UNIVERSAL HEALTH COVERAGE AND ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

Health services play an important role in reducing preventable poor health and supporting young people to make a healthy transition into adulthood. In addition to essential curative care, health services are also a crucial source of preventive services for a range of adolescent health needs, including SRH. Many young people come into contact with health services for common health complaints, therefore, health facilities are an important entry point to reach young people with a range of SRH interventions (box 10).

While many countries in Asia and the Pacific have made considerable progress towards effective coverage, and to some extent equitable coverage, of SRH services, progress has not been realised for adolescents. Many national universal health coverage programmes exclude SRH services of particular priority for adolescents (such as contraception, HPV immunization, care for violence, comprehensive abortion services), and provide insufficient financial risk protection for young people. Across the region young people continue to have a high unmet need for essential SRH services and coverage is particularly low among rural, less educated, poorer, and marginalized young people.

BOX 11. SRH SERVICES FOR ADOLESCENTS

- SRH information, education and counselling
- Contraception counselling and commodities
- Antenatal, safe delivery, and postnatal care
- Prevention of unsafe abortion, safe abortion (to the fullest extent of the law), post-abortion care
- Menstrual health care
- Prevention, care and treatment of STIs and HIV (including provision of condoms)
- Human Papillomavirus (HPV) immunisation to prevent cervical cancer
- Prevention, surveillance and care for sexual and gender-based violence
- Action to eliminate harmful practices (forced child marriage, female genital mutilation)
- Address associated risk factors (substance use, mental health, nutrition)

BARRIERS THAT IMPACT ON ACCESS TO SRH SERVICES

Despite the incentives to provide SRH services to young people, many face considerable barriers to accessing quality SRH services, and services for adolescents are generally uneven in quality, poorly coordinated, and fail to comprehensively address young people's needs. The majority of adolescent girls report at least one serious barrier to accessing health care (figure 51), including financial barriers, lack of female health providers, barriers related to distance and transport, and needing to seek permission.

Common barriers reported by young people across the region are summarised in figure 52. These include young people's low knowledge of their own SRH needs, awareness of SRH services, and health literacy; embarrassment, fear, shame and stigma, in part driven by community disapproval and sociocultural norms; and lack of decision-making autonomy, particularly with respect to married adolescent girls.

On the supply-side, judgmental attitudes of health providers and lack of appropriate skills (including communication and counselling skills), as well as insufficient privacy and confidentiality, are major reasons why young people do not seek care or report poor quality care. Laws or policies that require parental or spousal consent, or that prohibit access to some services, also contribute to low uptake of SRH services and poorer health outcomes. In addition, lack of data describing young people's SRH needs and preferences with respect to service delivery is a key barrier to informing more responsive policy and approaches.

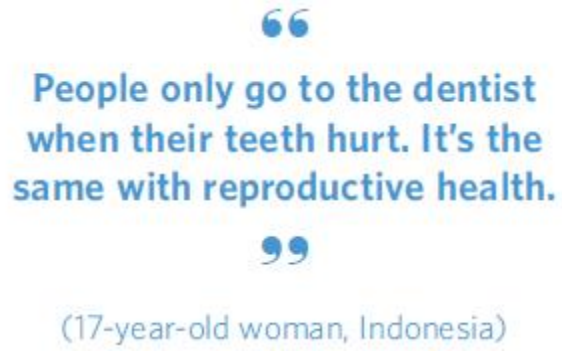
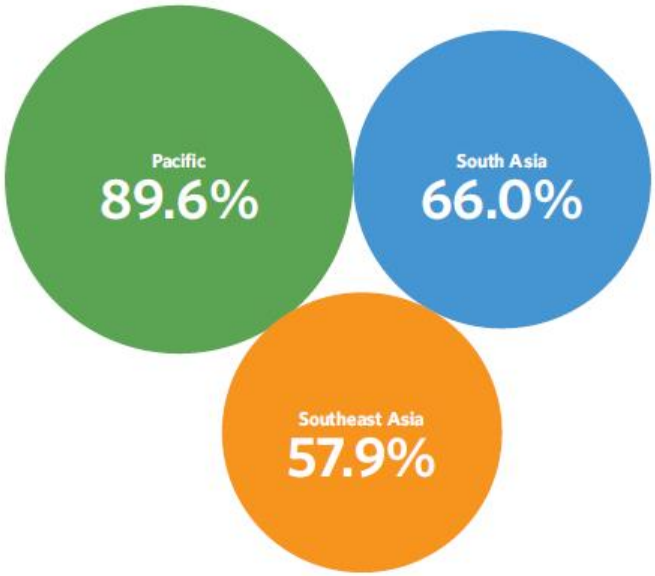


