ORIGINAL ARTICLE

A study of physical infrastructure and preparedness of Public Health Institution for providing adolescent friendly health services in Central India

Surya Bali¹, Kriti Yadav², Yash Alok³

ABSTRACT

Background - There is a need to address adolescents' reproductive and sexual health needs, which is not looked upon very well in India. To fulfill this aim, the concepts of the Adolescent Friendly Health Services were applied to all levels of the healthcare systems of the country. Objectives – To assess the infrastructure and preparedness of the health facilities to deliver adolescent friendly health services (AFHS) in central India. Methods – Data was gathered by visiting 30 secondary and tertiary level health facilities to assess their infrastructure and preparedness for providing AFHS using a pre-designed questionnaire based on WHO guidelines for assessing AFHS and Indian Public health standards (IPHS). Analysis was done using SPSS v21 and Microsoft Excel. Result – Most of the healthcare facilities in all the study districts were not yet perfectly ready to deliver the AFHS in Madhya Pradesh. Most physical infrastructure and preparedness to ensure privacy and confidentiality was better in health facilities in the districts where Rashtriya Kishor Swasthya Karyakram (RKSK) was launched, but with no statistically significant difference. Conclusion – The launch of RKSK neither resulted in substantial improvement in the health facilities with regards to the infrastructure for the provision of AFHS, nor the general preparedness of the facilities.

Keywords – AFHS, infrastructure, preparedness

Introduction

The World Health Organization (WHO) defines “ Adolescents” as people with age spanning between 10 to 19 years, “Youth” as those between 15-24 years age group and these two overlapping age groups as “young people” covering the age group of 10-24 years.¹ As of now, in the world there are currently 3 billion people in the adolescent age group², while in India, the population aged 10-19 years accounts for 253 million (20.9%) of the 1,210 million people with every third person belonging to this age group as per census 2011³, also making India the keeper of the largest adolescent population in the world.⁴

1. Additional Professor, Department of Community and Family Medicine, All India Institute of Medical Sciences, Bhopal. Email ID: surya.cfm@aiimsbhopal.edu.in. Contact No.: +91 8989988767
2. Senior Resident, Department of Community and Family Medicine, All India Institute of Medical Sciences, Bhopal. Email ID: kriti.srcfm@aiimsbhopal.edu.in. Contact No.: +91 7755070676
3. Junior Resident, Department of Community and Family Medicine, All India Institute of Medical Sciences, Bhopal. Email ID: yashalokv@gmail.com. Contact No.: +91 8105454973
4. Corresponding Author: Dr. Surya Bali, Department of Community and Family Medicine, Medical College building, All India Institute of Medical Sciences, Bhopal, Madhya Pradesh- 462 024; Phone: 8989988767; E-mail: surya.cfm@aiimsbhopal.edu.in

Received 10.11.2020 Revision 28.11.2020 Accepted 18.12.2020 Printing 30.12.2020

Prior Publication: Nil; Source of Funding: Nil; Conflicts of Interest: None declared
There is a plethora of unaddressed issues among the adolescents in India, the main being sexual and reproductive ill health, which is one of the major causes of morbidity and mortality in adolescent people. In a conservative society like India, where reproductive and sexual health related issues are considered taboo, it is frowned upon when young people actively seek counsel for their reproductive health needs or other health needs in general. As per a sub-national survey in the year 2006-07, most adolescents lacked detailed knowledge and awareness about contraceptive methods. The same study also found that pre-marital sex was reported in 12% of unmarried males and 3% of unmarried females. There is an unmet need of contraception for 23 million adolescents, which is a staggering figure as a problem. The nutritional status of adolescents is also a major challenge. According to the data provided by the UNICEF, about 56% of the females and 30% of the males in the adolescent age group are anaemic. Even though programs and policies directed towards improvement of youth reproductive health like National Population Policy 2002, National AIDS Prevention and Control Policy, 2002, the 2003 National Youth Policy, and the Adolescent Reproductive and Sexual Health which was incorporated into NRHM in 2005, have existed, the impact of the these programs have not been very successful and largely uneven across the country. For a further more holistic approach to the problems of the adolescents, the RKSK(Rashtriya Kishor Swasthya Karyakram) was launched by the Government of India in 2014, the impact of which yet remains to be seen.

