Gap Analysis

Final Report

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A GAP ANALYSIS OF THE READINESS OF THE MINISTRY OF HEALTH TO OFFER QUALITY ADOLESCENT HEALTH SERVICES

Consultancy to Pilot Test Adolescent Health Standards

Contract for the Services of National Professionals Adolescent Health

Contract #004

Submitted to:

The Director,
Family Health Unit,
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EXECUTIVE SUMMARY

Introduction

Adolescent health is one of the priorities of the Ministry of Health (MoH) because adolescents comprise an especially vulnerable population subgroup. That vulnerability is closely linked to adolescents' young age, their lack of social and economic power as well as their general lack of information about health issues and especially about how to navigate the health system.

The official mandate of the health ministry is "to ensure the provision of quality health services and to promote healthy lifestyles and environmental practices". In an effort to achieve this mandate as well as the goal of the national strategic plan for preadolescent and adolescent health, the Ministry, in 2014, commissioned the development of a set of adolescent health standards and related criteria. These standards would assure the delivery of quality services to adolescent clients who use MoH facilities.

Ten quality standards and related criteria were approved by the Ministry and a process to pilot test them was implemented in June 2015. Seven sites participated in the pilot test.

The Gap Analysis

Simultaneous with the testing of these quality standards, the Ministry commissioned an activity that would identify and analyse the gaps in the system that would hinder achievement of the best quality care for adolescents. This report presents the key findings of that analysis and makes recommendations for eliminating or at least minimizing the gaps found.

The gap analysis focused on three issues associated with adolescent health service delivery – provider competence, the legal and policy framework and service provision and quality. The underlying assumption for applying this framework is that where providers have the required technical and social skills and competencies to serve adolescent clients and where the legal and policy environment enables rather than retards their ability to provide services to adolescent clients, quality services will be assured. The argument is that health service providers need to operate within an appropriate policy environment for quality, and with a proper understanding of the needs and expectations of those they serve, in order to deliver the best results.

Multiple sources of data were used to help identify the gaps. Primary data sources included baseline audit data generated by the pilot test activity (this provided an objective assessment of current quality of care in the facility); data from the survey of sites to identify the training in adolescent health or adolescent issues generally received by the providers in their facility who serve adolescents; and data from a consultation with NGO providers of care to adolescents who served as proxy for reporting on adolescents' experiences with the health system. In addition, two secondary sources of data were tapped. First was data from recent quantitative and qualitative research conducted with adolescents. The second source of secondary data derived from a recent UNFPA supported assessment of the legal and policy environment.

Findings of the Gap Analysis

The findings were mixed. In terms of provider skills, the data indicate a glaring skills gap for providers of care to adolescents. An unacceptably large number of providers have no specific preparation in adolescent issues. In addition to poor competence in dealing with adolescents and their issues, there appears to be an inability on the part of providers to communicate in simple terms to the adolescent.

The baseline audit of the seven pilot test sites found that none of the sites was fully compliant on any of the 20 criteria. All sites were non-compliant on two criteria. Six of the 7 sites were compliant on Criteria 4.6 (STI diagnosis and treatment are provided according to case management guidelines and protocols).

Five sites reported full compliance on three of the 20 criteria.

- Standard 2.3 (Maintaining confidentiality of clients);
- Standard 4.2 (Providers perform physical examinations and investigations according to case management guidelines and protocols) and 4.6 (STI diagnosis and treatment provided according to case management guidelines and protocols), and on
- Standard 8.2 (A system to ensure effective referrals and counter-referrals is used by health providers).

When the overall compliance was computed as a percentage of the number of criteria being assessed, important differences were found between the test sites in the quality of care being provided currently to adolescent clients. Although there is clear need for improvement across all the test sites, the data indicate that, currently, the Mandeville health centre is offering better quality care than the other pilot sites. Mandeville with compliance on 50% of the 20 criteria is followed by St. Ann's Bay Health Centre with compliance on 35% of the 20 criteria and University Hospital Teen Clinic with compliance on one third of the required criteria.

Adolescents' experiences with MoH services, as reported to NGO providers, were recorded for a comprehensive range of clinical and non-clinical services. Their experience with each service was rated on a scale of 1-5 where 1 is poor and 5 is excellent.

Among the clinical services, the dental service was given the highest rating (a rating of 'excellent'). To quote participants in the consultation:

> *"Care is terrific*" (Participant #1)
> *"Due to the Special Olympics, our students are able to access treatment at any SERHA clinic"* (Participant #2).
> *"Dental Nurses go into the school to encourage students to attend the clinics for free treatment"* (Participant #3).
> *"University of Technology has a free dental clinic for young people".* (Participant #4)

Pharmacy services received the next highest rating – a rating of "4".

The NGO representatives who attended the consultation were not able to rate four of the clinical services - Dermatology, Immunization, Dressing and Surgery. One participant, however, made the following comment concerning Immunization: "*The immunization rate has fallen from 80% to 60% in Jamaica*" (Participant) implying that the quality of the immunization service had deteriorated over the past years[1].

The three pregnancy–related services (antenatal, delivery, and post natal) all, with one exception, received a low score. The exception was the services offered at the Victoria Jubilee Hospital (VJH). Adolescents appear to have very good experiences with the services at the VJH. The VJH site was given a score of 4 for each of the three service areas.

[1] In 2011 the Expanded Programme on Immunization (EPI) was awarded the PAHO's Henry Smith cup for excellence in the Caribbean.

One of the criticisms of the pregnancy-related services is that adolescent mothers no longer get a Pap test or a contraceptive discussion at their 6 six week postpartum checkup. Equally harsh criticism was leveled at the family planning services. The criticism of that service was on two levels – first, method choice and second, the quality of the counselling provided to the new acceptor. On the matter of method choice, the observation was that:

> "*They* (adolescents) *get the method but not the one of choice, due to availability or cost - 20% are offered".*

And in the matter of counseling and preparation to use the method given, the observation is that:

> *"They do not have a family planning conversation. Young people need a conversation to enable them to choose. A number of them are "given" the injection, then they have bleeding for 3 months, but because there is no conversation they are not told to expect it, it makes some vomit – sick, so others refuse it as they don't want the 'bleeding thing". No provision is made for young persons to discuss family planning"*

Overall, the HIV services received a 'Good' rating. And while the care in the Mother to Child Transmission programme was thought to be good, the view was that programme quality was not sustained, because *"… once you have the baby the care falls apart".*

Adolescents with disabilities, adolescents living with HIV (ALHIV) and many pregnant adolescents who use the MoH health centre services do not have a positive experience. Based on their reports to the NGO providers they are treated poorly. The representative from Jamaica Association for the Deaf at the consultation offered the following thoughts to support that contention in regard to adolescents with disabilities:

> "*Our clients are discriminated against, saying things like 'what you doing getting pregnant, it's not a right as you are disabled'. The communication lacks sensitivity, quality of service delivery, language is offensive; service providers relate to the mother or aunt of the adolescent. Adolescents feel disempowered"*

The representative went on the say:

> *"We are not expecting all service providers to Sign* (communicate in Sign Language) - *but can we write the questions and the client write the answer? Our clients are unable to adequately access the services. Information shows while writing is not accessible to the blind – the attitude of the staff is poor".*

In terms of mental health services, the following comments were made:

> *"Data tell us how many of our young people have thoughts of suicide, yet there is no referrals, no mental health intervention. Young people are displaying a high level of depression. Children with ADHD are expelled, as are children displaying behavioral problems. The guidance counsellors and teachers agree that the school cannot cope or accommodate these students. The referral process - there is a long line; in the meantime these students cannot attend school"* (Participant 1)

> *"For the Deaf student there is the cost and waiting time. The Deaf students often have difficulty getting attention at home and from service providers. University of the West Indies waiting time is long, once they have been seen it could be 2 months before your appointment*" (Participant 2)

In addition to the clinical services, participants in the consultation were asked also to rate three non-clinical services offered by the MoH – again based on the experience of adolescents in their programmes. The services rated were: education; individual counselling and group counselling. Group counselling was the only service that received a rating lower than 1. Education services were rated "good" and individual counselling rated "fair". The observation made in support of the low rating for these non-clinical services was that:

> *"SRH services are failing and ineffective. There is no one, there is no time, and communication is poor".*

The 2015 review of the law and policy framework for adolescent sexual and reproductive health provided data for the gap analysis of the law and policy environment. The review identified the following gaps.

- The difference between the age of majority (18 years of age) and the age at which adolescents can consent to sexual intercourse and medical procedures (16 years of age).
- The absence of a comprehensive policy position on adolescent sexual and reproductive health (ASRH). The author reported that there is no single policy position on the sexual and reproductive health rights of adolescents. This gap, she argues, leads to inconsistencies in the way different agencies, including the Ministry of Health, treat adolescents' right to information and services.
- Contradictory approaches in the Child Protection law vs Health Policy. Chambers observes that health policy aims to prevent high risk sexual activity among minors while the child protection law aims to prevent ANY sexual activity among minors. This difference, she contends, often puts the health professional at odds with child protection law especially when they (the provider) provide contraceptives to persons who are below the age of consent for sex (age 16 years).
- Lack of psycho-sexual support for adolescent victims and perpetrators of sexual offences

Based on feedback from care providers in Ministry of Health facilities and from the NGO participants in the consultation, the law has contributed to limiting access to services for some adolescents in need. One NGO provider noted:

> " … a*n adolescent is not able to walk into a health facility and ask for treatment without an adult. We have created a dilemma! The child has a right to care! We signed the Convention on the Rights of the Child and we should be promoting it"*

Also:

> *"Adolescents can't be tested without parental permission; Hospital staff is at risk of prosecution and are guarded against providing testing to unaccompanied adolescents. Adolescents are not receiving the best care"*.

Another NGO provider stated the following as evidence of the inconsistency presented by the legal framework:

> *"A teen mother is unable to apply for PATH- the grand mother has to be the one that applies; adolescents are NOT seen as a group".*

Taken together, the gaps identified by this study in provider competence and in the legal and policy framework work against the provision of quality services for all adolescents. These barriers also serve to limit access to care for many adolescents. And so, although on paper the Ministry of Health offers health

services to adolescent clients from its 15 general hospitals; 6 specialist hospitals; 331 health centres and 23 satellite clinics, in reality that access is limited by geography, poor provider skills to manage the adolescent client and the law which limits who can access care and the type of care that can be accessed.

Brainstorm sessions with adolescents and with non-government agency directors who interact with adolescents and with the health service system generated a list of possible causes of poor provider performance. These causes were narrowed down using "Five-why" analysis technique - an iterative interrogative technique used to explore the cause-and-effect and that focuses attention on the root cause – not the symptom of the problem.

When this analysis was applied to the problem of poor provider skills to manage the adolescent client, the results are as shown in Figure A. What is suggested by this analysis is that the way to make changes in the present system and to improve the skill levels of adolescent service providers is to make adjustments to the basic training curricula as well as in-service education programmes for care providers and to the recruitment criteria and position descriptions of new hires. These changes will require strategic re-allocation of human and financial resources.

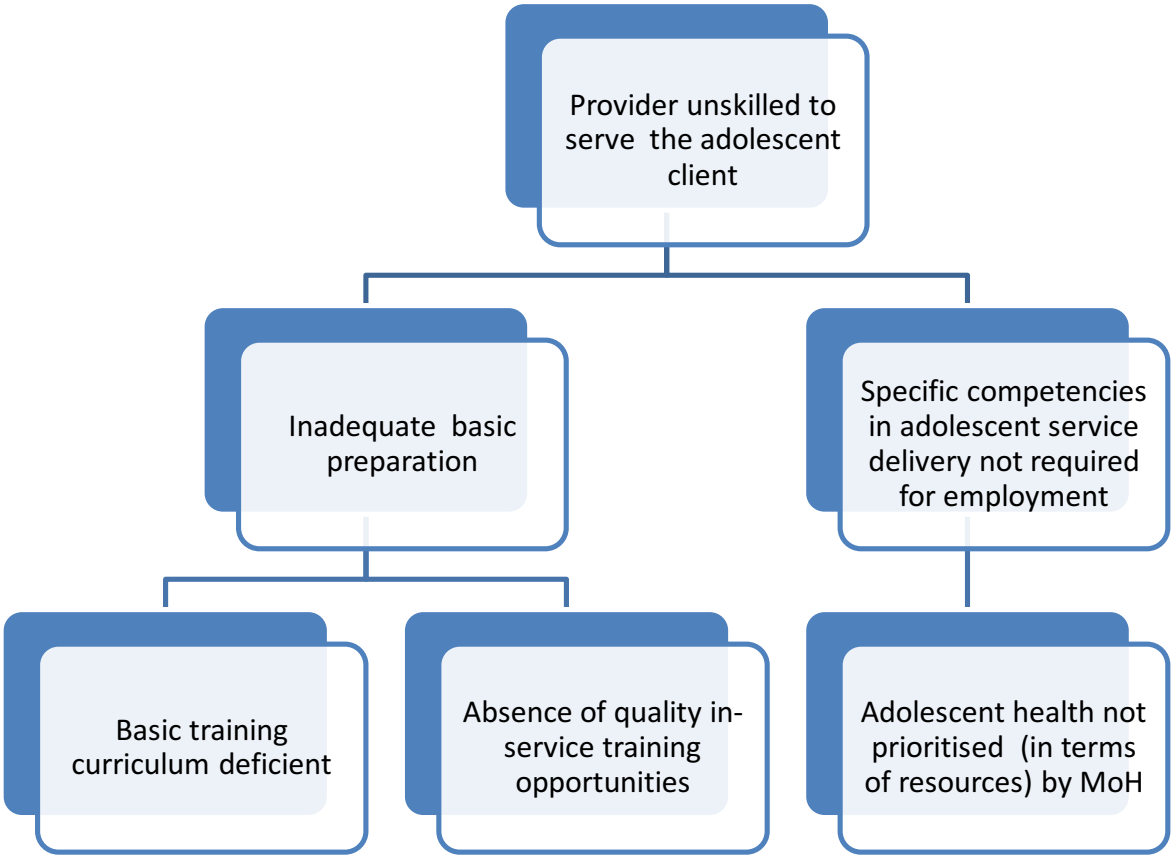

Figure A: Possible Reasons for Poor Provider Skills in Adolescent Service Delivery

When the Five-Why analysis was applied to the problems related to the legislative framework, the set of results shown in Figure B emerged. The bottom line appears to be that because health care providers and law enforcement entities have different perspectives – one on preventing and curing disease, the other on enforcing the law - they come to the problem from different perspectives. There is tension between these two perspectives and that tension is reflected in present legislative framework. The challenge is how to minimize that tension so that legislation can be drafted that accommodates the two perspectives.