FIGURE 51. PROPORTION OF 15-19-YEAR-OLD GIRLS REPORTING AT LEAST ONE SERIOUS PROBLEM ACCESSING HEALTH CARE



Source: DHS and MICS

FIGURE 52. BARRIERS THAT LIMIT ACCESS TO SRH SERVICES

Demand-side barriers	Health system barriers	Policy, regulatory and legal barriers
• Low SRH knowledge • Low health literacy • Lack of decision-making autonomy (particularly girls) • Embarrassment, shame, stigma • Socio-cultural norms	• Judgmental health providers • Poor communication and counselling skills • Lack of privacy and confidentiality • Unwelcoming environment • Discrimination • Cost of services/commodities • Poor quality of care • Inconvenient opening hours	• Exclusion of young people and SRH services from UHC • Mandatory requirement for parent, guardian or spouse consent • Policies that restrict access to services on the basis of marital status, age, migrant status

> **“As a person with a mental disability, it’s difficult for me to get services.... When I go there to see someone they don’t allow me, and they don’t take me seriously.”**
>
> (Young person, Fiji)

Many of these barriers are substantial for unmarried young people, young people living with disability, young people with diverse SOGI/E, young key populations, and marginalized adolescents. Young people living with disability in particular can face considerable stigma, discrimination, and violation of their right to privacy and autonomy when seeking SRH services. Importantly, socio-cultural norms that prohibit sex outside of marriage are a strong disincentive to seek care if young people are afraid of disclosing sexual activity, particularly if confidentiality is not guaranteed. This often results in young people delaying seeking care, or turning to private clinics, pharmacies, unskilled providers, or self-treatment rather than public facilities.

ADOLESCENT-RESPONSIVE HEALTH SYSTEMS

The particular health needs of young people, their rapidly evolving emotional and cognitive capacity, and the socio-cultural context in which they live have important implications for health systems and service delivery. Health workers require additional knowledge and skills, including counselling skills, to deal sensitively and effectively with young people. Young people's increasing autonomy and need for privacy have implications for the facility environment and policies related to confidentiality and consent. Health financing mechanisms need to ensure inclusion of adolescents and their health needs.

Adolescent-responsive health systems are those that provide quality care addressing these factors, in a way that is accessible, appropriate and acceptable to young people. Key characteristics are summarised in box 11. Where efforts have been made to incorporate these features into health services (with particular attention to improving health worker guidelines, protocols and training, improving facilities' physical environment, and engaging communities to increase support) use of services by young people has increased.

BOX 12. WHO GLOBAL STANDARDS FOR QUALITY SERVICES FOR ADOLESCENTS

Standard 1. Adolescents are knowledgeable about their own health, and know where and when to obtain health services, and use them.

Standard 2. Parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents. They support such provision, and utilization of services by adolescents.

Standard 3. The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfil the needs of all adolescents. Services are provided in the facility, through referral linkages and outreach.

Standard 4. Health care providers demonstrate technical competence required to provide effective health services to adolescents. Both health care providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-judgmental attitude and respect.

Standard 5. The health facility has convenient operating hours, a welcoming and clean environment, and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.

Standard 6. The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, schooling, ethnic origin, sexual orientation or other characteristics.

Standard 7. The health facility collects, analyses and uses data on service utilization and quality of care disaggregated by age and sex to support quality improvement. Health facility staff are supported to participate in continuous quality improvement.

Standard 8. Adolescents are involved in the planning, monitoring and evaluation of health services, in decisions regarding their own care as well as in certain appropriate aspects of service provision.

Source: WHO 2014

National policies and standards

Nearly all countries refer to 'adolescent-friendly' health services (AFHS) in national reproductive health, HIV or youth policies. Most have also developed, or are developing, national standards or guidelines defining adolescent-responsive service delivery and supporting implementation (figure 53).