According to WHO, AFHS can be considered adolescent-friendly if they are – Equitable, Accessible, Acceptable, Appropriate and effective. Various things come together to make the services adolescent friendly - motivated and competent service providers, community participation, increased awareness, and a conducive and comfortable environment for the delivery of these services. Clearly, infrastructure plays an important role in any health institution and even more so in the context of AFHS. The characteristics of AFHS that pertain to infrastructural aspects of the public health institutions as per the WHO guidelines are - The point of health service delivery has convenient hours of operation, ensures privacy, has an appealing and clean environment, provides information and education through a variety of channels about the available range of services and how to obtain them and has the required equipment, supplies, and basic services necessary to deliver the required health services. The same has been suggested as per the Facility characteristics/Standard 5 of ‘The Global Standards for Quality Health-care Services for Adolescents’ by WHO. A study reported that the facility’s physical environment (cleanliness, design features that enable privacy and confidentiality) is a characteristic highly valued by adolescents and is a major driver of the client satisfaction with the AFHS.

A study found out that the estimated incremental costs of scaling up adolescent friendly services per intervention as percentage of total costs for infrastructure and equipment is only 0.07%, therefore a lot of improvements can be made with very little of investments. But, it is important to have an understanding of the existing infrastructure situation before any improvement can be planned as they form the cornerstone of AFHS.

In India, Adolescent Friendly Health Clinics (AFHCs), counselling and curative services are provided at all levels of care on fixed days and fixed time with due referral linkages. The numbers of operational Adolescent Friendly Health Clinics have increased from 3356 in 2011-12 to 6302 in till December 2013- showing 88% increment over a period of 2 years, which has led to increased service utilization as suggested by many studies.

The RKSK programme incorporated components such as provision of counselling at both the facility and at outreach sessions, behavioural change communication and a major component being strengthening of the adolescent friendly health clinics. But very few studies have been done to assess the physical characteristics of AFHS being provided at the newly opened centres as well as the impact of the programme on the improvement of the facilities catering...
to adolescent health. Therefore, the aim of this study was to assess the infrastructure, supplies and preparedness of the existing health centres in central India to deliver AFHS and to evaluate the fruitfulness of the RKS SK programme.

Methods

The present study was conducted in 10 districts of a state in central India. One district was chosen from each of the 10 administrative divisions of the state to ensure geographic representation. One District Hospital and two CHCs were selected randomly from each 10 selected districts. The districts were Chhatarpur, Datia, Dewas, Guna, Harda, Jhabua, Mandla, Raisen, Satna and Umaria (Table 1). The data collection period was for four months (September 2017 to December 2017). The study covered 30 public health institutions from 10 districts - 10 District Hospitals and 20 CHCs from 10 study districts.

Sampling Method

In the first stage of sampling, one district was selected from each administrative division of the state using purposive sampling. Then all 10 District Hospitals were selected. In second stage, because there were many CHCs in a district so simple random sampling technique was used to selected 2 CHCs from each district. Thus finally 20 CHCs were included from the 10 districts. Out of 10 selected districts 5 were Rashtriya Kishor Swasthya Karyakram (RKS K) districts where the Government run adolescent health program had already been implemented since 2014.

A team of consultant and field investigator visited all the selected facilities in person and data was collected regarding facility’s physical environment and preparedness for providing AFHS using a pre-designed and pre-validated questionnaire which was developed and adopted from the Global Standards for Quality Health-care Services for Adolescents 30 and Indian Public Health standards (IPHS) 31. The client exit surveys were conducted to measure client satisfaction. All clients between the ages of 10 and 19 years were asked to participate in the client exit interview; those who agreed to participate completed the questionnaire. Data was analysed using Microsoft Excel and SPSS 21. Appropriate statistical measures were identified and calculated. Ethical clearance was obtained from the institutional ethics committee of AIIMS Bhopal.

Results

Thirty public health institutions including 10 district hospitals and 20 community health centres were surveyed to assess their physical environment and the drug and equipment supply.