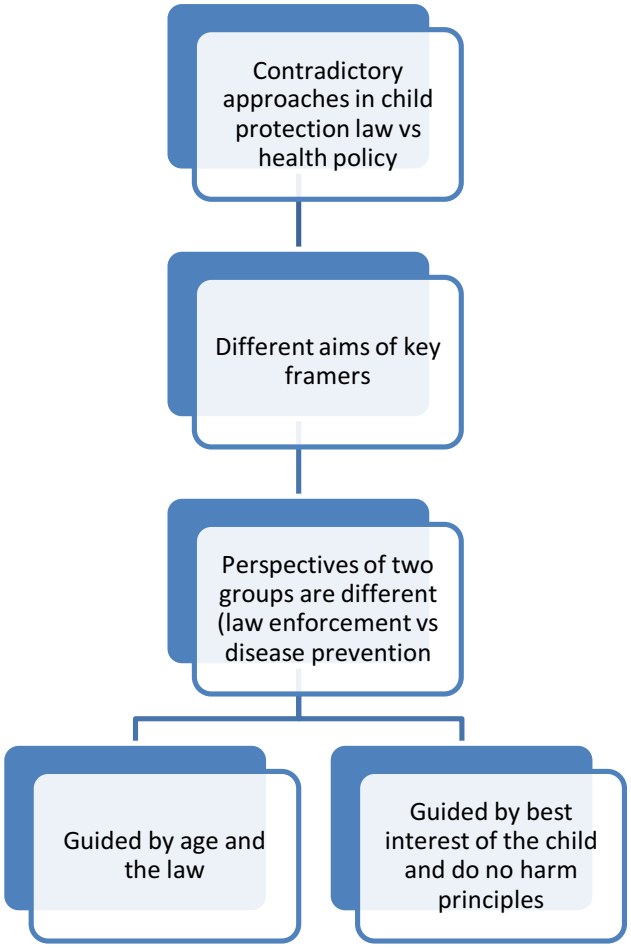

Figure B: Possible Reasons for Contradictions in Legal and Policy Framework for Adolescent Health

Conclusion and Recommendations

A focus on quality care as desired by the MoH should be adequate to achieve the goal of the national strategic plan for preadolescents and adolescents. Quality care contributes to Client Satisfaction should result in Improved compliance which results in Improved health outcomes for the client and ultimately in health system that reports positive results.

Based on the research reported here, that quality of care for adolescents can be achieved if there are improvements in provider competence and if the legal and policy framework is made less contradictory. Given the gaps identified, what steps should the MoH take in order to move from the current situation to its desired state? The following recommendations are being made based on the analysis of the gaps. These recommendations fall into two categories – i) recommendations that should be effected as soon as possible and ii) recommendations given a longer implementation time line.

1. Capacity building using two approaches simultaneously

The United Nations Development Programme defines capacity as "the ability to perform functions, solve problems, and achieve objectives" at three levels: individual, institutional and societal. Capacity building has typically been defined as the development and strengthening of human and institutional resources. But the process should go beyond the public sector to include private sector and Nongovernmental Organizations (NGO)/ civil society organization (CSO)

There are several NGOs which can and should be engaged to support the MoH in its delivery of services to adolescents and especially to meet quality standards 1 (1.3); 2 (2.2); 3 (3.2); and 5 (5.1.and 5.2). To that end, we recommend using two capacity building approaches – partnerships and community development. Both of these are suggested as ways of using the technical resources of the NGO/CSO in the one instance, and the empowerment of adolescents with special needs in the other.

1.1 **Partnerships to support service delivery (non-clinical)**

There is no one model for partnership building. The model adopted by the parties must be mutually agreed and will be dependent on the reason for the partnership, the resource exchange that is agreed on, and the expected nature of the relationship. We recommend that the Ministry of Health:

- Explore avenues for partnership(s) with NGO entities that have a desire to partner and work towards solutions and are willing to support the Ministry's work especially in education, counselling, sensitivity training for members of the health team and interpreting – including virtual interpreter support.
- Ensure that clear Memoranda of Understanding are in place to guide the partnership arrangements.

1.2 Community Organising – focus on adolescents with special needs:

This is an ambitious approach to community development that if effectively implemented raises people's knowledge, awareness and skills to use their own capacity and that from available support systems, to resolve the more underlying causes of difficulties they are experiencing. Through this approach adolescents with special needs (those with a disability, those living with HIV, etc.) can better understand how to make decisions and to communicate more effectively at different levels with the health system; and develop a sense of confidence to manage their own destinies.

Recommend that:

- The MoH, through the Health Education and Health Promotion Officers seek to establish partnerships with NGOs/ CVOs that have established relationships or that work with adolescents with special needs.

- The MoH together with the partner NGO/CSO plan and conduct client empowerment education workshops/sessions that focus on building self confidence, decision making, effective communication as well as common adolescent health issues.

2. Training for health care providers

2.1 Training for providers currently employed

Even though the MoH has begun the process to improve provider competence to serve the adolescent populations, the research has highlighted the need for better qualified (technically competent and empathetic) health care providers. Already, the MoH has exposed some 475 public sector health care professionals to training that should assist them in supporting the adoption of the adolescent health standards.

Training and preparing health care providers is a long term undertaking but we recommend that in the short term the MoH initiate plans to improve the competence of providers currently in the system. In that regard we recommend:

- The Family Health Unit review the content and material delivered in adolescent health training workshops conducted by the Unit over the past 2 years;
- Repackage the material for delivery to other groups of care providers who have direct contact with adolescent clients and;
- Identify resources to deliver the programme in a series of 1 or 2 day workshops or seminars.

2.2 Training for future employees

The plan to get all health care providers who work with adolescents competent to do their tasks is a longer term plan. However, the MoH can initiate plans to assure the competence of future providers. In that regard we recommend that the MoH:

- Conduct a review of curricula of health professional colleges and schools to determine the course content required for matriculation in each discipline;
- Consult with professional colleges, starting with nursing, midwifery and counselling in the first instance and later expanding the professional mix) to explore the possibility of modifying their matriculation requirements to accommodate inclusion of adolescent health development components;
- Establish partnerships with these institutions to develop adolescent health and development curricula that reflect the guidance provided by the WHO regarding the expected competencies of an adolescent care provider;
- Consult with the Human Resource Division to draft position descriptions for new hires in adolescent health and development.

3. Legal and policy framework

3.1 Immediate action recommended

The analysis indicates, and anecdotally there is a vast body of evidence, that the current situation with laws, especially those pertaining to the delivery of sexual and reproductive health related services to the

adolescent, inhibit access and ultimately negatively impacts the health status of the individual adolescent as well as the community as a whole.

The MoH has begun a process to modify the existing law to allow access to treatment and care for young adolescents who may not attend with an adult (parent or guardian). That process appears to be well advanced. We recommend that the MoH:

- Continue the process and take whatever action is necessary to accelerate the process.

3.2 Longer term action required

Any effort to adjust perspectives requires investments of time and other resources. The Five-Why analysis of the problem with the legislative environment indicated that the challenges with the laws associated with service delivery to the adolescent revolve around the difference in perspectives of members of the health care and the law enforcement communities. We recommend that the MoH consider implementing two approaches to addressing the problem:

- Public education that targets law enforcement; and
- Advocacy: Explore partnering with adolescent and youth advocacy groups and agencies to design and implement a comprehensive advocacy programme that includes the strategic use of social media and of trained individuals to serve as Champions.

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LIST OF ACRONYMS

ALHIV	Adolescent Living with HIV
CSO	Civil Society Organisation
FAMPLAN	Jamaica Family Planning Association
JAD	Jamaica Association of the Deaf
JAID	Jamaican Association for Persons with Intellectual Disabilities
MoE	Ministry of Education
MoH	Ministry of Health
M(O)H	Medical Officer of Health
MoYC	Ministry of Youth and Culture
NERHA	North East Regional Health Authority
NFPB	National Family Planning Board
NGO	Non-government Organisation
RGD	Registrar General Department
RN	Registered nurse
RHA	Regional Health Authority
SDP	Service Delivery Point
SERHA	South East Regional Health Authority
SRH	Sexual and Reproductive Health
SRHA	Southern Regional Health Authority
UHWI	University Hospital of the West Indies
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHJ	Victoria Jubilee Hospital

WCJF	Women's Centre of Jamaica Foundation
WHO	World Health Organization
WRHA	Western Regional Health Authority

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I. INTRODUCTION

The official mandate of the Ministry of Health (MoH) is "to ensure the provision of quality health services and to promote healthy lifestyles and environmental practices". The vision of the Ministry "Healthy People, Healthy Environment" is a vision which envisages a health system that is client-centred and that guarantees access to quality health care for every Jamaican, at reasonable costs, and which takes into account the needs of the vulnerable.

Of special interest to the Ministry of Health are adolescents - those individuals in the age group 10-19 years[2]. It is estimated that they make up some one fifth of Jamaica's total population.[3] They comprise an especially vulnerable group. That vulnerability is closely linked to adolescents' young age, their lack of social and economic power as well as their general lack of information about health issues and especially about how to navigate the health system.

In 2010, the MoH developed a national Strategic Plan (2010-2016) to guide its programming for the pre-adolescent and adolescent clients. The goal of that plan is that, by 2016,

> *"the majority of Jamaican pre adolescents and adolescents are equipped with knowledge, emotional intelligence and skills to make healthy lifestyle choices and are supported by effective systems at the levels of the home, community, school and health services to transition successfully to adulthood"*

The explicit acknowledgment of the crafters of the plan is that success in achieving the goal depends on the adoption of a multipronged approach to programming and service delivery – an approach that requires simultaneous focus on increasing adolescents' knowledge and skills and changing their attitudes while creating and supporting enabling environments at home, school, community, the policy arena and in the health system.

One of the specific objectives of the health services component of the Strategic Plan is that at least 15 (at least one per parish) adolescent centred (or adolescent friendly) health facilities that comply with approved adolescent centred (friendly) standards and criteria are operational by 2016[4]. In order to satisfy that objective, the Ministry of Health, in 2014, commissioned the development of adolescent health standards and related criteria designed to assure the delivery of quality services to adolescent clients.

Several of the 10 approved standards were pilot tested in seven sites island-wide between June and December 2015[5] and were rolled out in a select number of sites in early 2016. However, in order to move from its current state to its desired state, that is, to achieve the health goal, the Ministry needs to identify and analyse the gaps in the system.

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[2] The Ministry of Health uses the World Health Organization's definition of adolescence. http://www.who.int/topics/adolescent_health/en/

[3] Statistical Institute of Jamaica: http://statinja.gov.jm/demo_socialstats/newMidYearPopulationbyAgeandSex2008.aspx

[4] National Strategic Plan - Preadolescent and Adolescent Health and Development (2011 – 2016), Ministry of Health, Oceana Complex

[5] The sites include one primary health care centre in each of the four health regions, the adolescent clinic at the Victoria Jubilee Hospital (VJH), the adolescent clinic at the University Hospital of the West Indies (UHWI) and the mobile HIV testing service operated by the National Family Planning Board (NFPB).

This report presents the findings of an analysis of the gaps in the system that is expected to provide quality care to adolescents. The focus of the research will be on three areas, namely, Service Provision, Provider Skills, and the Legal and Policy Framework. It will provide a summary of the observed versus desired results for each category and then briefly address the reasons believed to be responsible for the gaps identified. Each of the three categories will be addressed fully in its own section, followed by a conclusion that summarizes the report and calls for action – a call to create an improvement plan to address the gaps.

II. ADOLESCENTS – THEIR HEALTH SITUATION

Adolescents comprise approximately 20 percent of Jamaica's estimated 2.8 million population. Pre-adolescents, individuals in the age group 8-9 years, comprise another 3.2%[6]. The data on pre-adolescent and adolescent health indicate that, in many respects, their health situation is positive. But in many other respects the data provide cause for concern.

There should be concern, for example, at the age of initiation of drug use as well as the changing gender differentials in the timing of that initiation. By age 12, 20 percent of adolescents have tried drugs including alcohol. It also is reported that pre-adolescents are introduced to alcohol by family members and, as a rite of passage, and encouraged to drink at social events. Those who report use of marijuana are more likely to have ever had sex than adolescents who do not use marijuana. Increasing numbers of girls compared to boys are initiating the use of drugs.

