preventive and Social Medicine (NIPSOM), Dhaka 1212, Bangladesh. (NIPSOM/IRB/2019/111).

Results

In the Table-I, the health facility managers (HFMs) had a mean age of 38.8 years (SD±8.4) with 60% female. Their designations varied by setting, including project manager, monitoring officer, admin/account officer in NGOs, and UFPA/UHFPO in government facilities. Most (80%) held post-graduate degrees and had over one year of experience, with a mean working duration of 51.4 months (SD ±32.8). All HFMs oversaw administrative and managerial tasks, arranged staff training, and some provided clinical services. No facility had policies restricting adolescent services, and most adolescents (80%) received free services. Facility operation times were generally found inconvenient by 80% of HFMs. All HFMs reported providing community services on SRH, nutrition, mental health, anaemia, adolescent pregnancy and child marriage, with government facilities additionally covering

drug addiction and pads for schoolgirls, and NGOs offering life skills, computer training, and cultural programs. Confidentiality policies were absent, but referral systems and staff training were in place. Waiting rooms were equipped with educational materials. About 60% of HFMs involved adolescents in decision-making and suggestions. Medicines and equipment were insufficient for 60% of HFMs, though inventory systems existed, and no service disruptions occurred in the past six months. Regarding the reproductive health services for adolescent clients, all health facility managers (HFMs) reported providing a wide range of reproductive health services for adolescents, particularly SRH counseling, pregnancy cares, contraceptive counseling, and post-assault support. However, only 80% offered STI/RTI diagnosis, and a major service gap was noted in HIV-related counseling, with just 20% offering support for HIV-positive adolescents. Regarding the competence (knowledge and skills) to provide services, the majority of HFMs confirmed that their staffs were well-trained and skilled in delivering almost all RH services. However, similar to service provision, staff knowledge and skills were weaker in STI/RTI diagnosis (80%) and particularly in counseling HIV-positive adolescents (20%), indicating a training gap in HIV-specific adolescent care. Protocols and guidelines were consistently followed for most RH services, including SRH counseling, pregnancy and childbirth care, and contraception-related services. Nevertheless, gaps existed in protocol use for STI/RTI diagnosis (80%), HIV counseling (80%), and especially counseling HIV-positive adolescents (0%), which reveals critical areas where standardized guidelines are lacking or not implemented (Figure-1).

Table-I: Findings outline form the health facility managers (n=5)

Variables	Frequency (f)	Percentage (%)	
Socio-demographics			Mean age= 38.8 (SD ±8.4) years 60% female 80% post-graduated Mean working duration= 51.4 (SD ±32.8) months
Work and responsibilities	All engaged in admin/management, training arrangement; doctors were also provide treatment.		
Policies/restrictions	0	0.0	No restrictive policies/procedures
Service charges taken	1	20.0	Ticket fee (5 BDT), rest free
Free services	4	80.0	
Convenience of service hours			
Convenient	1	20.0	
Not convenient	4	80.0	
Community services	5	100	Provided SRH, nutrition, mental health, drug addiction info, pads, cultural programs
Confidentiality policies	0	0.0	
Referral system & training	5	100	All knew referral pathways, arranged trainings
Adolescent involvement	3	60.0	Suggestions, and decision-making
Medicines & equipment			Adequate medicines: 2 (40%); Equipment: 3 (60%)