The available national and regional standards detail characteristics of adolescent-responsive health services that are consistent with the WHO global standards: emphasizing non-judgmental care that respects young people's rights, privacy and confidentiality; skills and training of providers; attention to the facility environment and opening times; provision of information and education materials; and, linkages with activities to increase awareness and demand for services and generate community support. Most also specify a package of services that should be available to young people, with a strong focus on SRH including information and counselling about puberty and SRH, provision of condoms and contraception, pregnancy-related care, management of STIs, and provision of, or referral for, HIV testing and care, and services for sexual violence. Some guidelines address other key adolescent health concerns (such as mental health and substance use) that are priority needs for young people and are also linked to SRH outcomes. However, these issues are often not comprehensively addressed.

There are important gaps: while many policies and guidelines highlight marginalized young people, young key populations, and those with diverse SOGI/E as facing particular barriers, few national standards provide specific guidance on actions required to meet the needs of these young people. Additionally, few policies and strategies provide clear guidance around adolescents' evolving capacity to consent to medical care, nor their rights and agency with respect to making decisions about their SRH, in line with the Convention on the Rights of the Child. Even where legislation exists that enables access to some services (such as HIV testing) to young people under the age of 18 as 'mature minors', there are few specific guidelines about how to assess a young person's capacity to provide consent effectively.

FIGURE 53. EXISTENCE OF NATIONAL AFHS POLICY AND STANDARDS

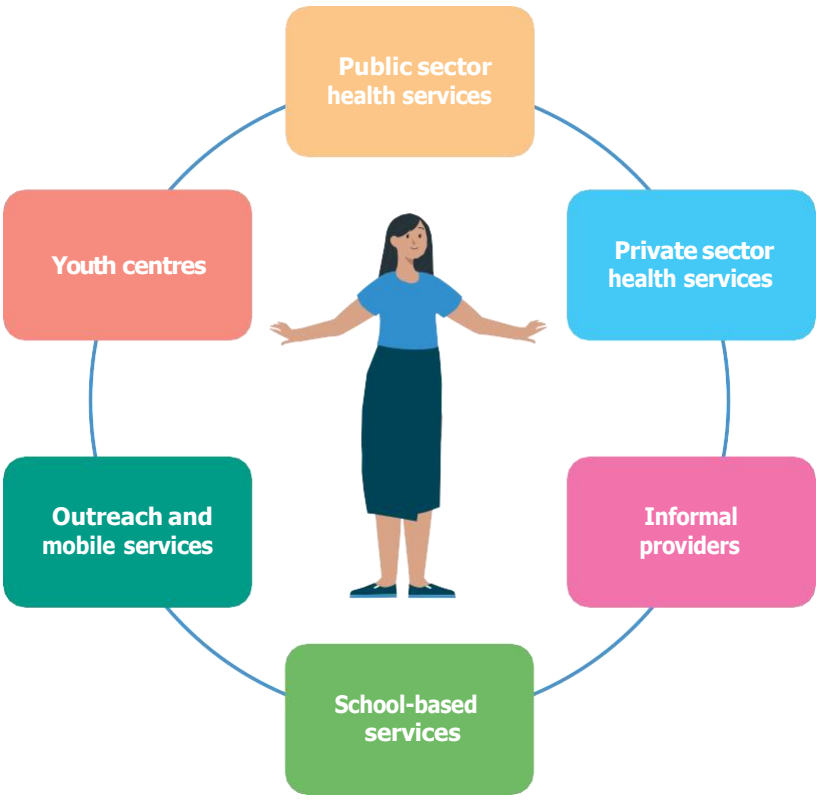
Source: Review of available national policies conducted by authors

Consideration also needs to be given to other policies and legislation that impact on young people's access to comprehensive SRH services. As discussed previously, policy or legal restriction on the access of unmarried young people to some services, legal requirements for parental or spousal consent, and criminalization of some behaviours will continue to result in low coverage of effective care, even where 'youth-friendly' health services exist.

Platforms for service delivery

There are several different platforms for reaching young people with SRH services in the region (figure 54), reflecting the diversity of young people's needs and preferences, and the diversity of approaches to overcome barriers to access. While each is likely to have an important role in improving young people's SRH, these multi-sectoral platforms are often poorly coordinated, leading to gaps in coverage and quality.