Table 1: Facilities chosen for assessment (District Hospitals and CHC)

<table>
<thead>
<tr>
<th>RKS K districts Hospital &amp; CHC</th>
<th>Non-RKS K districts Hospital &amp; CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chhatarpur Badamalhera Guna</td>
<td>Binaganj Kaghograh</td>
</tr>
<tr>
<td>Bijavar</td>
<td></td>
</tr>
<tr>
<td>Umaria Manpur Pali Pali Dewas</td>
<td>Bagli Barotha</td>
</tr>
<tr>
<td>Satna Maihar Nagod Raisen</td>
<td>Obdullahganj Sanchi</td>
</tr>
<tr>
<td>Mandla Gluhghari Mawai Datia</td>
<td>Bhandara Indergraht</td>
</tr>
<tr>
<td>Jhabua Rama Thandla Harda Sirali</td>
<td>Timarni</td>
</tr>
</tbody>
</table>
ARSH Clinic, AFHC Clinic, Counselling Centre and Samvad Centre were available respectively in 16.2%, 26.7%, 16.7% and 23.3% facilities only. However, in more than half (53.3%) of the facilities family planning services were available. Half of the health care facilities were from the districts where RKSK had been launched and half of them were from districts where it had not been launched. Comparisons between them were made as part of the analysis.

**Physical infrastructure and working hours:** Majority of the health facilities had specific room for YFHS (70%), adequate clinic room space (60%) and had adequate light inside the clinic (73%) as per the IPHS standards. Most of the physical environment characteristics were better in health facilities in RKSK districts - visible signboard (67% vs 7%), specific room (93% vs 47%), sufficient furniture (47% vs 20%), sitting arrangement outside clinic (33% vs 13%) and cleanliness (60% vs 53%) except adequate clinic room space (47% vs 73%) and adequate light (67% vs 80%). But apart from the visible signboards and a specific room for the YFHS there were no statistically significant differences between the two. Strikingly, only around one-fifth of the adolescent clinics had wash basin (20%) with running water and sitting arrangements (23%) (Table 2).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total</th>
<th>RSKK (N=15)</th>
<th>Non-RSKK (N=15)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visible signboard of the YFHS facility</td>
<td>11</td>
<td>37</td>
<td>10 7</td>
<td>0.001*</td>
</tr>
<tr>
<td>Specific Room for the YFHS</td>
<td>21</td>
<td>70</td>
<td>14 93</td>
<td>0.005*</td>
</tr>
<tr>
<td>Adequate Clinic Room Space</td>
<td>18</td>
<td>60</td>
<td>7 47</td>
<td>0.571</td>
</tr>
<tr>
<td>Sufficient Furniture inside clinic</td>
<td>10</td>
<td>33</td>
<td>7 47</td>
<td>0.121</td>
</tr>
<tr>
<td>Sitting arrangement outside clinic</td>
<td>7</td>
<td>23</td>
<td>5 33</td>
<td>0.195</td>
</tr>
<tr>
<td>Cleanliness of the clinic</td>
<td>17</td>
<td>57</td>
<td>9 60</td>
<td>1.000</td>
</tr>
<tr>
<td>Adequate light inside clinic</td>
<td>22</td>
<td>73</td>
<td>10 67</td>
<td>0.409</td>
</tr>
<tr>
<td>Wash Basin with running water</td>
<td>6</td>
<td>20</td>
<td>3 20</td>
<td>1.000</td>
</tr>
</tbody>
</table>

*(p value<0.05 is significant)*

In most of the facilities (90%) the services were available on daily basis with only 10% facilities providing services on alternative days in a week. The services were provided for 4 hours (46.7%), 5 hours (16.7%) or 6-7 hours (36.7%) in various health facilities (Table 3).

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub Category</th>
<th>Total</th>
<th>RSKK (N=15)</th>
<th>Non-RSKK (N=15)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent &amp; Youth friendly health service providing</td>
<td>Every Day</td>
<td>27</td>
<td>90</td>
<td>14 93</td>
<td>13 86</td>
</tr>
<tr>
<td></td>
<td>Alternative day in a week</td>
<td>3</td>
<td>10</td>
<td>2 13</td>
<td>1 7</td>
</tr>
<tr>
<td>Clinic hours</td>
<td>9 AM-1 PM (4 hrs)</td>
<td>14</td>
<td>46.7</td>
<td>6</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>9 AM-4 PM (6-7 hrs)</td>
<td>11</td>
<td>36.7</td>
<td>9</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>9-1 PM &amp; 5-6 PM (5 hrs)</td>
<td>5</td>
<td>16.7</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

*(p value<0.05 is significant)*
RKSK centres were proving services 4 days in health centre and 2 days out reach works, non RKSK centres providing services on a daily basis in the OPD. The OPD hours were found to be more in the RKSK districts but the evening OPD was only found to be present in the non RKSK districts and not in the RKSK districts which was found to be statistically significant. The evening clinic was supposed to be the hallmark of the RKSS programme which was supposed to provide an added respite for the adolescents. Hence the absence of the finding is an appalling revelation (Table-3).