There is also concern regarding the increasing prevalence of non-communicable diseases among adolescents. The prevalence of pre-hypertension in the 15-19 age group is about 29 percent and the rate is significantly higher among male than female adolescents. In 2005, 10 percent of the 15-19 year olds surveyed in the YRRS reported asthma and 2 percent were diabetic. Twenty-five percent of a national sample of 15-19 year olds surveyed in 2006 was overweight or obese. The problem was significantly greater among females than males. In addition, 2005 data show that girls 13-15 years living in urban communities are more likely to be obese than girls in rural communities [11% compared to 3-4%].

The prevalence of mental health issues is also of concern. Close to 1 in 5 pre-adolescents surveyed in 2005 and adolescents 15-19 surveyed in 2006 reported being sad or lonely. But maybe more concerning is the statistically significant relationship found between feelings of loneliness, sadness and a desire to cry, and suicidal ideation (Wilkes et al, 2006; Fox & Strachan, 2005).

Mental health professionals attached to the Ministry of Health report that depression is the single most common mental health problem seen among adolescents[7]. Based on survey results, between 10-20 percent of 15-19 year old adolescents are depressed, (the problem is more significant among female than male adolescents). Suicide is attempted by some 3% of 10-15 year olds and 3% of 15-19 year olds: females are significantly more likely than males to attempt suicide and the fact of having a friend who tried to commit suicide appears to be significantly associated with attempted suicide. A more recent MoH/UNICEF study reports that significantly more females than males attempted suicide ($p<0.05$) and the mean age of the suicide attempters is 17.7 years (s.d. +/-3.379), with significantly more females presenting to hospital.

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[6] Based on mid-year population data for 2014 provided by Statistical Institute of Jamaica. http://statinja.gov.jm/demo_socialstats/newMidYearPopulationbyAgeandSex2008.aspx

[7] Workshop presentations – Ministry of Health Standard of Care Training parish-level training workshops conducted between June and August, 2016.

The sexual behaviour of adolescents has been under scrutiny for several years because of the timing of first sexual intercourse and the negative, and often life changing consequences for adolescents, especially female adolescents, who engage in unprotected sexual activity. The age of sexual initiation is reported as 13 for boys and 16 for girls (ARHS, 2008). By age 20 years, it is estimated that 40 percent of young women have had at least one child.

Although still unacceptably high, the evidence is that the adolescent fertility rate in 2014 was 60.6/1000 women 15-19 years, down from 72 in 2008, 79 in 2002 and a high of 112 in 1997. Live births to adolescents 15-19 years declined by 7 percent in the past 3 years – moving from 7,488 in 2009 to 6,973 in 2012; while there was a 36 percent decrease in the births to pre-adolescent girls, that is, those younger than 15 years, in the same period (RGD, 2016)[8]

In the area of sexually transmissible infections, new data available from the Spectrum project indicate that the HIV prevalence among boys is 0.5% while that in girls is 0.4% (Spectrum, 2005). These new data contradict the prevailing conventional wisdom which, until recently, contended that female adolescents were at higher risk of HIV infection than male adolescents. From a programme perspective, these data strongly suggest that equal attention (whether prevention education, testing or treatment and care) must be paid to both male and female adolescents.

Health-related actions do not occur in a vacuum. They result from an array of inherent behavioral influences interfaced with external environmental forces. Sorting out the behavioral influences provides the public health practitioner with insight to assist in taking the next appropriate steps. Three sets of factors, also referred to as determinants, contribute to health related actions and their outcomes in adolescents.

First, predisposing factors are more inherent motivational forces (e.g., values and attitudes) that provide reasons for taking a given action; second, enabling factors facilitate or impede such action based on their degree of availability (e.g., health insurance coverage), while reinforcing factors support and potentially reward the action taken (e.g., family, partner or peer encouragement).

The health behaviour literature informs us that many of the health outcomes for adolescents result from factors which are external to the individual – factors which may enable or reinforce behaviours that have harmful consequences. Among these for Jamaican adolescents are crime and violence, the media and the peer group. The environmental influence of crime and violence on individuals is well documented (Bailey, 2011; Coore, 2008; Samms-Vaughn, 2005). Large and increasing numbers of adolescents have witnessed a violent crime or have been victims of violence. One in three males and 28 percent of females in a 2005 national survey reported being a victim of physical attack in the past year (Samms-Vaughn et al, 2005).

A recent qualitative study of adolescents indicate that many adolescents are exposed to more than 14 hours per week of local and international television programming and live in an environment of *"unhealthy listening",* that is cursing, fighting, swearing, abusing children and certain types of music. That music, in the voice of one adolescent in the study *"once you hear it, it take over yu mind".* The adolescents also acknowledge that the noise and loud music also prevent restful sleep[9]. It is likely that this 'noise' and lack restful sleep is positively associated with the increasing prevalence of depression in adolescents.

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[8] Data reported at the recent series of parish level adolescent standard of care workshops.

[9] Qualitative research conducted to help guide the preparation of the national strategic plan for preadolescent and adolescent health and development (2011-2016).

The negative influence of the peer group on behaviour that leads to poor health outcomes is strong. Bullying and gang membership significantly influence the likelihood of suicide and drug use as well as sexual activity and the membership of gangs in and outside of the school (Meeks Gardner, Thomas & Khan, nd). Too many adolescents perceive that parents do not care for them even if they know that parents have high expectations of them (Fox & Gordon-Strachan, 2005).

Factors internal to the individual, for example, health knowledge, attitudes and perceptions, also act as powerful determinants of health behaviours. Knowledge about specific health issues has been shown to predispose to positive health outcomes in safe sexual behaviours (REF), nutrition (Reza et al, 2014); obesity (Ramirez, et al 2007); diabetes (Martha, et al, 2004) and cancer (Goldman et al, 2008). It should be worrying, therefore, that only 53 percent of adolescents living with HIV know their HIV status and only 24 percent of those who know are on ARV and 12 percent (167) of adolescents living with HIV are virally suppressed (Spectrum, 2016)[10].

The health situation of adolescents summarized above highlights the need for interventions in the areas of prevention, treatment, care and support, education and counseling for adolescents as well as those who care for adolescents. The Ministry of Health has an essential, even fundamental, role in assuring the delivery of appropriate and effective interventions and services. It is with this in mind that the Ministry commissioned an analysis of the 'gaps' that exist in the system. This report will present the findings of an analysis of the gaps in three areas: Provider skills, Legal and Policy Framework and Service Quality. The rationale for selecting these three elements is explained in the Conceptual Framework section of the paper.

III. THE GAP ANALYSIS

1. Introduction: The term "gap analysis" is one that is more commonly used in the business sector rather than in the social services sector. The business directory defines gap analysis as:

> "A technique that businesses use to determine what steps need to be taken in order to move from its current state to its desired, future, state". http://www.businessdictionary.com/definition/gap-analysis.html

The value of a gap analysis applied to adolescent health is that it should help to reveal areas where the Ministry - its assets or employees - falls short. Gap analysis can also direct how the assets and resources are allocated. For example, gap analysis may reveal inadequacies in the service delivery system or expose faults in the inventory system or supply chain.

2. Conceptual Framework

The provision of quality health service to adolescents, like any other group of clients of the Ministry of Health, is predicated on several factors – some of them are provider-related, for example provider technical skills, provider social competence and provider knowledge, others, like the legislative environment and cost are system-related and yet others are client-related, like perceptions, attitudes and severity of the health concern.

This gap analysis will focus on three sets of factors – two sets of provider-related factors, specifically provider technical and social skills and one set of system-related factors, namely the legal and policy framework of service delivery to the adolescent. The assumption here (see Figure 1) is that where providers have the required technical and social skills and competencies to serve adolescent clients and where the

[10] Data presented by Coordinator of the ALL-In Programme in the Ministry of Health to Adolescent Standard of Care parish-level training workshops – May-August, 2016).

legal and policy environment enables rather than retards their ability to provide services to adolescents, quality services will be assured. The argument is that health service providers need to operate within an appropriate policy environment for quality, and with a proper understanding of the needs and expectations of those they serve, in order to deliver the best results.

Figure 1: Conceptual Framework for the Gap Analysis

3. Methodology

A three step approach was used to complete this Gap analysis. First, characteristic factors of the present situation were listed (referred to as "what is"). Second, a list of factors that are needed to achieve future objectives was made (referred to as "what should be"), and third, the gaps that exist and need to be filled were highlighted and subsequently analysed using the Five-Why analysis approach.

The data required for the analysis were derived from multiple sources. To discover '**What is'**, three sources of primary data were tapped. These were: i) baseline data from each of the pilot test sites; ii) data from a consultation with representatives of adolescent-serving quasi-government and non-government organizations;[11] and iii) survey of skills of health care providers in parishes that have a pilot test site. In addition to these primary data, secondary data from recent quantitative and qualitative research conducted with adolescents and a recent assessment of the legal and policy environment conducted with UNFPA support were corralled to form the fourth and fifth legs of the data stool.

To highlight **'What should be'** the report includes objectives from the Pre-adolescent and Adolescent Strategic Plan as well as the Adolescent Health Standards and Criteria. The section of the report on **What are the Gaps?** will highlight the Gaps in three areas: i) Services; ii) Skills and iii) Laws and Policies.

[11] Five youth-serving agencies participated in the consultation – Eve for Life, FAMPLAN, PEY & Associates, Jamaica Association for the Deaf and Women's Centre of Jamaica Foundation.

4. Findings and Discussion

4.1. The Present Situation - What is.

4.1.1. Services – Availability and Accessibility

As the preceding discussion of the health status of adolescents should indicate, as a whole, adolescents are especially vulnerable because of their age and stage of physical and emotional/ psychological development. But the evidence is that adolescents in the transition years – transitioning from the primary to the secondary level of education (those who are between 11 and 13 years) - appear to be the most vulnerable of all.

The Ministry of Health, together with its four Regional Health Authorities (RHAs), Agencies and related organizations make up the public health system and are responsible for health care delivery across the island. Services are delivered through a network of facilities that comprise General hospitals (15); Specialist hospitals (6); health centres (331) and satellite clinics (23). The latter two groups of facilities are classified by 'Type'. It is estimated (Table 1) that 4000 persons are served by Type 1 health centres, 12,000 by Type 2 health centres and 20,000 are served by Type 3-5 health centres.

Table 1

Description of Services Available in each Type of Health Centre Operated by the Ministry of Health

Health Centre Type	Services Offered
Type I **Serves a population of not more than 4,000. Staffed by nurse and community health aide. Located in more rural areas.**	Basic maternal and child health; health education, family planning, immunization and nutrition.
Type II **Serves a population of about 12,000 persons. Serviced by resident nursing staff and a visiting Doctor and Nurse Practitioner.**	Family health (including antenatal, postnatal, child health, nutrition, family planning & immunization); curative, dental, environmental health, Sexually Transmitted Infections (STIs) treatment, counselling & contact investigation; child guidance, mental health and pharmacy.
Type III **Serves a population of about 20,000 people.**	Family health (including antenatal, postnatal, child health, nutrition, family planning & immunization); curative, dental, environmental health, Sexually Transmitted Infections (STIs) treatment, counselling and contact investigation; child guidance, mental health and pharmacy.
Type IV **The health programmes for the parish are administered from that office.**	The Type IV Health Centre has all the services of the Type III; however the Type IV Health Centre has the Parish Administrative Office on the same premises.
Type V **Considered Comprehensive Health Centres with all the facilities of a Type III Health Centre and are located in the urban areas.**	Services offered are similar to those of the Type III in addition to a specialty. Laboratory facilities are also available.

Source: www.serha.gov.jm; / www.wrha.gov.jm; www.serha.gov.jm;

Access to Services

Based on the number of health care service delivery points (SDP) and their physical location, adolescents should have no difficulty accessing health services. The MoH and its affiliates, namely the Child and Adolescent Mental Health Services (Child Guidance Clinic service) and the National Family Planning Board (NFPB) into which the National HIV Prevention Programme (NHP) has been integrated, offer clinical and counselling services through a network of fixed health centres (Type I to Type V), hospitals, mobile service delivery facilities, and specialist service centres. Figure 1 shows the distribution of health facilities across Jamaica.

Services for adolescents are provided through an estimated 332 public sector health centres and 23 public hospitals island-wide. A survey of agencies indicates that agencies in both the government and NGO sectors are engaged in providing a very comprehensive menu of health–related services - education, health and social services - for pre-adolescents and adolescents. The services they offer range from life skills education, counselling, and sexual and reproductive health education to games and recreation, and mentorship.