FIGURE 54. COMMON SERVICE DELIVERY PLATFORMS



Public sector health services

Many young people come into contact with public sector health services, so it is important that existing service delivery points are strengthened to provide quality care for adolescents. Most governments in the region have developed specific guidance to improve the quality and accessibility of public services (including those that provide SRH care) for adolescents, and there is some evidence that such efforts to standardize and improve government-run health facilities can improve quality and coverage.

Smaller-scale projects, typically led by non-governmental organizations, have generally focused on: upgrading facilities to improve privacy and provide a separate waiting area for adolescents; health worker training; and community engagement to increase demand and support. Evaluations of these projects have reported improved quality and utilization by young people. There are fewer documented and evaluated examples of large-scale or nation-wide implementation of AFHS in government facilities. Evaluations of large-scale government initiatives in Nepal and India have demonstrated that efforts to improve health provider training, provision of clear implementation guidelines and operational support (in addition to technical support), and use of formative research to inform approaches can improve quality and uptake of priority adolescent health services, although sustained non-government organization technical support, improved monitoring and supportive supervision, and community engagement are required to maintain quality.

Youth-centres

Young people may be reluctant to access public health facilities because of concerns about privacy and confidentiality. Youth-only centres can have the advantage of providing young people with a greater degree of privacy in an environment that is welcoming and appealing. They may also have the advantage of being located in areas that young people already congregate, making them physically more accessible. Youth-centres that provide SRH services often also provide an array of resources, activities and other supports, enabling young people to avoid the stigma associated with SRH services (such as family planning clinics, or STI/HIV clinics).

There are a number of examples of youth centres or youth-only clinics that provide SRH counselling and services, although many are small-scale or pilot projects. Most are run by, or in partnership with, non-government organisations. While often providing high quality services, youth-only facilities are generally only located in urban areas and so have limited coverage. The resources required to establish and maintain such facilities, and their sustainability, also remains unclear. A review of youth-friendly health services in five Pacific Island countries (Tonga, Solomon Islands, Vanuatu, Kiribati and Tuvalu) as part of the Adolescent Health and Development Programme found that non-government youth clinics were generally performing better than government facilities on all indicators, in large part due to greater resources and operational and management support. However, the review emphasized the need to prioritize investment in government facilities given their population coverage. A global review of youth centres in low- and middle-income countries concluded that these approaches generally only reach a small proportion of young people, are mainly used by women and men outside the target age group, and are often accessed for non-SRH education or recreational activities.

School-based services

Schools are potentially an important provider of SRH services, particularly in settings with high rates of school participation, although, there is currently limited quality research evaluating their impact on health behaviours and outcomes. Many young people report a preference for services to be delivered in schools, including SRH counselling and provision of commodities (such as condoms). Several countries have national school health or health-promoting schools programmes, with a focus on improving health education, life-skills, health literacy and linkages with health services and health providers. However, there is currently a paucity of documented examples or evaluations of approaches providing SRH services (beyond some aspects of sexuality education) in school settings, and both school and community objection to school-based SRH services have been noted as key barriers. An increasing number of counties have introduced, or planning the introduction, of national HPV immunization programmes, typically delivered in school settings. These programmes offer a potential opportunity to reach adolescents in

schools with other SRH information and services, although careful community education and engagement is required to improve community support.

Outreach and mobile services

Not all young people will be able to access adolescent-responsive services, even if they exist. Young people in rural or remote areas, or poorly serviced urban settings, may have very little geographical access to services. Marginalized young people, including those with diverse SOGI/E, disability, young people who sell sex, young people who inject drugs, and street-based adolescents can face considerable barriers to accessing health facilities. While the strength of global evidence documenting the impact of outreach services on SRH outcomes is currently limited, for some populations outreach services and mobile clinics may help overcome barriers accessing facilities, and can also provide an essential link between these young people and mainstream services. Mobile clinics and outreach services (often complemented by peer-based distribution of commodities) is a common approach for reaching young key populations in this region and may improve access to services and condom use. In Lao PDR, mobile clinics have also been used in rural areas to reach underserved young people. The approach demonstrated an increase in knowledge of modern methods of contraception and an increase in the proportion of sexually active young people who had ever used contraception.