Manpower

Out of 30 Facility included 10 District Hospital and 20 Community centres, majority 22 (73.3%) of the Adolescent and youth-friendly health clinics were having Counsellors and 8 (26.7%) of clinics did not have counsellors. Out of 30 counsellors in District hospital and Community health centres majority, 18 (60%) of the counsellors were trained and 12 (40%) of the counsellors were untrained.

Availability of contraceptives and registers: All the facilities had an availability of condoms. Most centres were also equipped with Emergency pills (96.7%), IUDs 380 (96.7%) and STI/RTI services (83.3%). Pregnancy test kit, oral pills, condoms, emergency contraceptive pills, IUDs and abortion pills were adequately present at 83.3%, 90%, 46.7%, 80%, 46.7% and 73.3% of health facilities respectively (Table-4).

Table-4: Availability and supply of Adolescent and Youth Friendly Health Facilities Services (N=30)

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub Category</th>
<th>Total</th>
<th>RKSK (N=15)</th>
<th>Non-RKSK (N=15)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of contraceptive supplies</td>
<td>Oral pills</td>
<td>28</td>
<td>14</td>
<td>14</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Condom</td>
<td>30</td>
<td>15</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Emergency pills (ECs)</td>
<td>29</td>
<td>14</td>
<td>15</td>
<td>0.309</td>
</tr>
<tr>
<td></td>
<td>IUDs 375</td>
<td>23</td>
<td>10</td>
<td>13</td>
<td>0.195</td>
</tr>
<tr>
<td></td>
<td>IUDs 380</td>
<td>29</td>
<td>14</td>
<td>15</td>
<td>0.309</td>
</tr>
<tr>
<td>Sufficient stock of contraceptive supplies</td>
<td>Pregnancy test kits</td>
<td>25</td>
<td>13</td>
<td>12</td>
<td>0.361</td>
</tr>
<tr>
<td></td>
<td>Oral pills</td>
<td>27</td>
<td>9</td>
<td>14</td>
<td>0.543</td>
</tr>
<tr>
<td></td>
<td>Condom</td>
<td>14</td>
<td>7</td>
<td>7</td>
<td>0.118</td>
</tr>
<tr>
<td></td>
<td>Emergency pills (ECs)</td>
<td>24</td>
<td>8</td>
<td>11</td>
<td>0.361</td>
</tr>
<tr>
<td></td>
<td>IUDs</td>
<td>14</td>
<td>8</td>
<td>5</td>
<td>0.726</td>
</tr>
<tr>
<td></td>
<td>Abortion pills</td>
<td>22</td>
<td>13</td>
<td>9</td>
<td>0.09*</td>
</tr>
<tr>
<td>Expired supplies</td>
<td>Yes</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>1.00</td>
</tr>
<tr>
<td>Sterilization Services</td>
<td>Female Sterilization</td>
<td>23</td>
<td>10</td>
<td>13</td>
<td>0.195</td>
</tr>
<tr>
<td></td>
<td>Male Sterilization</td>
<td>20</td>
<td>11</td>
<td>9</td>
<td>0.439</td>
</tr>
<tr>
<td>Abortion Services</td>
<td>Medical Abortion</td>
<td>16</td>
<td>8</td>
<td>8</td>
<td>0.464</td>
</tr>
<tr>
<td></td>
<td>Surgical Abortion</td>
<td>19</td>
<td>10</td>
<td>9</td>
<td>0.705</td>
</tr>
<tr>
<td>Other services</td>
<td>STI/RTI</td>
<td>25</td>
<td>13</td>
<td>12</td>
<td>0.624</td>
</tr>
<tr>
<td>Availability of registers</td>
<td>Patients OPD Register</td>
<td>30</td>
<td>15</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Contraceptive Register</td>
<td>14</td>
<td>7</td>
<td>7</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>Counselling Record</td>
<td>19</td>
<td>14</td>
<td>5</td>
<td>0.002*</td>
</tr>
</tbody>
</table>

*(p value<0.05 is significant)

Around 11(36.7%) of the Adolescent and Youth friendly health facilities stored contraceptives properly. At other places contraceptive stocks were exposed to sunlight, dusted and not in proper bag/box. Emergency pills were found to be
in broken blisters, not kept in a cupboard or at closed place. At some facilities there were no separate room or place for to keep the supplies. Also out of 30 Facilities, at 10(33.3%) facilities the contraceptive supplies were found to be expired. Medical abortion services, surgical abortion services and the facility of male sterilization were only available at 53.3%, 63.3% and 66.7% of the centres. In all the facilities the OPD registers were available. Further in 19 and 14 facilities the counselling record registers, and contraceptive registers were available. However no significant differences were observed between the two types of districts (Table 4).