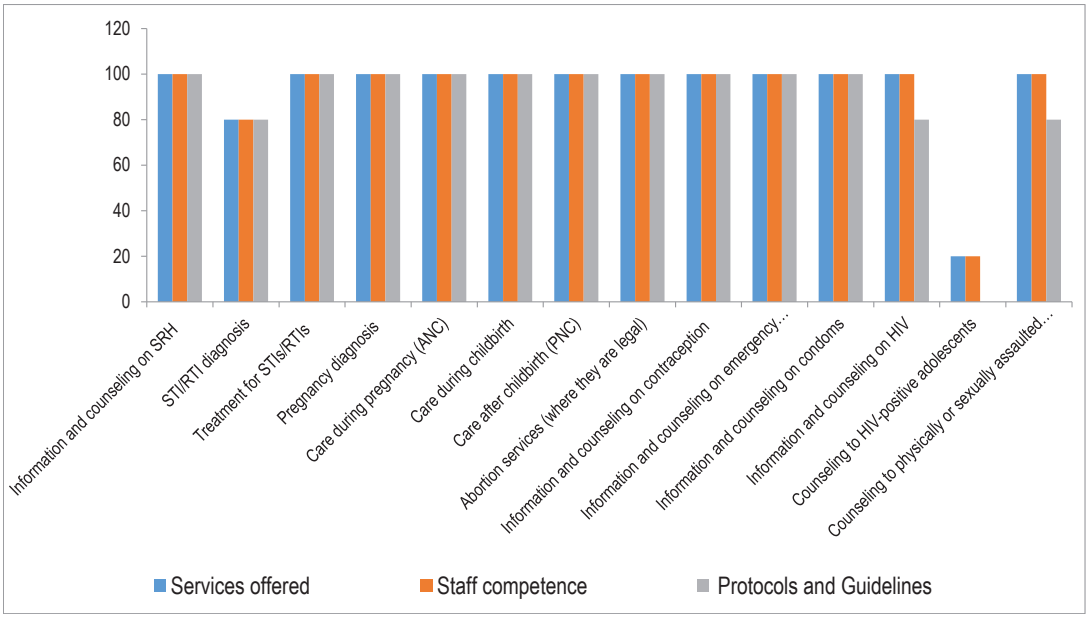

Figure-1: Services availability, staff competence and protocols in adolescent reproductive health care (n=5)

In the Table-II, the healthcare providers (HCP) had a mean age of 34.8 years (SD ±10.15), with 62.5% female. Half were counselors, and 25% each were paramedics and SACMOs, with most holding a graduate degree (62.5%) and a mean working duration of 8.5 months (SD ±8.8). Paramedics and SACMOs provided treatment, counseling, and sessions with adolescents, parents, and teachers, while counselors mainly provided treatment. All respondents knew referral procedures, 87.5% assisted adolescents with referrals, and the same proportion reported being trained to communicate treatment risks and alternatives. Regarding resources, 87.5% lacked adequate medicines, 75% lacked sufficient equipment, but service provision disruptions were rare. NGO facilities suggested more training, signboards, waiting space, and educational/entertainment materials, while government facilities emphasized skilled manpower, school sessions, menstrual regulation services, pads, beds, vaccination programs, and waiting space. Policies did not restrict adolescent services, and all reported community support. Confidentiality policies were absent, but privacy during consultations was maintained. Most providers (62.5%) had enough consultation time, though 62.5% occasionally had to see clients quickly due to high demand.

Table-II: Findings outline form the healthcare providers (n=8)

Variables	Frequency (f)	Percentage (%)	
Socio-demographics			Mean age= 34.8 (SD ±10.2) years 62.5% female 62.5% graduate Mean working duration= 8.5 (SD ±8.8) months
Designation			
Counselor	4	50.0	
Paramedic	2	25.0	
SACMO	2	25.0	
Comfort of adolescents			
No	1	12.5	All groups comfortable except 12.5% noted issues
Yes	7	87.5	with unwanted pregnancy cases
Community supports	8	100	
Confidentiality policies	0	0.0	No written policies
Privacy during service	8	100	Assured privacy
Consultation time enough	5	62.5	
Often had to see clients quickly	5	62.5	
Referral knowledge	8	100	87.5% provided referral assistance
Training	7	87.5	Trained in communication & alternatives
Medicines adequate	1	12.5	
Equipment adequate	2	25.0	
Service improvement suggestions	More training, equipment, waiting space, sanitary pad supply, MR & vaccination services		

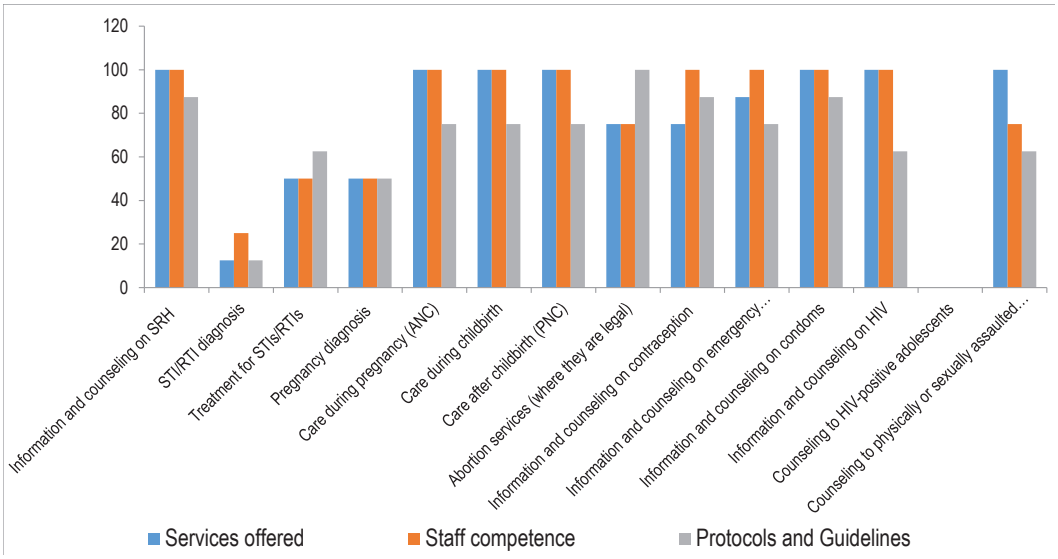

Figure-2: Services availability, staff competence and protocols in adolescent reproductive health care (n=8)