Engaging the private sector

To overcome challenges accessing care from public health providers, adolescents seek a range of health services and advice from non- public sector providers, such as private clinics, pharmacies, non-government organisations, and informal providers (shops, unregistered drug sellers, traditional healers) who may offer less judgmental care, with greater privacy, more convenient locations and opening hours, and with less stigma than public-sector services. While the need to engage the private sector in adolescent health programmes in the region is fairly well recognized in national policies, evidence of the role of the private sector in improving access to and quality of services for adolescents, and understanding of the opportunities and challenges to effective private sector engagement, is very limited.

There are some innovative examples of engaging pharmacies and private clinics to provide young people with better access to commodities such as condoms and contraceptives. This has included training pharmacy staff to increase their counselling skills and knowledge about young people's SRH, providing them with youth-friendly educational resources, providing branding and demand generation support. Evaluations of such approaches in Vietnam demonstrated improved knowledge and quality of services provided by pharmacy staff, and contributed to an increase in contraceptive use at last sex by young people.

Social franchising approaches have also been used to reach young people, although it has been noted that adolescents and unmarried young people may not access services that are potentially stigmatizing (such as large community-based outreach

clinics for contraception). Suggested strategies to overcome these concerns have included demand-side vouchers, linking services with youth-friendly hotlines and websites to provide advice and referral, and delivering services in locations such as schools, marketplaces, and workplaces. Social marketing can also be an effective way of generating behaviour change, with some evidence from the region that social marketing of condoms specifically targeting young people may increase uptake.

Adolescent-competent health workforce

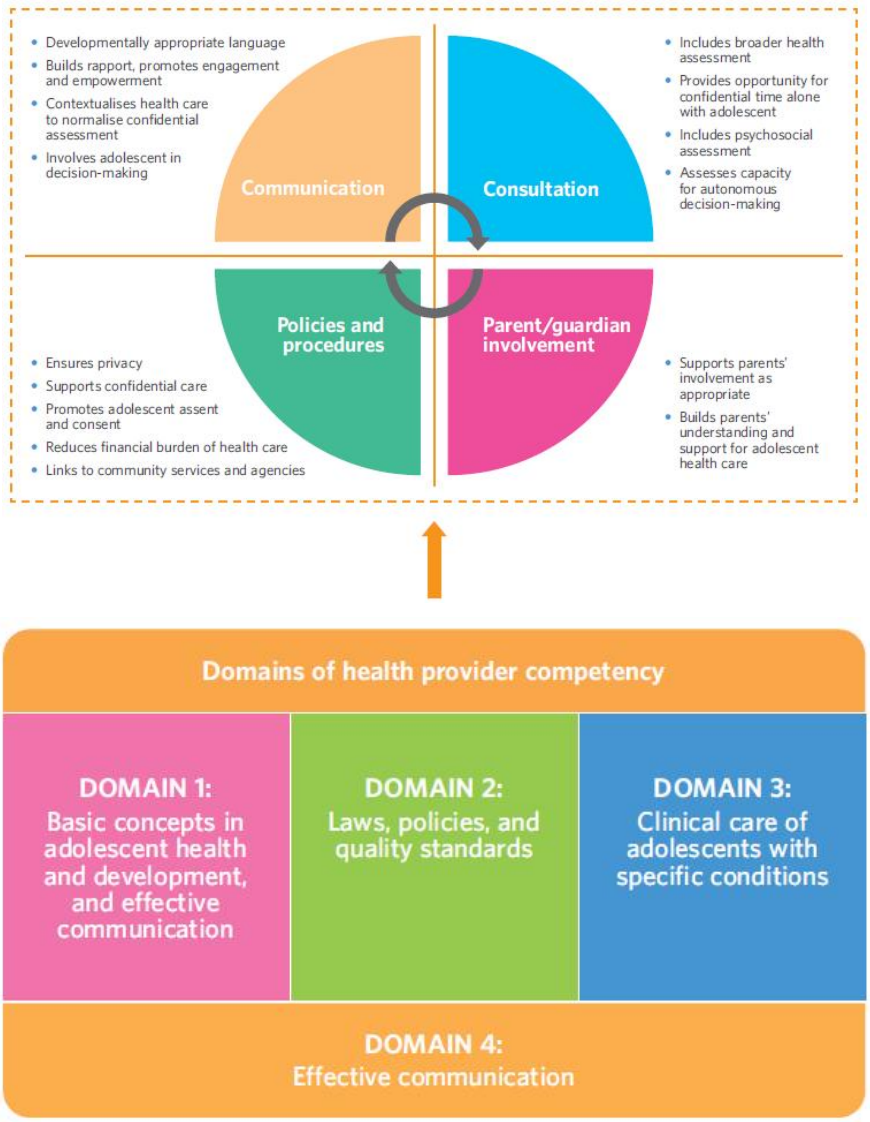
Assuring universal health coverage for adolescents requires renewed attention to the education, training and support of health providers. **Health care staff are important gate-keepers to health care, and their knowledge, attitudes, and skills are major determinants of young people's access to quality services, including SRH services.** Improving providers' education in adolescent health and development improves clinical performance; however, many health providers lack access to quality education and training programmes that build required knowledge, attitudes and skills.