**Preparedness to provide YFHS**

The number of trained counsellors in RKSK districts was more (13) as compared to Non RKSK districts (5) and this difference was found to be statistically significant. When interrogated deeply by the survey team it was observed that only 11 counsellors knew about the standard counselling principles, with RKSK counsellors being more (8) than non RKSK counsellors (3) and the difference being statistically significant. Hardly 5 (16.7%) of the facilities have any token system for patients. 17 (56.7%) of the facilities have no curtain or screen. Further about 20 (66.7%) of the facilities can hear the conversation of client and counsellor from outside the clinic with more of the non RKSK facilities being such 14(90%). Thus privacy and confidentiality of the patient and mismanagement of patients were major issues at most of the non RKSK facilities (Table 5).

**Table - 5:** Preparedness of Public health institutions to provide YFHS: Comparison of Clinical providers and trained providers (N=30).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total</th>
<th>RKSK (N=15)</th>
<th>Non-RKSK (N=15)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>% No.</td>
<td>% No.</td>
<td></td>
</tr>
<tr>
<td>Trained service provider</td>
<td>18</td>
<td>60</td>
<td>13 86</td>
<td>5 33</td>
</tr>
<tr>
<td>Knew about GATHER counselling principle</td>
<td>11</td>
<td>36</td>
<td>8 53</td>
<td>3 20</td>
</tr>
<tr>
<td>Token System</td>
<td>5</td>
<td>16</td>
<td>1 7</td>
<td>4 26</td>
</tr>
<tr>
<td>Conversation was visible from outside</td>
<td>17</td>
<td>56</td>
<td>5 33</td>
<td>12 80</td>
</tr>
</tbody>
</table>
  (no curtain)                           |
| Conversation could be heard from outside| 20    | 66          | 6 40            | 14 93   | 0.005* |
  (no sound proofing infra-structure)    |

*(p value<0.05 is significant)

**Discussion**

The present study reported a significant number of lacunae in the implementation of YFHS Services in both the RKSK and non RKSK districts. Though the preparedness was better at the RKSK districts however no significant difference was observed between the two. As it is paramount that the standing infrastructure is conducive and friendly to provide not only high quality services but also a service that respects the needs of the adolescents, it is important that the state facilities are not yet ready to deliver the adolescent friendly health services still, and that the implementation of the RKSK programme has had no significant impact in the districts where it has been implemented. However, contrary to the findings of the present study reported non RKSK facility to be better than RKSK in terms of the infrastructure, yet the message remains the same; the delivery of the services to the adolescents is compromised.
The guidelines recommend that all AFHCs have a display sign board indicating the location & timing of the clinic. Our study revealed display board in only 67% of RSKK AFHC in comparison to 7% of non-RSKK AFHCs. Similar observations were reported by a study on ARSH centres (non-RSKK) in Vadodara\textsuperscript{32}, another study by Bhat et al.\textsuperscript{32} and in a study by Hoopes et al.\textsuperscript{32}. Due to this, a lot of the adolescent were not getting proper guidance for where to go and receive the services; even the majority of the CHCs do not have any Front help desk, so adolescent used to approach 1st OPD and then Doctor used to direct them to the A&YFHS clinic. It's time-consuming for the school going adolescents and refrains them from utilizing these services. In addition, most of the RSKK and Non-RSKK facilities did not have a waiting area with proper sitting arrangement outside the clinic and at most of the facilities cleanliness, water supply was found to be substandard. As per the RSKK guidelines basic amenities like sitting arrangement, clean drinking water, and clean toilets should be made available for the adolescents visiting the clinic. Also, the studies done by Dixit et al.\textsuperscript{33} and Yadav et al.\textsuperscript{34} have stressed upon the importance and the role of good physical environment and adequate waiting space in increasing uptake of services from these facility.

This shows again that despite the implementation of the RSKK programme, there has not been much improvement in the facilities, indicating the fact that the giant funding for a nationwide programme implementation, which already is coming from a low national budget for health, is not being put to proper use. Thus, the lacuna reported by the present study needs to be addressed promptly for smooth functioning of these clinics as well as building a trust in the adolescent population with the public health facilities, and for proper implementation of the programme as well.