In the Table-III, the respondents had a mean age of 29.3±13.8 years, with 58.3% female. Most (66.7%) were outreach workers and 33.3% were peer educators, with no adolescent or peer educator involvement in government facilities. Education-wise, 58.3% were undergraduates and 41.7% graduates, with a mean working duration of 22.7± 44.8 months. Peer educators organized awareness programs, satellite health camps, and community sessions, while outreach workers also provided MCH and family planning counseling, engaged parents and teachers, and in government settings, conducted deliveries and supervised EPI programs. Adolescents were involved in 66.7% of NGO facilities, helping organize programs, cultural activities, and health awareness. Most respondents (91.7%) knew referral procedures, 83.3% assisted with referrals, and 83.3% had received training. To improve services, NGO facilities suggested continuous staff presence, adequate medicines, investigation facilities, and more educational/entertainment materials, while government facilities highlighted the need for more waiting space, separate toilets, community programs, pad supply and adolescent-friendly materials. Outreach workers were responsible for providing adolescent health services in the community. All provided information on nutrition and child marriage, 91.7% on SRH and mental health, 83.3% on adolescent pregnancy and 75% on anaemia. In government settings, they also offered information on drug addiction and TT vaccination (Figure-3).

Table-III: Findings outline form the outreach workers (n=12)

Variables	Frequency (f)	Percentage (%)	
Socio-demographics			Mean age= 29.3 (SD ±13.8) years 58.3% female 58.3% undergraduate Mean working duration= 22.7 (SD ±44.8) months
Designation			
Peer educator	4	33.3	
Outreach worker	8	66.7	
Adolescent involvement	8	66.7	NGO only; no involvement in Govt. facilities.
Referral knowledge	11	91.7	
Referral assistance	10	83.3	
Training received	10	83.3	
Improvement suggestions	Full-time paramedics/counselors, medicine supply, baseline investigations, waiting space, toilets, sanitary pad supply, educational/entertainment materials.		

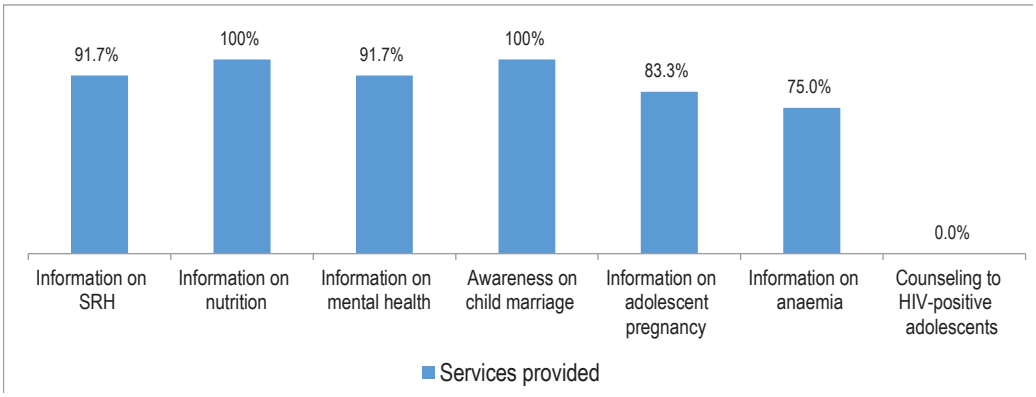

Figure-3: Outreach workers providing services in the community

In the Table-IV, the supporting staff had a mean age of 36.2±14.2 years, with 60% female. Most were cleaners (60%), followed by MLSS and office assistants (20% each), with 60% completing primary education and 40% secondary. The mean working duration was 34.8±24.2 months, with 80% employed for over a year. In NGOs, cleaners managed cleaning and food assistance, while MLSS handled cleaning, registration and some office tasks. In government facilities, cleaners maintained the AFHC and office assistants handled documentation, with one facility lacking a cleaner. Most staff (80%) was comfortable with all adolescent groups, while 20% felt discomfort with drug-addicted adolescents or those coming after family conflicts. Waiting time for adolescents averaged 16.0±9.6 minutes, with 60% waiting ≤15 minutes. Regarding referrals, 40% knew the procedures and provided assistance, while 60% did not, and none received formal training. To improve services, both NGO and government facilities suggested expanding waiting space and adding educational and recreational materials, with government facilities emphasizing enhanced adolescent involvement through outreach and referral systems.