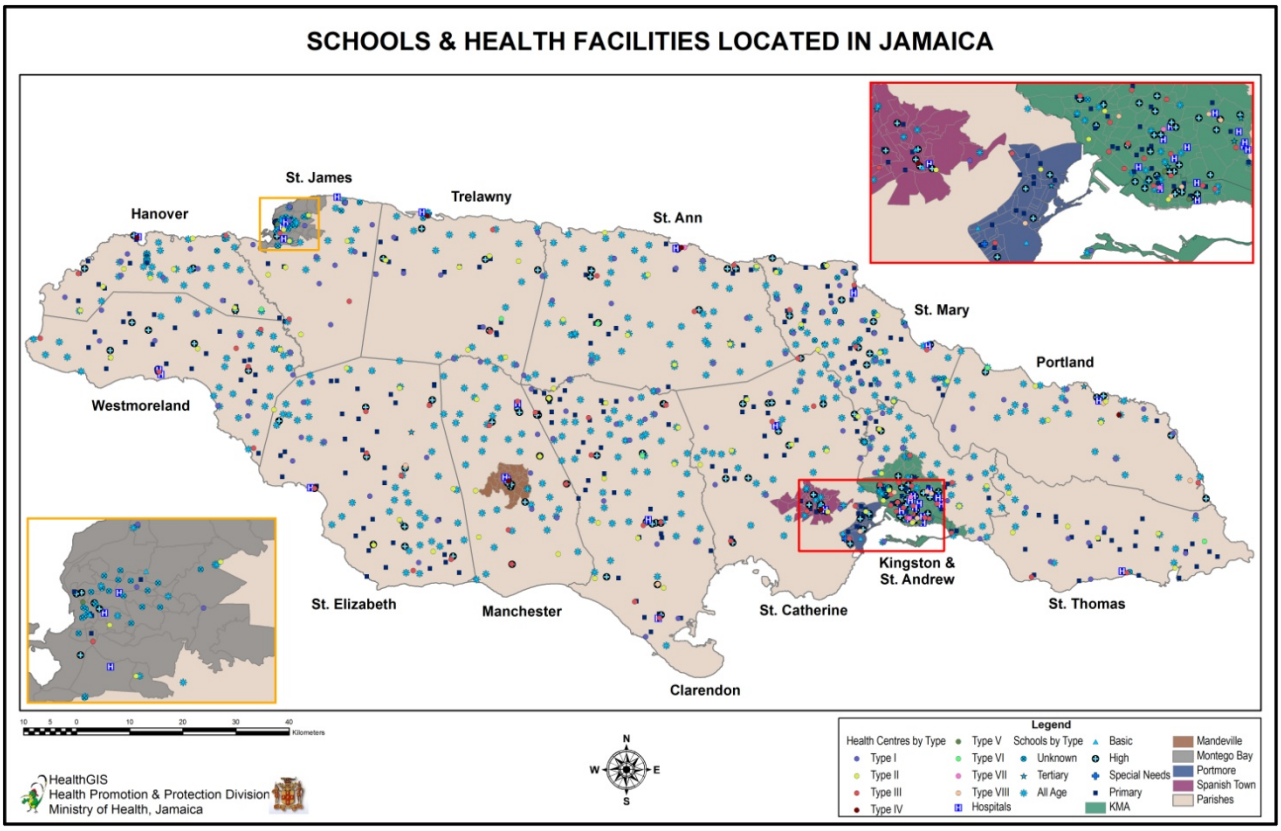

Figure 2: Map showing Distribution of Public Sector Health Facilities and Schools in Jamaica

The Ministry of Health also partners with civil society organisations to provide clinical and non-clinical services to adolescents. More than any other service area, the Ministry gets programme support from civil society organisations in the area of sexual and reproductive health for adolescents. A list of the partnerships that exist and the contribution of each partner agency to the delivery of health services is shown in Table 2.

Table 2: Sexual and Reproductive Health Services provided by Government and Select Non-Government Organisations to Youth in Jamaica.

Agency	Group(s) Served	Locations	SRH and Related Services Offered
Government			
Ministry of Health (MoH)	All groups – including PLHIV, SW, MSM, youth at risk	Island-wide network of health centres (Type 1-5) and hospitals Child Guidance Clinics	Preventive, diagnostic, treatment and curative health services, psycho-social support. Public education, risk reduction education, policy development.
MoH (National HIV Prevention Programme)	In-school youth, pregnant women, MARPS	Special interventions to schools – whole school project	Prevention education BCC and referral Testing
MoH Child and Adolescent Mental Health Service (Child Guidance Clinics)	0 – 18 years	Select parishes – KSA, Manchester, Portland, St. Ann, St. Catherine, St. James, St. Mary, St. Thomas.	Medical care for children with emotional and psychological needs/ concerns.
Ministry of Education (MoE)	All youth	Island wide network of primary and secondary institutions.	HFLE life skills education, SRH/HIV education. Guidance and counselling with referral to health facilities for follow-up care (testing, condoms, contraceptives, etc.)
MoE (Health Promotion Education Officers)	In and out-of-school youth	All primary and all-age schools	HIV/SRH prevention education though health promotion education officers
MoE (ASTEP)	Students with special literacy needs	191 Primary, All Age and Junior HS – 258 centres to reach 6200 students	Counselling and referral, skills training
MoE (PASS)	Students with disciple/behaviour problems		Education, counselling and referral
Ministry of National Security (Citizen Security & Justice Programme	Communities	Select communities (especially inner city communities) Juvenile Correction Centres	Education, counselling and referral
Ministry of Youth and Culture (MoYC)	Adolescents and youth	Network of 6 Youth Information Centres Kingston and St. Andrew	Education, outreach, referral, peer counselling, mentoring, remedial education.

Agency	Group(s) Served	Locations	SRH and Related Services Offered
	Homeless boys (The Possibility Programme)		
Quasi-Government			
Child Development Agency (CDA)	Children, families	Network of offices – 4 regions	Public education
Child and Family Clinic (at UHWI)	0-12 years	Kingston and St. Andrew	Medical care for children with physical, emotional and psychological needs.
National Council on Drug Abuse (NCDA)	Children, youth, adults	HQ and field offices	In-school and community-based prevention education, counselling and referral
National Family Planning Board (NFPB)	Guidance counsellors, health practitioners	Sylvan Ave, Kingston 5.	School-based education Training for teachers and Guidance Counsellors Telephone counselling – Marge Roper. Research Policy development
Office of the Children's Advocate	Children and Families	Network of sites across the country	Advocacy, research, educational services, care and protection
Women's Centre of Jamaica Foundation (WCJF)	Pregnant teens	8 locations across the country	Prevention education, Counselling, Referral for testing, Referral for MTCT prevention, Psycho-social support, continuing education, placement in school post-delivery.
Selected Non-Government Organisations			
Ashe	Inner city youth	Kingston and St. Andrew	Remedial education, dance, singing, edutainment
Caribbean HIV & AIDS Research, Education and Services (CHARES)	PLHIV	Kingston and St. Andrew (UHWI)	Treatment, psycho-social support for PLHIV and persons affected.
Children First	Vulnerable youth (comprehensive programme)	Spanish Town, St. Catherine and Kingston.	Remedial education, job skills development, job placement, mentoring, health care via mobile (Bashy Bus) clinic service with peer to peer edutainment.
Eve for Life	Women living with HIV, pregnant teens	Kingston and St. Andrew, and St. James	Education, counselling, psycho-social support, referral for testing and treatment.
FAMPLAN	Adults and adolescents	St. Ann's Bay (St. Ann), Montego Bay (St. James) and Kingston (East Street).	Sexual and reproductive health services – commodities, counselling,

Agency	Group(s) Served	Locations	SRH and Related Services Offered
			education, outreach, testing, and referral.
Jamaica AIDS support for Life (JASL)	MSM, SW, PLHIV, OVC	Network of sites – one in each of 3 parishes (KSA, St. James and St. Ann)	Counselling (one on one and group), support groups, clinical care, HIV testing, public education.
Jamaica Forum for Lesbians, All-Sexuals and Gays (JFLAG)	Lesbians. Gay, bisexual, transgendered people	Kingston and St. Andrew	Education, referral, advocacy
Jamaica Network of Sero-Positives (JN+)	PLHIV	Network of individuals across the country	Psycho-social support, referral.
Jamaica Red Cross	MSM, vulnerable youth	St. Catherine (HQ), Clubs formed in schools across the country	Training education and outreach workers – peer educators. Education through peer educators. Produce educational material.
Rise Life Management	Substance users, vulnerable youth	Kingston and St. Andrew	Substance use counselling, referral, remedial education.
Young Men's Christian Association (YMCA)	Vulnerable youth (male)	Kingston and St. Andrew	Remedial education, job skills training, referral
Young Women's Christian Association (YWCA)	Vulnerable youth (female)	Kingston and St. Andrew, St Catherine	Remedial education, job skills training, peer education, referral.

The health policy literature is replete with research on the measurement of service utilization and access – evidence of the central role of access to healthcare in the performance of health care systems around the world (Shengelia, Murray & Adams, 2003; Penchansky and Thomas, 1981). The vast literature, notwithstanding, access to health care remains a complex notion as exemplified by the varying interpretations of the concept across authors (Haddad, 2002; Daniels, 1982).

If the definition of access is limited to availability, then the evidence is that Jamaican adolescents have access to health services. However, if as suggested by Levesque et al (Levesque, et al 2013) a broader definition of access is used – one that includes issues of: Approachability; Acceptability; Availability and accommodation; 4) Affordability; and 5) Appropriateness (or restated in the language of abilities, 1) Ability to perceive; 2) Ability to seek; 3) Ability to reach; 4) Ability to pay; and 5) Ability to engage) then we must conclude that access for several Jamaican adolescents is limited.

Adolescents with disabilities (specifically the Deaf), for example, are unable to engage with the system. Even if they approach a service delivery point, access is restricted because of language difficulties and provider attitudes. They are stigmatized and made to feel that: *"You don't have the right to be here" 'what you doing here'.* They cannot engage with the system because, as a participant in the consultation from Jamaica Association for the Deaf observed:

"*The Deaf is unable to 'eaves drop', this is a way that people are able to gain information, this is not so for the Deaf. Providers need to put things in simple language*".

Access, in the opinion of civil society mangers who participated in the consultation, is also limited by service providers' inability to explain complex information and so adolescents are not receiving the best care possible. Many adolescents, therefore, prefer to use the NGO services like, Jamaica AIDS Support for Life (JAS) and Bashy Bus than the MoH services. They feel more comfortable and less threatened using those services.
Adolescents' ability to seek and to reach health services is also hampered by the law. The law does not allow an adolescent who is a legal minor to access HIV testing services without parental permission. Health care providers feel vulnerable and at risk of prosecution and so are guarded against providing testing to unaccompanied adolescents.

Although there are several service delivery points (SDP) from which adolescents can access SRH services, the services available to the adolescent are varied. They may range from programmes that offer training for care providers (NFPB, MoH) to those that provide education and communication for behaviour change among youth, service providers, parents and other adults (MoH, MoE, several NGOs), to those that offer clinical care including counselling, contraceptive commodities and prophylaxis, and treatment and diagnostic services (MoH, FAMPLAN), to policy making (MoE, MoH, MoYC).

Finally, access for the adolescent client may be limited by place of residence (geography). The majority of the SRH services for adolescents and youth are located in the Kingston metropolitan area - rural areas are underserved (Murray et al, 2002). In some rural communities, for example, the MoE Primary and All-age school HFLE programme and MoH Type 1 health centre which offers only basic child health services are the only sources of SRH services for young people. Chambers (nd) also notes that many of the programmes offering SRH information, services and treatment to adolescents do not have national reach and argues that this leads to inconsistency in access to services, especially to minors.

4.1.2. Provider Skills

Health services for adolescents are provided by a cadre of trained professionals – medical doctors, psychiatrists, psychologists, nurse practitioners, public health trained nurses, registered nurses, midwives, community health aides, social workers, counsellors, nutritionists, and others. These professionals would have been trained in accredited programmes offered by recognised institutions.

A survey of the skill set of health providers who serve adolescents in the 7 sites used to pilot test the adolescent health standards was attempted. The response was poor. However, the limited data available revealed that the majority of health care providers who serve adolescent clients in those facilities have had no specific preparation to deal with the adolescent client. In addition, the majority of those health professionals who have some specific preparation to serve the adolescent client, that preparation was gained through their participation in short term in-service training workshops and seminars.

The following (Table 3) is a summary of the skills data reported by 4 of the 7 pilot test sites which responded to the survey. These data highlight a major gap in the preparedness of health care providers to effectively manage their adolescent clients. And, if the requests from health care providers who participated in the recently completed series of MoH training workshops to prepare providers to introduce the adolescent health standards are any indication - providers recognize their lack of proficiency in

managing adolescent clients. They unabashedly request special training to improve their competence in serving adolescent clients

Table 3: Summary Information on Providers' Preparation to Care for Adolescent Clients

Pilot test Site	Provider Skills
Mandeville Health Centre	Eleven members of the health team received special 3-day training in adolescent issues. These included: 3 MD in the curative/STI service, 1 FNP assigned to STI clinic, 2 PHN assigned to the immunization clinic, 1 Nutrition officer assigned in the nutrition clinic and 2 HEO. In addition, 1 PHN who is assigned to the ANC and another in the post-natal clinic and 2 dental health nurses were exposed to 1-day on site in-service training in adolescent health issues.
St. Ann's Bay Health Centre	1 Medical Officer has training in adolescent health; HEOs are trained social workers and in addition have diploma in education (guidance and counselling) and attended special adolescent reproductive health counselling workshop organized by the NFPB. One registered midwife is trained in adolescent reproductive health counselling; 1 PHN attended special workshop on adolescent issues; STI/HIV Contact Investigation certification, BA – Guidance and Counselling, MSc – Counselling and Consulting Psychology, in-service training in adolescent health; and Mental Health Officers all have been introduced to adolescent health in their training and have also continued with workshops.
St. Jago Park Health Centre	No training data provided
UHWI Teen Clinic	The staff complement in the adolescent clinic includes 3 or 4 doctors, 1 PCA, 1 RN and 1 intern – a master-level psychology student. Three staff members - a doctor, RN and PSA – have had training in adolescent service delivery issues.