Every health provider requires core competencies in adolescent health, including adolescent SRH. A recent review of the reproductive and maternal and child health workforce in the Pacific estimated that around 10% of health provider time was required to address adolescent health and development. Core competencies for all providers include understanding of adolescent health and development, awareness and application of relevant laws and policies that affect service delivery (such as legal age of consent, national standards for quality adolescent care), effective communication and counselling skills, and clinical skills to address common adolescent health needs (figure 55). Particular attention is needed to provider attitudes to support non- judgmental, non-discriminatory, confidential care that respects the evolving capacity of young people, their agency, and right to self-determination.

Pre-service (undergraduate) training in adolescent health in the region is limited, with many existing programmes focused on the knowledge delivered using traditional didactic teaching methods, rather than competency-based education. There are some examples in the region of integration of adolescent health into university undergraduate curriculum: Sri Lanka's University of Kelaniya has integrated adolescent health into several subjects as part of the Bachelor of Medicine, Bachelor of Surgery degree; and curriculum also been developed in India that can be integrated into undergraduate and postgraduate medical training. Limited existence and/or involvement of specialist professional associations or leadership with expertise in adolescent health, as well as limited availability of competent teaching staff are noted challenges in many countries. Much of the current approach to health provider education in adolescent SRH has focused on in-service training, typically as part of continuing education, and often one-off training programmes led or supported by non-government organisations and/or academic institutions. Some countries, such as Thailand have developed standard training materials and guidelines for health workers, but generally, there is little documented

regarding the coverage and quality of training in adolescent health competencies in the region. A key challenge is the lack of data to assess current adolescent health competency of providers, necessary to inform effective education and training programmes. In addition to strengthening pre- and in-service training and education, health providers also need ongoing support through the provision of job aids, supportive supervision, and monitoring; however, these remain major gaps in many countries in the region.

FIGURE 55. CONSIDERATIONS FOR HEALTH CONSULTATIONS WITH ADOLESCENTS, AND SUPPORTING HEALTH PROVIDER COMPETENCIES (ADAPTED FROM WHO269 AND SAWYER