Along with physical environmental convenience, temporal convenience is immensely important too because adolescence is the age when they are either in school or college or are actively involved with an occupational activity during the morning hours. So, provision of AFHS during an evening OPD should increase the service utilization. Similar findings have been reported in a study done by Dixit et al.\textsuperscript{33}. However, in our present study none of the RSKK facilities and only 5 of the non-RSKK facilities were providing timely services which are quintessential for providing quality services. This also suggests a major gap: the satisfaction of the beneficiaries is not being considered and there is a bound-by-duty-only and a lethargic attitude to provide the services among the facilities.

The present study also assessed the preparedness of the facilities to ensure privacy and confidentiality of the clients. The RSKK facilities were significantly better than the non-RSKK facilities but still in some facilities the clinic was running at OPD room and duty doctor was providing these services also. In these situations, comfort and privacy of the adolescent was a major concern. The adolescents were not able to share their health issues openly in the overcrowded OPD setting and were not satisfied with the consultation provided to them. Therefore, beneficiary satisfaction on which the success of the programme lies has been shown minimal consideration by these facilities, which will ultimately lead to decline of trust among the adolescents for the health facilities and programme failure. Dixit et al.\textsuperscript{35} in their study in Gujarat and Wadiwa R et al.\textsuperscript{36} in their study in six states of India reported that design features that enable privacy and confidentiality to be a characteristic highly valued and considered indispensable by the adolescents. The finding was also shared by Bhat et al.\textsuperscript{32}

Along with the physical infrastructure and timely services the provider should be specifically trained in providing healthcare services to the adolescents. There were significantly more trained counsellors in the facilities with RSKK implementation than without RSKK but still the lacunae were found to be in both districts, which should have been absent at least in the districts where RSKK has been implemented. Again the findings highlight the fact that the impact of the RSKK programme has not been much of a success. In the absence of counsellor any duty doctor or sister in charge was providing counselling services during OPD time. Therefore, counselling was not specific for A & YFHS Services and all type of counselling, e.g., Family Planning, ICTC, STI/RTI, NRC, etc was been given. The findings are comparable to that reported by Yadav et al in their study in three medical colleges at Delhi, Kolkata and Chandigarh.\textsuperscript{29}
Surya Bali et al. A study of public health institution providing adolescent friendly health services

Insufficient stock of contraceptives and non-availability of sanitary napkins was another major issue at these clinics as also reported by Wadhwa R et al.44. Thus most of the facilities do not comply with the RKSK standards and need attention of the policy makers for redressal of these issues and provision of quality services. Also, regular audits of the facilities are essential to know the ends of the flow of funds from an already thinned out national budget.

Conclusion and Recommendations

The present study found no visible impact of the RKSK program with various structural and implementational issues; suggesting following measures to be taken for addressing the identified gaps, There is a need to put visible sign boards / direction signage/ information boards both inside and outside the health facility and to develop appropriate strategies to create awareness in the community about the adolescent clinics and adolescent related services at health centres for easily accessibility to adolescent health services. Special attention is needed while designing / building adolescent corners to ensure privacy and confidentiality. It is also recommended that evening clinic times should be allocated for the school going adolescents. There is a strong need to train / retrain all adolescent health service providers on the latest techniques of adolescent health issues. Counsellors must be non-judgemental while dealing with health care need of adolescents. Provision of the services by trained providers drove the satisfaction and friendliness of the services. Sufficient stock of sanitary napkins should be maintained at these clinics for the girls along with contraceptives and medicines. Lastly, the lacunae as to why the programme implementation has not made much of difference have to be explored and rectified by the programme managers and the policy makers.

References

1. World Health Organization, Adolescent health and development. SEARO. Published online 2017.
10. WHO | Quality assessment guidebook. WHO. Published online 2013.
11. Global Standards for Quality Health-Care Services for Adolescents Volume 1: Standards and Criteria A Guide To Implement a Standards-Driven Approach to Improve the Quality of Health-Care Services for Adolescents.
Surya Bali et al  A study of public health institution providing adolescent friendly health services


23. UNFPA. Assessment of Adolescent Reproductive and Sexual Health (ARSH) Centers in Gujarat.


30. Global Standards for Quality Health-Care Services for Adolescents the Quality of Health-Care Services for Adolescents.