4.1.3. Laws and Policies

A varied menu of laws and policies guide the provision of health services to the adolescent. They range from the more comprehensive Child Care and Protection Act to specific legislation that deals with one specific health concern – Sexual Offensive Act.

1. **Child Care and Protection Act (2004):** The CCPA is intended to strengthen the legislative framework for the care and protection of children. It provides protection, provision and participation rights for persons under the age of 19 years. Enactment of the Act was Jamaica's response to its commitment under the International Convention on the Rights of the Child (CRC) approved in 1989.

2. **Public Health (Immunization) Regulation 1986:** Requires that all children be immunised against communicable diseases on a schedule determined by the Ministry of Health.

3. **Sexual Offences Act**: The sexual offences act of 2009 was passed in the House of Representatives but is not yet signed into law. The act is an amalgamation of various laws relating to rape, incest and other sexual offences. It will repeal the incest (punishment) act and several

provisions of the offences against the persons act. The bill also provides for the establishment of a sex offenders registry which will maintain a register of sex offenders.

4. Law reform (Age of Majority) Act[12]: states, **"**As from the appointed day a person shall attain the age of majority and be of full age and capacity on attaining the age of eighteen years instead of attaining the age of twenty one years, and any person who, on the appointed day is over the age of eighteen years but under the age of twenty one years, shall be deemed to have attained the age of majority and be of full age and capacity on that day".

5. Health and Family Life Education Policy (Rev 2010): The HFLE policy provides a framework to: ensure consistent and sustained exposure to HFLE for Jamaican children, increase their knowledge, skills, attitudes and behaviours, facilitate the adoption of healthy and productive life styles, and enable them to contribute to a healthy society and prosperous economy.

6. Policy on Access to Contraceptives for Minors: permits the provision of contraceptive counselling and supplies to minors by health care providers// if in the best interest of the child. Providers who in good conscience cannot comply are guided to refer the child to another provider.

7. National Gender Policy: addresses several issues including violence and sexual violence against women and girls. It also seeks to promote gender equality and equity.

8. The Disabilities Act Part VIII Section 35.

4.1.4 Current Quality of Services to Adolescents

Within the health sector, health services for adolescents are provided by a cadre of trained professionals – medical doctors, psychiatrists, psychologists, (family) nurse practitioners, public health trained nurses, registered nurses, midwives, contact investigators, community health aides, social workers, counsellors, nutritionists, dentists and dental nurses and others.

The current quality of the services offered by the MoH in primary care centres and special hospitals that serve adolescent clients was measured in two ways – one objective and the other subjective. The objective measure of quality relied on data generated through the pilot test exercise conducted in the 7 pilot sites. The more subjective rating of quality services was provided by a convenience sample of representatives from Non-government organizations which provide services to special needs adolescents[13].

i. Subjective Measure of Quality Care

Adolescents' experience of the MoH services as reported to NGO providers were recorded for each clinical and non-clinical service offered by the MoH. Each service was rated on a scale of 1-5 where 1 is poor and 5 is excellent (see Attachment 2). The ratings for clinical and non-clinical services are summarized in Table 3.

Dental services were given the highest rating (a rating of 'excellent'). To quote the participants in the consultation:

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[12] www.goj.gov.jm

[13] Adolescents represented at the consultation were: i) those living with HIV; ii) adolescents with disabilities – deaf; adolescents who discontinue their education due to pregnancy; iv) pregnant adolescents, and v) adolescents from poor circumstances.

"Care is terrific" (Participant #1)
"Due to the Special Olympics, our students are able to access treatment at any SERHA clinic" (Participant #2).
"Dental Nurses go into the school to encourage students to attend the clinics for free treatment" (Participant #3).
"University of Technology has a free dental clinic for young people". (Participant #4)

Pharmacy services received the next highest rating – a rating of "4".

The NGO representatives who attended the consultation were not able to rate four of the clinical services – these are: Dermatology, Immunization, Dressing and Surgery. One participant, however, made the following comment concerning Immunization: "*The immunization rate has fallen from 80% to 60% in Jamaica*" (Participant) implying that the quality of the immunization service had deteriorated over the past years[14].

The three pregnancy–related services (antenatal, delivery, and post natal) all, with one exception, received a low score. The exception was the services at the Victoria Jubilee Hospital (VJH) which was given a score of 4 for each of the three service areas.

Table 4: Civil Society Partners Rating of MoH Services Accessed by Adolescent Clients

Service	Rating Scale (1=poor – 5=excellent)
Clinical Services	
Dental	5
Pharmacy	4
Family Planning	3 (weak 3)
Mental health	3
Drug abuse	3
HIV	3
Ante-natal	2
Delivery	2-4
Nutrition	2-3
Post natal	2
STI (not HIV)	2
TB	DK
Dermatology	DK
Immunization	DK
Dressing	DK
Surgery	DK
Non-clinical Services	
Education	3-4
Individual counseling	2
Group counseling	**0**
Record keeping	2-3

[14] In 2011 the Expanded Programme on Immunization (EPI) was awarded the PAHO's Henry Smith cup for excellence in the Caribbean.

One of the positive aspects of pregnancy-related services mentioned during the consultation with NGO providers is the availability of dedicated space for adolescents. They raise the matter of the absence of space devoted to adolescents.

> *"There is no special place for adolescents except in Reproductive health. If an adolescent has a broken leg, they are put on an adult ward.*

She went on to observe:

> *"We have developed a system that does not include adolescents; there are no service providers for that age group".*

Another criticism of the pregnancy-related services is that adolescents' mothers no longer get a Pap smear or contraceptive discussion at their 6 six week postpartum checkup. This is consistent with the harsh criticism leveled a the family planning services. The criticism was on two levels – first, method choice and second, the quality of the counselling provided to the new acceptor.

On the matter of method choice, the observation was that:

> "*They* (adolescents) *get the method but not the one of choice, due to availability or cost - 20% are offered".*

And in the matter of counseling and preparation to use the method given, the observation is that:

> *"They do not have a family planning conversation. Young people need a conversation to enable them to choose. A number of them are "given" the injection, then they have bleeding for 3 months, but because there is no conversation they are not told to expect it, it makes some vomit – sick, so others refuse it as they don't want the 'bleeding thing". No provision is made for young persons to discuss family planning"*

Adolescents are affected by the lack of communication by health care providers; they are disempowered, while the adults who are able to speak up are empowered.

HIV services overall received a 'Good' rating. And although the care in the Mother to Child Transmission programme was thought to be good, it was not sustained, because *"… once you have the baby the care falls apart".*

Adolescents with disabilities who use the health centre services do not have a positive experience. They are treated poorly. The representative from JAD offered the following thoughts to support that contention:

> "*Our clients are discriminated against, saying things like 'what you doing getting pregnant, it's not a right as you are disabled'. The communication lacks sensitivity, quality of service delivery, language is offensive; service providers relates to the mother or aunt of the adolescent. Adolescents feel disempowered"*

The representative went on the say:

> *"We are not expecting all service providers to Sign* (communicate in Sign Language) - *but can we write the questions and the client write the answer? Our clients are unable to adequately access the services. Information shows while writing is not accessible to the blind – the attitude of the staff is poor".*

In terms of mental health services, the following comments were made:

> *"Data tell us how many of our young people have thoughts of suicide, yet there is no referrals, no mental health intervention. Young people are displaying a high level of depression. Children with ADHD are expelled, as are children displaying behavioral problems. The guidance counsellors and teachers agree that the school cannot cope or accommodate these students. The referral process, there is a line; in the meantime these students cannot attend school"* (Participant 1)

> *"For the Deaf student there is the cost and waiting time. The Deaf students often have difficulty getting attention at home and from service providers. University of the West Indies waiting time is long, once they have been seen it could be 2 months before your appointment*" (Participant 2)

Participants in the consultation were asked also to rate three non-clinical services based on the experience of adolescents in their programmes. The services were: education; individual counselling and group counselling. Group counselling was the only service that was given a rating lower than 1. Education services were rated "good" and individual counselling rated "fair". The observation made in support of the low rating was that:

> *"SRH services are failing and ineffective. There is no one, there is no time, and communication is poor".*

ii. Objective Measure of Quality Care to Adolescents: Baseline data from pilot test sites

With guidance from the MoH, a selected number of the 10 Standards and related Criteria were pilot tested in the process that took the form of a small scale version or trial run of the full blown application of the Standards (Polit et al., 2001: 467). The pilot test was carried out in seven facilities selected by the Ministry of Health in collaboration with its partners.

The sites included five public sector health centres (one in each health region and one at Victoria Jubilee Hospital which serves pregnant women from across the island), two quasi-government sites (the UHWI Adolescent clinic and one of the two mobile HIV-testing sites operated by the National Family Planning Board (NFPB). Two of the seven sites (UHWI and VJH) serve adolescents only. All the others serve a general population which includes adolescents. One of the seven sites (NFPB mobile service) provides only HIV counselling, testing and referral, one provides only ante-natal and post-partum services (VJH), the others offer a range of diagnostic, counselling and treatment services.

A baseline audit was conducted at each of the seven sites using a standard audit tool[15]. The audit found that none of the sites was fully compliant on all 20 criteria, all sites were non-compliant on two criteria. Six of the 7 sites were compliant on Criteria 4.6 (STI diagnosis and treatment are provided according to case management guidelines and protocols).

Five sites reported full compliance on three of the 20 criteria.

- Standard 2.3 (Maintaining confidentiality of clients);
- Standard 4.2 (Providers perform physical examinations and investigations according to case management guidelines and protocols) and 4.6 (STI diagnosis and treatment provided according to case management guidelines and protocols), and on
- Standard 8.2 (A system to ensure effective referrals and counter-referrals is used by health providers).

[15] The reader is referred to the for details on methodology for the audit. A copy of the audit tool is attached to this report.

Generally, high levels of non-compliance were observed across sites on the same set of criteria. More than half the sites were doing poorly in respects of 12 of the 20 criteria included in the audit. They are: 1.2; 1.3 (Service availability and accessibility); 2.1; (Policies that support adolescents' rights and responsibilities); 3.1; 3.2 (Multifaceted approach to inform, educate and communicate with adolescents); 4.1 (Adequate support and care for adolescents); 5.1; 5.2 (Adolescent involvement); 6.3 (Effective management of human resources); 7.1; 7.2 (Supportive health facility environment); and 9.6 (Adequacy of supplies).

Table 5: Reported Compliance Levels for Criteria Selected for Baseline Audit in Seven Pilot Sites

Standard	# of Criteria Selected for Testing	Criteria	Compliance Level[16]			
			C	PC	MC	NC
1: Appropriate adolescent health services are available, affordable and accessible.	3 of 6	1.1: A basic package of services is available to meet adolescent general health, sexual and reproductive health, nutrition, mental and dermatological health needs.	2	3	1	1
		1.2: The health centre/facility communicates to the community, the hours, schedule and services available to adolescents.	0	0	0	7
		1.3: The health centre/facility collaborates with relevant community organisations and institutions to proactively promote health care services of adolescent clients, including their sexual and reproductive rights.	1	0	0	6
2: The health centre/facility has policies and processes that support the rights and responsibilities of adolescent clients	3 of 3	2.1: Health centre staff members are aware of the health care rights and responsibilities of all clients including adolescents.	0	0	0	7
		2.2: Adolescents know their own health care rights and responsibilities, including access to sexual and reproductive health care.	2	0	4	1
		2.3: Providers and staff maintain confidentiality of adolescent clients.	4	0	3	0
3: A multi-faceted approach is used to inform, educate and communicate with adolescents	2 of 2	3.1: Accurate culturally appropriate and simple information and education materials addressing adolescent information needs are available and displayed at the health centre/ facility.	0	0	1	6
		3.2: Health care workers and adolescents disseminate information at the health centre/facility and within the community.	3	0	0	4

[16] 95% or more – compliant; 85% - 94% - partial compliance; 75% -84% - minimal compliance; 74% or less - non-compliant

Standard	# of Criteria Selected for Testing	Criteria	Compliance Level[16]			
			C	PC	MC	NC
regarding their health						
4: Adolescents receive an adequate psychosocial and physical assessment and are provided individualized, holistic care sheets, intake forms and interviews.	4 of 6	4.1: Health centre/facility providers conduct a holistic assessment of adolescents, including an appropriate history using intake forms and interviews.	3	0	0	4
		4.2: Providers perform appropriate physical examinations and investigations according to case management guidelines/ protocols.	5	0	0	2
		4.5: Assessments are undertaken with consideration to the dignity, comfort and modesty of the adolescent.	1	0	1	5
		4.6: STI diagnosis and treatment are provided according to case management guidelines and protocols.	6	0	0	1
5: Adolescents are actively involved in design, implementation and improvement of adolescent health care services in the health centre/ facility and its target community	2 of 2	5.1: The health centre/ Facility has a functioning adolescent advisory group, or adolescent representative on a health committee.	1	0	0	6
		5.2: Adolescents participate in the delivery of information, education and services.	1	0	0	6
6: Human resources are effectively managed for effective and efficient delivery of adolescent-friendly health care.	2 of 3	6.2: A system exists to assure that all health centre/facility staff receives orientation and regular training or learning opportunities, to ensure effective delivery of adolescent health care.	0	1	5	1
		6.3: All staff receives supervisory support on an ongoing basis, to ensure the provision of quality adolescent health care.	1	0	0	6
7: The health centre/ facility	2 of 3	7.1: The health centre is clean, comfortable and with basic amenities.	1	0	2	4

Standard	# of Criteria Selected for Testing	Criteria	Compliance Level[16]			
			C	PC	MC	NC
has a supportive environment conducive to the provision of adolescent-friendly health services.		7.2: Privacy is maintained during consultation, exam and procedures.	2	0	0	5
8: The health centre provides continuity of care for adolescent clients.	1 of 4		5	0	0	2
9: The health centre/facility has appropriate and sufficient drugs, contraceptives, supplies and equipment necessary to provide the basis health care service package for adolescents.	1 of 6	9.6: Adequate staff for managing health care to adolescents available	1	0	1	5

The question is, which of the pilot sites are providing the better quality care? When the overall compliance was computed as a percentage of the number of criteria being assessed, important differences in the quality of care being provided currently to adolescent clients was found between the test sites. Although there is clear need for improvement across all the test sites, data in Figure 3 indicate that currently the Mandeville clinic is offering better quality care than the other pilot sites. Mandeville with compliance on 50% of the 20 criteria is followed by St. Ann's Bay Health Centre with compliance on 35% of the 20 criteria and University Hospital Teen Clinic with compliance on one third of the required criteria.