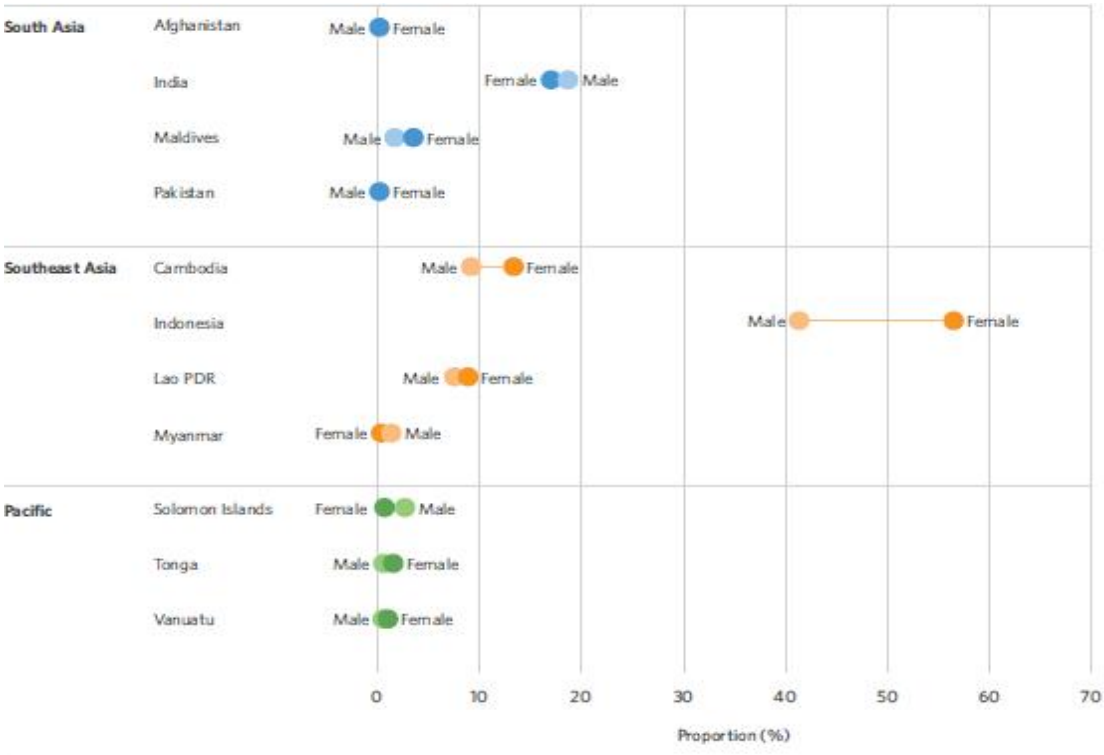


Health Financing

The cost of health services can be a significant barrier preventing young people from accessing quality SRH services. Globally, an estimated 100 million people are pushed below the poverty line each year as a result of out-of-pocket payments for health care. Despite the recognition that adequately financing the health care of young people is essential for achieving universal health coverage, there remains limited evidence on the impact of health financing on young people. Young people face unique challenges to accessing health care such as limited access to cash for user fees, and limited freedom to access services independently of their parents. Free services are also identified by young people themselves as a key feature of youth-friendly services although may not address other financial barriers related to transport costs or informal fees. Young people and their health needs may be overlooked in national health financing mechanisms due to competing health priorities and lack of visibility of their SRH needs in policy and national data.

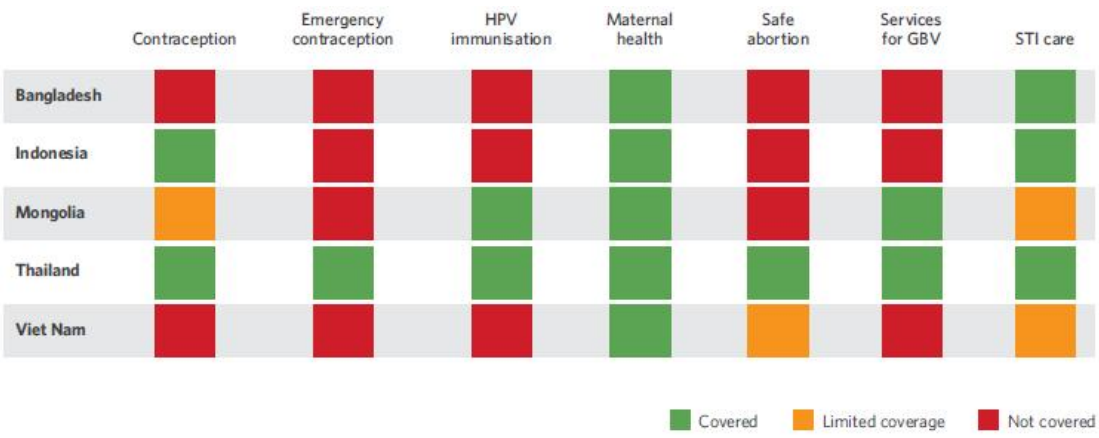
Financial barriers faced by young people can potentially be addressed through a range of mechanisms, such as waiving fees for young people under a specified age, health insurance or pooled financing, and voucher schemes. A number of countries in the region have national policies that provide for free essential services, which include several SRH-specific services relevant for young people such as maternal health care, HIV-related testing, counselling and treatment, and in some cases contraceptive services. However, adolescents may not always be included in such policies.