Table-IV: Findings outline form the supporting staffs (n=5)

Variables	Frequency (f)	Percentage (%)	
Socio-demographics			Mean age= 36.2 (SD ±14.2) years 60% female 60% primary education Mean working duration= 34.8 (SD ±24.2) months
Designation			
Cleaner	3	60.0	
MLSS	1	20.0	
Office assistant	1	20.0	
Discomfort with adolescents	1	20.0	Discomfort with drug-addicted/youth in conflict with parents
Waiting time for adolescents (minutes)			
≤15	3	60.0	Mean waiting time= 16.0 (SD ±9.6)
>15	2	40.0	
Referral knowledge	2	40.0	
Referral assistance	2	40.0	
Training	0	0.0	
Service improvement suggestions			More waiting space, entertainment or educational materials, stronger referral system via outreach

Discussion

This study provides insights into the current state of AFHS in Bangladesh, focusing on the perspectives of health facility managers, healthcare providers, outreach workers, and supporting staff. The findings underscore several strengths and areas for improvement in the delivery of adolescent health services. The study revealed that while a range of reproductive health services is offered, adherence to protocols and guidelines was inconsistent. For instance, services like STI/RTI diagnosis and HIV counseling were less frequently provided and when offered, they often lacked standardized protocols. This inconsistency can result in fragmented care and may undermine the effectiveness of the services. International guidelines emphasize the importance of standardized protocols to ensure the delivery of high-quality adolescent health services.[25-28]

Community support for adolescent health services was universally reported, indicating a positive environment for service delivery. However, the convenience of service hours was a concern, with the majority of health facility managers reporting inconvenient operating times. Aligning service hours with adolescents' schedules is essential to improve access and utilization. Studies suggest that flexible service hours can significantly increase adolescent engagement with health services.[29-32]

A significant challenge identified was the lack of formal training for supporting staff, which affects their ability to perform their roles effectively. Additionally, the absence of confidentiality policies and discomfort among some staff in dealing with certain adolescent groups highlight the need for comprehensive policies and training programs to create a supportive environment for both staff and adolescents.[21,33-35]

A significant concern identified across all staff categories was the lack of formal training in adolescent health services. None of the supporting staff received training, and while healthcare providers and outreach workers had some exposure, it was often insufficient. This gap in training can lead to suboptimal service delivery and may affect the quality of care provided to adolescents. Studies have shown that comprehensive training programs for healthcare providers are essential to improve the quality of adolescent health services.[33,36-39]

The study found that while referral systems were in place; their effectiveness was limited by staff knowledge and involvement. Only a minority of staff were aware of referral procedures, and even fewer provided assistance. Moreover, adolescent involvement in decision-making was minimal. Engaging adolescents in their healthcare decisions is crucial for improving service uptake and satisfaction. Global standards advocate for the meaningful participation of adolescents in health service planning and delivery.[8,29,40]

Adequate infrastructure and resources are fundamental to the provision of adolescent-friendly services. The study highlighted deficiencies in waiting spaces, educational materials, and privacy measures. These shortcomings can deter adolescents from seeking care and may compromise their experience. Research indicates that improving the physical environment and providing appropriate resources are effective strategies to enhance adolescent health service utilization.[19,20,41,42]

Conclusion

This study highlights significant gaps in the implementation of AFHS in both NGO and government facilities in Dhaka and Gazipur, Bangladesh. While a broad range of adolescent health services, including reproductive, nutritional, and mental health care, are provided, critical deficiencies exist in HIV-specific counseling, STI/RTI diagnosis, staff training, resource availability, and privacy policies. Health facility managers, healthcare providers, outreach workers, and supporting staff face infrastructural and operational challenges that limit service efficiency and adolescent engagement. Addressing these gaps through targeted capacity-building programs, improved resource allocation, adherence to standardized protocols, and active involvement of adolescents in service planning can enhance both the quality and accessibility of AFHS. Strengthening these areas is essential to ensure equitable, confidential, and comprehensive care for adolescents, ultimately contributing to better health outcomes and the long-term wellbeing of this vulnerable population.

Recommendations

To improve the quality and accessibility of AFHS in Bangladesh, it is recommended to strengthen staff capacity through targeted training on HIV counseling, STI/RTI management, and adolescent-specific reproductive health. Facilities should ensure adequate availability of medicines, diagnostic equipment, and educational materials, while expanding waiting areas and private consultation spaces to enhance confidentiality and comfort. Active engagement of adolescents in service planning and community programs should be promoted to align services with their needs. Establishing standardized protocols and monitoring systems for all services, particularly HIV and STI/RTI care, will improve consistency and quality. Additionally, collaboration between NGO and government facilities, along with sustained outreach and awareness activities, can enhance community support and utilization of AFHS. Regular evaluation and feedback mechanisms should be implemented to address service gaps and inform continuous improvement.

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