4.2 Future Objectives: What Should be

As stated before, Healthy People, Healthy Environment" is the vision of the Ministry of Health. That vision is of " … a health system that is client-centred and one that guarantees access to quality health care for every Jamaican, at reasonable costs, and which takes into account the needs of the vulnerable". The official

Ministry of Health Approved Standards of Care for Adolescent Health

1. Appropriate adolescent health services that are available, affordable, and accessible

2. The health facility has policies and processes that support the rights and responsibilities of adolescent clients.

3. A multi-faceted approach used to inform, educate, and communicate with adolescents regarding their health

4. Adolescents receive adequate psychosocial and physical assessments and are provided with individualised, holistic care according to standard case management guidelines and protocols.

5. Adolescents actively involved in the design, implementation and improvement of adolescent health care services in the health centre and its target community.

6. Human resources are effectively managed for effective and efficient delivery of adolescent-friendly health care.

7. The health facility has a supportive environment that is clean, safe, attractive, comfortable and private, and is conducive to the provision of adolescent-friendly health services.

8. The health facility provides continuity of care for adolescent clients

9. The health facility has appropriate and sufficient drugs, contraceptives, supplies, and equipment to provide basic reproductive health care service packages for adolescents.

10. Management and information systems are in place to lead, support, evaluate and improve the provision of adolescent health care services.

mandate of the Ministry of Health then is "to ensure the provision of quality health services and to promote healthy lifestyles and environmental practices".

Ten standards (and their related criteria) were developed for assuring quality health care for adolescent clients. Development of these standards took account of eight dimensions of quality identified in the health services literature. The dimensions are:

1. Technical performance
2. Effectiveness of care
3. Efficiency
4. Safety
5. Access to services
6. Interpersonal relations
7. Physical infrastructure and comfort
8. Youth and community involvement

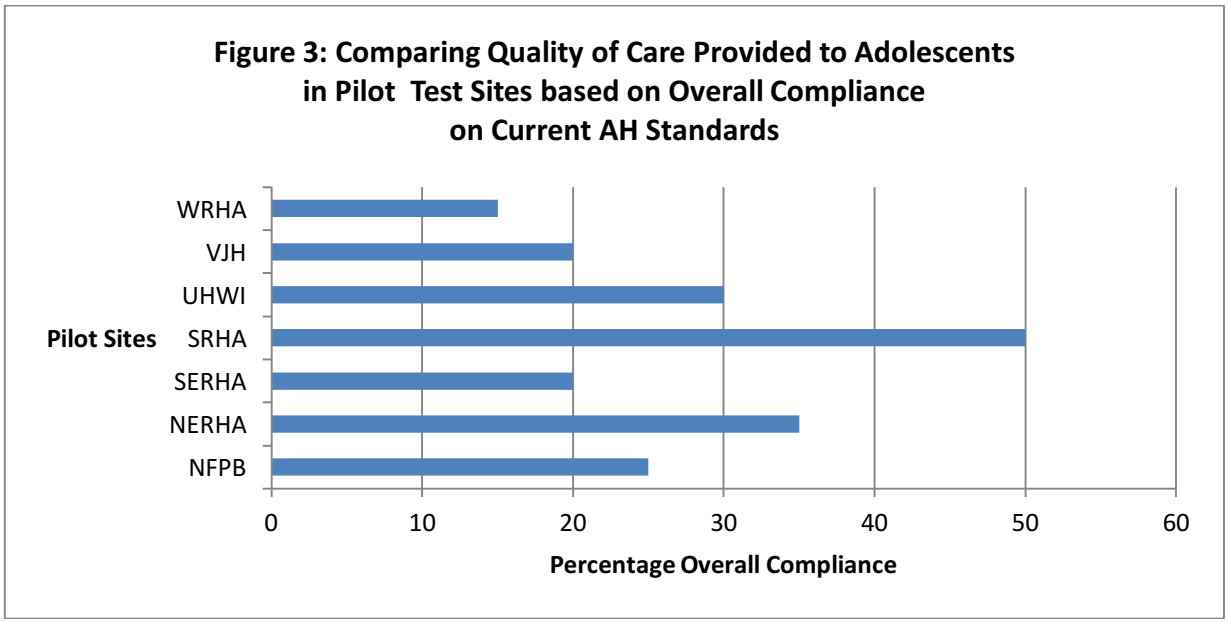
The baseline audit conducted in 7 plot test sites and two additional roll out sites indicates that the services are not where they should be in terms of quality care. Having completed analysis of the audit data, each site implementation team, guided by the consultant, discussed the findings with their team and other key individuals at the facility and developed a quality improvement plan to address the deficiencies identified in the audit. At the end of December 2015, all but one test site had developed a quality improvement plan and some test sites had moved forward to implement their plans.

The following is a list of the quality improvement actions proposed by the test site-based implementation teams.

- Signage (post signs, refresh signs re hours of operation, etc.)
- Physical space (enhance by painting, installing water coolers, etc.)
- Charter of Rights (display prominently)
- IEC material (source and display)
- Adolescent health committees (establish with TORs).
- Capacity building (Train health care providers (in adolescent health care)
- Continuity of care (improve/ establish links with CBO)

In terms of the legislative framework that supports adolescent health service delivery: there was wide agreement by health care providers that something be done to allow them to provide care and services without fear of legal sanctions. If nothing else, there needs to be an attempt to address the stark consistencies in how key terms and populations are

defined in the laws and policies that guide service delivery to adolescent clients. If such consistency is achieved, several of the present barriers to adolescents' access to services will be removed. Adolescent clients will be better able to seek, to reach, and to engage with the system (Levesque el al, 2013).



4.3. What are the Gaps?

Conceptually, this analysis focused on three issues associated with adolescent health service delivery – provider competence, the legal and policy framework and service provision and quality

In terms of provider skills, the data indicate a glaring skills gap for providers of care to adolescents. An unacceptably large number of providers have no preparation in adolescent issues. In addition to poor competence in dealing with adolescents and their issues, there appears to be an inability to communicate in simple terms to the adolescent.

A recent review of the law and policy framework for adolescent sexual and reproductive health[17] lists the following gaps.

- The difference between the age of majority (18 years of age) and the age at which adolescents can consent to sexual intercourse and medical procedures (16 years of age).
- The absence of a comprehensive policy position on adolescent sexual and reproductive health (ASRH). The author reported that there is no single policy position on the sexual and reproductive

[17]Tania Chambers for UNFPA. The Law and Policy Framework for Adolescent Sexual and Reproductive Health (ASRH) in Jamaica: A rights-based approach to assessing ASRH issues in Jamaican Law and Policy.

health rights of adolescents. This gap, she argues, leads to inconsistencies in the way different agencies, including the Ministry of Health, treat adolescents' right to information and services.

- Contradictory approaches in the Child Protection law vs Health Policy. Chambers observes that health policy aims to prevent high risk sexual activity among minors while the child protection law aims to prevent ANY sexual activity among minors. This difference, she contends, often puts the health professional at odds with child protection law especially when they (the provider) provide contraceptives to persons who are below the age of consent for sex (age 16 years).
- Lack of psycho-sexual support for adolescent victims and perpetrators of sexual offences

The law has contributed to limiting access to services for some adolescents in need. One NGO provider noted:

> " … a*n adolescent is not able to walk into a health facility and ask for treatment without an adult. We have created a dilemma! The child has a right to care! We signed the Convention on the Rights of the Child and we should be promoting it"*

Also:

> *"Adolescents can't be tested without parental permission; Hospital staff is at risk of prosecution and are guarded against providing testing to unaccompanied adolescents. Adolescents are not receiving the best care"*.

Another NGO provider stated the following as evidence of the inconsistency presented by the legal framework:

> *"A teen mother is unable to apply for PATH- the grand mother has to be the one that applies; adolescents are NOT seen as a group".*

Taken together, the gaps in provider competence and in the legal and policy framework identified in the study work against (conspire) the provision of quality services for all adolescents – thus limiting access to care for many adolescents.

The WHO recommends that providers of care to adolescent clients should have three sets of competencies (WHO, 2015). First, providers of adolescent health care require specialized skills in consultation, interpersonal communication and interdisciplinary care "appropriate to the developmental phase and context of the individual". This implies competence in "confidentiality, integrated health risk assessment, motivational and cognitive approaches to counselling and care in the transition from paediatric to adult care".

Second, the provider should be able to apply clinical practice laws and policies that promote, protect and fulfill adolescents' right to health in a manner that is consistent with human rights principles of equity, non-discrimination, participation and inclusion, and accountability. This represents what WHO refers to as Domain 2: Laws, policies and quality standards. Competencies in Domains 1 and 2 are crosscutting and should not be limited to any particular clinical condition.

The third set of recommended competencies is "linked to the effective management of an adolescent client in specific clinical situations" in what WHO defines as "Domain 3: Clinical care of adolescents with specific conditions".

These recommendations clearly indicate that a health care provider who works with the adolescent client needs to be proficient in the clinical areas but also in the so called 'soft skills".

Analysing the Gaps

In analyzing the gaps, the challenging question is not how far actual performance of the Ministry of Health in its service to adolescents falls below target, but why the gap exists. Brainstorm sessions with adolescents and with non-government agency directors who interact with adolescents and with the health service system generated a list of possible causes of poor performance. These causes were narrowed down using "Five-why" analysis technique[18] an iterative interrogative technique used to explore the cause-and-effect and that focuses attention on the root cause – not the symptom.

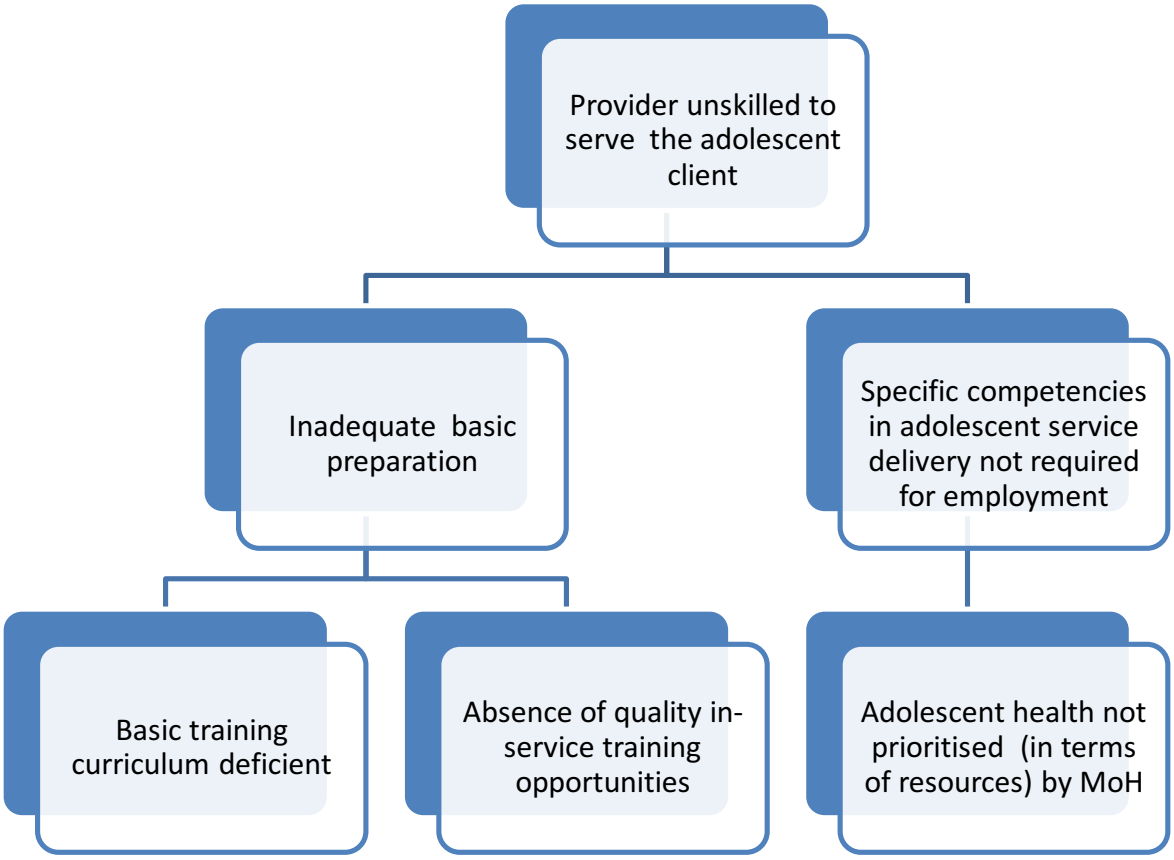


Figure 4: Possible Reasons for Poor Provider Skills in Adolescent Service Delivery

When this analysis is applied to the problem of poor provider skills to manage the adolescent client, the results are as shown in Figure 4. What is suggested by this analysis is that the way to make changes in the present system and to improve the skill levels of adolescent service providers is to make adjustments to the

[18] http://www.educational-business-articles.com/5-whys/

basic training curricula as well as in-service education programmes for care providers and to the recruitment criteria and position descriptions of new hires. These changes will require strategic re-allocation of human and financial resources.