FIGURE 56. PROPORTION OF 15-19 YEAR OLDS COVERED BY ANY HEALTH INSURANCE



Source: DHS

FIGURE 57. GENERAL SRH SERVICES COVERED BY NATIONAL SOCIAL INSURANCE SCHEMES



Source: UNFPA 2017[232]

With the exception of Indonesia, fewer than **20%** of **15-19 year olds** are covered by any health insurance programme

Prepaid pooled financing arrangements such as taxes or insurance schemes can be effective in increasing coverage of health services. A number of countries in the region have adopted pooled financing for health care including Vietnam, Indonesia, India, the Philippines and Thailand. In many countries, young people are able to access health care services through family, employee or school-based insurance schemes. Financial benefits for children through insurance or co-payments may cover young people up to a specific age, often 18 years. Age-disaggregated data for this region are limited, but indicate that a substantial proportion of adolescents are not covered by any health insurance programme (figure 56). Additionally, pooled financing programmes may not always include services needed by young people, such as contraceptive services. A recent review of universal health coverage at a population level in six countries in the region revealed that SRH services of particular importance to adolescents are often not covered by social health insurance; these include contraception (particularly emergency contraception), abortion-related care, HPV immunization, and services for gender-based violence (figure 57).

Older adolescents and young adults, and those who are unemployed, out-of-school, marginalized or from low-income households are more likely to face financial barriers to accessing health services and may be excluded from national financing mechanisms. Other strategies that have shown potential to overcome financial barriers include the use of vouchers entitling young people to subsidized or free SRH services, often linked with other interventions to improve the quality of adolescent health services. There are examples of voucher schemes for reproductive health in a

number of countries in Asia, including Pakistan, Bangladesh and Cambodia but these typically target married women with no published studies examining the effectiveness of such approaches for adolescents and unmarried young people in the region.

CHALLENGES AND APPROACHES TO SUPPORT SUSTAINABLE ADOLESCENT- RESPONSIVE HEALTH SYSTEMS

Despite many smaller project examples, delivery of quality adolescent SRH care at large scale remains challenging and coverage is generally low. Common challenges in the region include:

- Inadequate budget to implement national standards and guidelines
- Poor facility infrastructure and lack of private waiting areas for young people
- Lack of private counselling and consultation rooms offering both visual and auditory privacy
- Inadequate health worker training and supportive supervision, and lack of job aids
- Infrequent or absent monitoring and quality improvement processes
- Poor record-keeping and data management to track progress
- Shortages of commodities such as condoms and contraceptives
- Inadequate publicity and awareness of services among young people, particularly in conservative settings where the promotion of SRH is difficult, and weak links with activities to address community support
- Poor access to contraceptive services for unmarried young people/adolescents with policy barriers in some countries
- Poor access for young people in rural areas and underserved urban areas
- Little documented regarding accessibility and utilization by marginalized young people

Despite these challenges, there are many opportunities to improve young people's access to SRH service and transition from small projects that provide adolescent-friendly services, to those approaches that build adolescent-responsive health systems. The few evaluated approaches in the region have highlighted important factors that would support this transition:

- Ensuring government engagement and ownership
- Building partnerships with non-government organisations to increase coverage and provide quality services where government facilities do not have capacity
- Undertaking advocacy and community sensitization to increase support for service provision
- Conducting needs assessments to identify priorities for training and facility upgrade
- Providing ongoing training and supportive supervision to health workers
- Supporting health workers with clinical guidelines, education materials and job aids
- Integrating services with other initiatives to increase young people's awareness, demand and uptake
- Engaging young people in the design, implementation and evaluation of services, and using local research to define 'youth-friendly.'
- Monitoring and evaluation to ensure the quality and accessibility of services

- Beginning with pilot projects with gradual scale-up based on successful models

Recent WHO recommendations to improve the inclusion of adolescents in universal health coverage a
re summarised in figure 58.

FIGURE 58. RECOMMENDATIONS TO IMPROVE UNIVERSAL HEALTH COVERAGE FOR ADOLESCENTS