Challenges in Implementing Adolescent Sexual and Reproductive Health Programs: Are Healthcare Workers Part of the Problem?

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Respected Editor,

As per the World Health Organization (WHO) report from 2019, adolescent pregnancies have become a global phenomenon, with an estimated 21 million pregnancies in low and lower-middle income regions each year.¹ Out of these 21 million pregnancies approximately 50% were unintended.¹ Adolescent pregnancy, thus, has stronger roots in less developed parts of the world, and renders serious implications on the health of the mother; as for adolescents in particular, pregnancy is associated with a higher risk of complications which are a major cause of death among girls within this age range.² Adolescent pregnancy, therefore, becomes a topic of great interest, especially in light of current events.

The recent overturning of Roe v. Wade by the US Supreme Court prompted us to explore the repercussions this ruling could have on the provision of reproductive healthcare in low and lower-middle income countries. In pursuit of gaining an insight regarding this, we came across a qualitative exploratory study conducted by Hailemariam et al³ addressing challenges encountered in accessing and utilizing sexual and reproductive health (SRH) services among adolescent females. We would like to extend our appreciation to the authors for their notable contribution to the subject and choosing adolescents as their target population.

The inclusion criteria outlined by the authors gave priority to adolescent females who had been active participants in different SRH activities such as member youth associations, and HIV prevention and control program. It can be assumed that adolescent females who actively participated in the community would have adequate knowledge and access to the SRH services, resulting in opinions not entirely representative of all out-of-school female adolescents. This is important to consider as adolescent pregnancy is greater among those with limited education and/or those belonging to low economic status.⁴,⁵

In their study, in-depth interviews were conducted with district health officers and maternal and child health coordinators on the assumption that they would be more knowledgeable about the challenges encountered by out-of-school adolescent girls. An important aspect to highlight here is that owing to insufficient knowledge of healthcare providers regarding SRH of adolescents,⁶ and strong personal values infiltrated with cultural and religious beliefs,⁷ healthcare workers may be part of the problem rather than part of the solution. It has been reported that even though healthcare providers deem SRH services a fundamental right, the services they offer are greatly influenced by their personal beliefs and cultural norms.⁷

When healthcare delivery is perceived through a moral lens, quality of care is compromised. It should be realized that district health officers and healthcare providers contribute immensely to making SRH services accessible to young adults, and when these vectors of change become agents of “moral policing,”⁸ health of individuals seeking these services is put in jeopardy. Moreover, several studies report how judgmental and unfriendly attitude of SRH service providers prevents young adults from accessing these services.⁹ This reason for reluctance to utilize services has been stated by the respondents in the study conducted by Hailemariam et al.³ Negative attitudes which stem largely from their own religious beliefs and cultural values are mirrored in the treatment offered to these young people which may include denial of services to them, demanding authorization before offering treatment, and imposing the treatment acceptable to them. This may force adolescents to resort to inexperienced and less educated personnel for seeking these services, resulting in more harm than good. One of the global standards developed by WHO for improving quality of healthcare services provided to adolescents is “equity and nondiscrimination.”¹⁰ It demands

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healthcare providers to practice a non-discriminatory attitude of respect toward all adolescents irrespective of their age, gender, cultural and ethnic backgrounds, geographic origin, socioeconomic status, disability, or any other factors.  

In addition to this, a fear of breach of confidentiality and lack of privacy have been expressed as major concerns while seeking SRH services. As accessing SRH services is still surrounded by stigma, adolescents put immense trust in healthcare service providers to uphold the principles of patient-doctor confidentiality, but when anonymity is compromised, this trust is lost. Moreover, a lack of knowledge of healthcare providers regarding SRH of adolescents in particular is another barrier in utilization of these services. This may be attributed to the fact that training of healthcare providers in handling adolescents is deficient, resulting in a communication barrier between SRH service providers and young adults, which becomes more pronounced in cases of older healthcare providers.  

In order to attain universal health coverage, relevant stakeholders of the health sector will need to transform how healthcare needs of the adolescents are met and responded to, especially SRH needs, as myriads of barriers have been reported on part of healthcare providers. Thus, it is recommended that multidisciplinary efforts should be funneled toward recognizing these barriers and devising actionable policies and procedures to ensure sustainable solutions. When healthcare providers act as barrier to healthcare delivery, lives of young people are put at risk. Therefore, healthcare workers and SRH service providers should offer treatment given the best interest of the patient, regardless of their personal beliefs and cultural values.

Acknowledgments
No acknowledgments to be declared.

Declaration of Conflicting Interests
The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding
The author(s) received no financial support for the research, authorship, and/or publication of this article.

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