When Five-Why analysis was applied to the problems related to the legislative framework, the same set of results emerged. A simplified version of the results is shown in Figure 5. The bottom line appears to be that because health care providers and law enforcement entities have different perspectives – one on enforcing the law, the other from a perspective of preventing or curing disease – they come to the problem from different perspectives. There is tension between these two perspectives and that tension is reflected in legislation. The challenge is how to minimize that tension so that legislation can be drafted that accommodates the two perspectives.

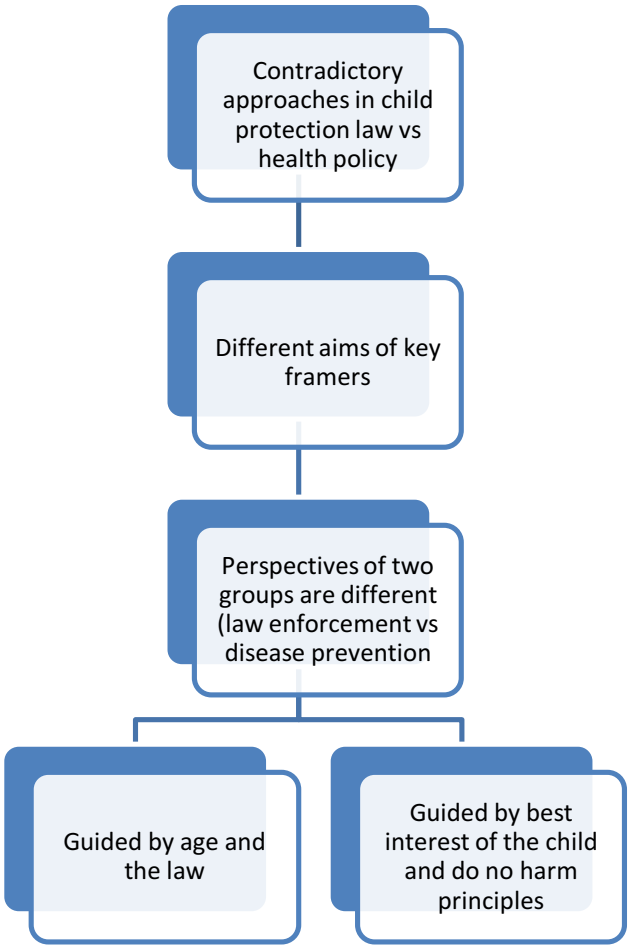


Figure 5: Possible Reasons for Contradictions in Legal and Policy Framework for Adolescent Health

5. CONCLUSION AND RECOMMENDATIONS

What is needed to achieve the goal of the national strategic plan for pre-adolescent and adolescent health and development? A focus on quality care as desired by the MoH should be adequate. Quality care contributes to Client Satisfaction should result in Improved compliance which results in Improved health outcomes for the client and ultimately in health system that shows positive results.

Based on the research reported here, that quality of care for adolescents can be achieved if there are improvements in provider competence and if the legal and policy framework is made less contradictory. Given the gaps identified, what steps should the MoH take in order to move from the current situation to its desired state? The following recommendations are being made based on the analysis of the gaps. These recommendations fall into two categories – i) recommendations that should be effected as soon as possible and ii) recommendations given a longer implementation time line.

1. Capacity building using two approaches simultaneously

The United Nations Development Programme defines capacity as "the ability to perform functions, solve problems, and achieve objectives" at three levels: individual, institutional and societal. Capacity building has typically been defined as the development and strengthening of human and institutional resources. But the process should go beyond the public sector to include private sector and Nongovernmental Organizations (NGO)/ civil society organization (CSO)

There are several NGOs which can and should be engaged to support the MoH in its delivery of services to adolescents and especially to meet quality standards 1 (1.3); 2 (2.2); 3 (3.2); and 5 (5.1.and 5.2). To that

end, we recommend using two capacity building approaches – partnerships and community development. Both of these are suggested as ways of using the technical resources of the NGO/CSO in the one instance, and the empowerment of adolescents with special needs in the other.

1.1 **Partnerships to support service delivery (non-clinical)**

There is no one model for partnership building. The model adopted by the parties must be mutually agreed and will be dependent on the reason for the partnership, the resource exchange that is agreed on, and the expected nature of the relationship. We recommend that the Ministry of Health:

- Explore avenues for partnership(s) with NGO entities that have a desire to partner and work towards solutions and are willing to support the Ministry's work especially in education, counselling, sensitivity training for members of the health team and interpreting – including virtual interpreter support.
- Ensure that clear Memoranda of Understanding are in place to guide the partnership arrangements.

1.2 Community Organising – focus on adolescents with special needs:

This is an ambitious approach to community development that if effectively implemented raises people's knowledge, awareness and skills to use their own capacity and that from available support systems, to resolve the more underlying causes of difficulties they are experiencing. Through this approach adolescents with special needs (those with a disability, those living with HIV, etc.) can better understand how to make decisions and to communicate more effectively at different levels with the health system; and develop a sense of confidence to manage their own destinies.

Recommend that:

- The MoH, through the Health Education and Health Promotion Officers seek to establish partnerships with NGOs/ CVOs that have established relationships or that work with adolescents with special needs.
- The MoH together with the partner NGO/CSO plan and conduct client empowerment education workshops/sessions that focus on building self confidence, decision making, effective communication as well as common adolescent health issues.

2. Training for health care providers

2.1 Training for providers currently employed

Even though the MoH has begun the process to improve provider competence to serve the adolescent populations, the research has highlighted the need for better qualified (technically competent and empathetic) health care providers. Already, the MoH has exposed some 475 public sector health care professionals to training that should assist them in supporting the adoption of the adolescent health standards.

Training and preparing health care providers is a long term undertaking but we recommend that in the short term the MoH initiate plans to improve the competence of providers currently in the system. In that regard we recommend:

- The Family Health Unit review the content and material delivered in adolescent health training workshops conducted by the Unit over the past 2 years;

- Repackage the material for delivery to other groups of care providers who have direct contact with adolescent clients and;
- Identify resources to deliver the programme in a series of 1 or 2 day workshops or seminars.

2.2 Training for future employees

The plan to get all health care providers who work with adolescents competent to do their tasks is a longer term plan. However, the MoH can initiate plans to assure the competence of future providers. In that regard we recommend that the MoH:

- Conduct a review of curricula of health professional colleges and schools to determine the course content required for matriculation in each discipline;
- Consult with professional colleges, starting with nursing, midwifery and counselling in the first instance and later expanding the professional mix) to explore the possibility of modifying their matriculation requirements to accommodate inclusion of adolescent health development components;
- Establish partnerships with these institutions to develop adolescent health and development curricula that reflect the guidance provided by the WHO regarding the expected competencies of an adolescent care provider;
- Consult with the Human Resource Division to draft position descriptions for new hires in adolescent health and development.

3. Legal and policy framework

3.1 Immediate action recommended

The analysis indicates, and anecdotally there is a vast body of evidence, that the current situation with laws, especially those pertaining to the delivery of sexual and reproductive health related services to the adolescent, inhibit access and ultimately negatively impacts the health status of the individual adolescent as well as the community as a whole.

The MoH has begun a process to modify the existing law to allow access to treatment and care for young adolescents who may not attend with an adult (parent or guardian). That process appears to be well advanced. We recommend that the MoH:

- Continue the process and take whatever action is necessary to accelerate the process.

3.2 Longer term action required

Any effort to adjust perspectives requires investments of time and other resources. The Five-Why analysis of the problem with the legislative environment indicated that the challenges with the laws associated with service delivery to the adolescent revolve around the difference in perspectives of members of the health care and the law enforcement communities. We recommend that the MoH consider implementing two approaches to addressing the problem:

- Public education that targets law enforcement; and
- Advocacy: Explore partnering with adolescent and youth advocacy groups and agencies to design and implement a comprehensive advocacy programme that includes the strategic use of social media and of trained individuals to serve as Champions.

REFERENCES

Bailey, A. 2011. The Jamaican Adolescent's Perspective on Violence and its Effects, West Indian Med J 2011; 60 (2): 165

Borhani, M, et al. Effects of predisposing, reinforcing and enabling factors on self-care behaviors of the patients with diabetes mellitus in the Minoodasht city, Iran. J Diabetes Metab Disord. 2015; 14: 27.

Coore, C. 2008. "Life-events and post-traumatic stress in a sample of inner-city Jamaican children." Promoting Child Rights Through Research (Edited by A. Henry-Lee and J. Meeks-Gardner). Vol 1. Jamaica: Social and Economic Studies, University of the West Indies, Mona.

Daniels N: Equity of Access to health care: some conceptual and ethical issues. Milbank Mem Fund Q. 1982, 60: 51-81. 10.2307/3349700.

Delany-Moretlwe, S, Cowan, FM, Busza, J, Bolton-Moore, C, Kelley, K,and Fairlie, L. Providing comprehensive health services for young key populations: needs, barriers and gaps. J Int AIDS Soc. 2015; 18(2Suppl 1): 19833.Published online 2015 Feb 26. doi: 10.7448/IAS.

Fox K and Gordon-Strachan G. Jamaica Youth Risk and Resiliency Survey 2005 USAID/MEASURE.

Goldman, R. E., Barbeau, E, Hunt, MK et al. 2008. Perceptions of health promotion and cancer prevention among adults in working-class occupations and neighborhoods. *Health Education and Behavior* 35.6: 777–790.

Gulliford M, Figueroa-Munoz J, Morgan M, Hughes D, Gibson B, Beech R, Hudson M. What does 'access to health care' mean? J Health Serv Res Policy. 2002 Jul;7(3):186-8.

Haddad S, Mohindra K: Access, opportunities and communities: Ingredients for health equity in the South. Paper presented at the Public Health and International Justice Workshop. 2002, New York: Carnegie Council on Ethics and International Affairs.

Jonathan D. Klein, Marjorie J. Allan, Arthur B. Elster, David Stevens, Christopher Cox, Viking A. Hedberg, Rita A. Goodman. Pediatrics; February 2001, Volume 107 / Issue 2.Improving Adolescent Preventive Care in Community Health Centers.

Levesque, J-F, Harris, MF and Russell, G. 2013. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health 2013, 12:18 http://www.equityhealthj.com/content/12/1/18

Martha M, Anderson R, Funnell M. Using the empowerment approach to help patients change behavior. Clin Diabetes J. 2004: 22(3):123–7. doi: 10.2337/diaclin.22.3.123.

Meeks Gardner, J, Thomas J, & Khan, O. 2008. Reports of Gangs in Jamaican Schools.

Murray, N. et al. 2002. Adolescent and youth–serving organization in Jamaica: Results from the Youth Programmatic Inventory Survey of the National Centre for Youth Development. NCYD/Ministry of Education.

Penchansky R, Thomas WJ: The concept of access: definition and relationship to consumer satisfaction. Med Care. 1981, 19: 127-140. 10.1097/00005650-198102000-00001.

Ramirez, A. G., P. Chalela, K. Gallion, and L. F. Velez. 2007. Energy balance feasibility study for Latinas in Texas: A qualitative assessment. *Preventing Chronic Disease* 4.4.

Reza, S Al, et al. The association of predisposing and enabling factors on nutritional status in children. Volume: 03 Issue: 06 | Jun-2014, Available @ http://www.ijret.org

Samms-Vaughn, M. et al. 2005. Urban Jamaican children's exposure to community violence. West Indian Medical Journal 54, no. 1: 14-21.

Shengelia B, Murray CJL, Adams OB: Beyond access and utilization: defining and measuring health system coverage. Health Systems Performance Assessment: Debates, methods and empiricism. Edited by: Murray CJL, Evans DB. 2003, Geneva: World Health Organization, 221-234.

Wilks, R. et al. 2008. Jamaica health and lifestyle survey 2007-8: Findings at a glance. Epidemiology Research Unit, Tropical Medicine Research Institute, University of the West Indies.

Wilkes, R. et al. 2007. Jamaica youth risk and resiliency behaviour survey 2006: A baseline community-based survey of youth Aged 15-19. Final report.

Wilks R, Younger N, McFarlane S, Francis D, Van Den Broeck J. Jamaica Youth Risk and Resiliency Behaviour Survey 2006 USAID/MEASURE/ Ministry of Health.

World Health Organization, 2015. Core competencies in adolescent health and development for Primary care providers: Including a tool to assess the adolescent health and development component in pre-service Education of health-care providers. WHO.

Attachment 1

Consultation on Quality of Adolescent Health Services
with
Non-Government Organisation Providers of Services to Adolescents
August 27, 2015

Board Room of the National Family Planning Board
Sylvan Avenue, Kingston 5

AGENDA

9:30	Registration
9:45	Welcome and Introductions
9:50	Opening Remarks
	Setting the stage – Objectives of the Consultation
10:00	Activity 1: Participants complete Questionnaire
10:10	Activity 2: Large group discussion based on survey results
10:40	Summary of large group discussion
10:45	Activity 3: Small group discussion – What are the service gaps? How to fill them given resource limitations?
11:15	Reports from small groups
11:25	Summary and Recommendations
11: 30	Wrap up.

Consultation Purpose and Objectives

Purpose: Highlight, from NGO providers' perspective, the challenges adolescents experience in accessing health services from the Ministry of Health facilities and suggest ways of eliminating or mitigating the challenges.

Objectives:

1. Rate the quality of clinical and non-clinical services provided to adolescents in public health facilities;
2. Document concerns about the quality of health services provided to adolescents;
3. Identify gaps in health services available to adolescents; and
4. Suggest solutions to the 'gap' problem.

Attachment 2

Questionnaire

1. Agency: _____

2. Using the **Rating Sheet** below, please rate **(Circle the number)** the quality of services provided in Ministry of Health facilities to adolescents. Base your rating on information you have received from the adolescents you serve.

Rating Sheet

Service Areas	Rating					
	1 (poor)	2	3	4	5 (excellent)	Can't say
Clinical Services						
Ante-natal	1	2	3	4	5	6
Delivery	1	2	3	4	5	6
Post natal	1	2	3	4	5	6
STI (not HIV)	1	2	3	4	5	6
HIV	1	2	3	4	5	6
TB	1	2	3	4	5	6
Family Planning	1	2	3	4	5	6
Mental health	1	2	3	4	5	6
Drug abuse	1	2	3	4	5	6
Dental	1	2	3	4	5	6
Dermatology	1	2	3	4	5	6
Nutrition	1	2	3	4	5	6
Immunization	1	2	3	4	5	6
Dressing	1	2	3	4	5	6
Surgery	1	2	3	4	5	6
Pharmacy	1	2	3	4	5	6
Non-clinical Services						
Education	1	2	3	4	5	6
Individual counseling	1	2	3	4	5	6
Group counseling	1	2	3	4	5	6
Record keeping	1	2	3	4	5	6

Attachment 3

ADOLESCENT HEALTH STANDARDS & CRITERIA PILOT

AUDIT TOOL

Name of Facility: _____

Address: _____

_____

Contact Person/ Auditee

Name: _____

Title: _____

Telephone: _____ Email: _____

Date of Audit: _____

Time of Audit: _____

Start time: _____ End Time: _____

Audit Team:

Team Leader:

Name: _____ Signature: _____

Other Audit Team members

Name: _____ Signature: _____

Name: _____ Signature: _____

Name: _____ Signature: _____

Auditee Team:

Team Leader: Name: _____ Signature: _____

Attendance at Opening and Closing Meetings

Name	**Title**	Present (Yes/No)	
		Opening meeting	Closing meeting

GLOSSARY

EI	Exit Interview
FGD	Focus group discussion
I	Interview
KII	Key Informant Interview
NA	Not applicable
Obs	Observation
RA	Record Audit
S	Survey

SCORING

Assess the level of compliance for each Module separately using the following formula.

$$\frac{\text{Total Yes}}{\text{Total Yes + No}} \times 100$$

Level of Compliance

95% or higher	Compliant
85% - 94%	Partial compliance
75% - 84%	Minimal compliance
74% or below	Non-compliant

Prepare a Corrective Action Report for the Standards/ Modules on which the centre or facility is judged Partial compliant or Minimal compliant or non-Compliant.

ADOLESCENT HEALTH STANDARDS & CRITERIA PILOT

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
Standard 1. 1: A basic package of services is available to meet adolescent general health, sexual and reproductive health, nutrition mental and dermatological health needs.			
1. The following services are actively provided or an appropriate (xxx) referral is available:	KII with validation		
i) Syndromic management of sexually transmitted infections			
ii) HIV voluntary counselling and testing			
iii) Nutrition			
iv) Contraceptive information, counseling (at a minimum condoms , low dose oral contraceptives [OC's] and emergency contraception)			
v) Pregnancy (testing, antenatal, intra natal [where relevant] and postnatal care)			
vi) Dental health			
vii) Mental health			
viii) Information and counselling for other health care and social issues such as			

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
relationships, parent-child communication, partner communication, violence , abuse, nutrition and mental health issues			
2. Does the health centre/ facility have a link with a community based organization or public sector facility that offers home based care for adolescents living with HIV?	KII with validation		
3. Does the health centre/ facility staff support and promote sexual abstinence among adolescents?	KII		
4. Does the health centre/facility actively promote dual method use for sexually active adolescents (e.g. condoms and contraceptives)?	KII with EI for validation		
Total Yes = **Total Yes + No** = **Level of compliance** =			
1.2 The health centre communicates to the community, the hours, schedule and services available to adolescents.			
1. Are clear signs located in the front of the centre/facility indicating hours, schedule and available services for youth?	Obs		

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
2. Are signs indicating schedule and scope of adolescent services posted in key areas of the community?	Obs		
3. Are all services available to adolescents whenever they request them?	KII		
5. Are adolescents aware of the services available to them? [immunization, dental health, mental health, education & counselling, nutrition counselling, antenatal, post natal, family planning, curative, etc.]	EI – speak with 5-10 adolescents (10-19) as they leave the facility: ask: What services are available for young people in your age group?		
Total Yes = **Total Yes + No =** **Level of compliance =**			
1.3 The health centre collaborates with relevant community organizations and institutions to proactively promote health care services of adolescent clients, including their sexual and reproductive rights.			
1. Has the centreconducted or participated in outreach to sensitize the community about providing RH services to adolescents?	KII – Facility manager or health promotion officer		
2. Has the centre done outreach to build community support for providing RH services to adolescents?	KII – Facility manager or health promotion officer		

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
3. Did the centre develop partnerships with the community organization (Schools, NGO's) to promote and provide adolescent services?	KII – Facility manager or health promotion officer		
4. Do health providers discuss patient (adolescent) rights to health care when making community/school outreach and health talks?	I – Facility manager or Health Promotion Officer.		
5. Are activities conducted outside the centre to promote services to adolescents in the community?	I – Facility manager or Health Promotion Officer		
Total Yes = **Total Yes+No** = **Level of compliance** =			
Standard 2.1: Health centre staff members are aware of the health care rights and responsibilities of all clients including adolescents.			
1. Is the Clients' Charter of Rights displayed in locations that are easily seen by clients?	Obs		
2. Are all staff (technical) members informed of clients' rights, including all new staff during orientation?	KII - Facility manager		
7. Are there systems in place to ensure staff is regularly given policy updates made by the MoH in relation to the rights	KII - Facility manager		

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
of adolescent clients to services?			
10. Are adolescents included in adolescent health decision/policy-making activities?	KII - Facility manager with validation (record)		
Total Yes = **Total Yes + No =** **Level of compliance =**			
Standard 2.2: Adolescents know their own health care rights and responsibilities especially during their first visit to the health centre as is appropriate for the reason of the visit?			
1. Do health care providers inform adolescents about their clients' rights and responsibilities especially during their first visit to the health centre, or as is appropriate for the reason of the visit?	Obs - client/provider interaction for 1st visit clients only (and) I - with adolescent Ask: Did anyone at the health centre/ facility tell you about your rights today or any other time that you visited the clinic/ facility?		
4.Do health care providers inform adolescents of MoH policies e.g. contact tracing of STI cases?			
i. Contact tracing of STI cases			
ii. Prevention of mother to child HIV infection			

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
iii. Immunization			
iv. Contraceptives for minors			
v. Dental screening for students			
Total Yes = **Total Yes + No =** **Level of compliance =**			
Standard 2.3: Providers and staff maintain confidentiality of adolescent clients			
5. Is confidentiality maintained during registration and docketing?	Obs		
7. Does the health centre have a system to maintain the confidentiality of diagnostic test (HIV, pregnancy, etc.) results?	KII – Contact Investigator or Facility manager		
8. Are clients records kept so that the confidentiality of the adolescent is maintained?	Obs.		
9. Is confidentiality ensured when client records are disposed of?	I – with Records manager		
Total Yes + **Total Yes + No =** **Level of compliance =**			
Standard 3.1Accurate culturally appropriate, and simple information, and educational materials addressing adolescent information needs are available and displayed at the health centre.			
1. Does the health centre/ facility have IEC materials on HIV/AIDS, STI, contraception and abstinence?	Obs.		
2. Does the health centre/ facility have information material for persons with disabilities (e.g. blind, deaf, intellectual disability)	Obs.		

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
3. Are adolescents involved in the selection of IEC/BCC materials?	KII - Health promotion/ education personnel		
4. Are adolescents involved in the development of health specific health promotion materials?	KII		
5. Does the health centre have IEC materials regarding healthy lifestyles e.g. risky behaviors, nutrition, exercise, body awareness and substance abuse?	KII		
6.			
7. Are educational materials available for distribution to adolescents (that adolescents can take away from the centre/facility)?	Obs KII		
8. Is some form of participatory education/ entertainment provided at the health centre/ facility, such as role plays, group talks, rap sessions, videos, skits, etc.?			
9. Have all IEC materials been in stock (without stock outs) in the past six months?	KII (Health Education/ Promotion officer)		
Total Yes = **Total Yes + No** = **Level of compliance** =			
Standard 3.2Health care workers and adolescents (e.g. peer educators) disseminate information at the health centre and within the community			
2. Do health care providers use IEC during consultations or talks?	Obs		

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
3.			
4. Are adolescents involved in providing education and information at school and in the community (e.g. peer educators)?	Interview adolescent		
5. Are health centre staff involved in outreach activities (e.g. workshops, health fairs, community events) in the community?	KII–Health Education/ Promotion Officer		
Total Yes = **Total Yes + No =** **Level of compliance =**			
Standard 4.1 Health centre/ facility providers conduct a holistic assessment of adolescents, including an appropriate history using intake forms and interviews.			
1. Is the intake form relevant to the service requested, filled out completely?	Obs RA		
2. Is the recommended psycho social history taken? Information on: • Who lives in home /household composition • Education/ School status • Employment status/ income sources • Relationship status (married, has boy/girlfriend, has no boy/girlfriend) • Number of children (ages, relationship with father, etc.) • Whether individual passed the mental health test?			
Total Yes =			

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
Total Yes + No = **Level of compliance =**			
Standard 4.2 Providers perform appropriate physical examinations and investigation according to case management guidelines/ protocols			
1. Are current case management guidelines for basic reproductive health services available in the health centre/ facility			
i) National family planning guidelines	Obs		
ii) Practical case management of common STI syndromes			
2. Are current case management guidelines for primary health care management of:			
i) Violence/ sexual abuse/ incest	Obs		
ii) Mental health problems			
iii) Drug/alcohol abuse			
iv) Nutrition			
v) Pregnancy			
Total Yes = **Total Yes + No =** **Level of compliance =**			
Standard 4.5 Assessments are undertaken with consideration to the dignity, comfort, and modesty of the adolescent (see privacy q -6.1,2			
1. Has an effort been made to plan and provide services based on the most convenient time for adolescents?	Survey of adolescent users/ observation of clinic schedules. Ask any 5-10 adolescents in the health facility on the day of the		

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
	audit visit: Has anyone ever consulted you regarding your preference for service times?		
2. Has an effort been made to provide services mindful of the physical needs (disabilities) of the adolescents.	Obs KII (facility manager)		
3. Are there screens or a changing room for the adolescent to undress in privacy/ without being watched or does the doctor leave the room until the patient is undressed	Obs		
4. Do health care providers give detailed explanations for required examinations, e.g. what will be done, what to expect, what is needed?	Obsof provider/client interaction		
5. Is ascent/informed consent received and form signed before the consultation begins?	Record audit		
6. Is a chaperone always be present (e.g. male doctor plus female nurse or female family member) when treating female patients, or a male relative when treating a male patient (according to patient's preference)	Obs Interview with adolescent		
Total Yes = **Total Yes + No =** **Level of compliance =**			

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
Standard 4.6 STI diagnosis and treatment are provided according to case management guidelines and protocol.			
Is syndromic management of STI's provided at the centre for adolescents according to case management guidelines	KII Validation using client records		
Total Yes = **Total Yes + No** = **Level of compliance** =			
Standard 5 Adolescents are actively involved in design, implementation, and improvement of adolescent health care services in the health centre and its target community			
5.1 The health centre has a functioning adolescent advisory group, or adolescent representative on a community health committee.			
1. Are at least 40% of health committee members' adolescents?	KII Validation required		
2. Does the advisory group or health committee meet on a regular basis (e.g. at least every two months)?	KII Record (minutes) review		
3. Does the advisory group or health committee actively participate in the development, implementation and evaluation of adolescent-focused services?	KII Validation required		
Total Yes = **Total Yes + No** = **Level of compliance** =			

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
Standard 5.2 Adolescents participate in the delivery of information, education and services.			
1. Are young people actively involved in the design and delivery of adolescent services?			
2. Are young people actively involved in the dissemination of information to the community?			
Total Yes = **Total Yes + No =** **Level of compliance =**			
Standard 6.2 A system exists to assure that all health centre/ facility staff receives orientation and regular training, or learning opportunities, to ensure effective delivery of adolescent health care.			
1. Have staff identified training needs necessary to deliver quality health care to adolescents?	KII (senior supervisory staff)		
2. Is there a plan to address training needs?	KII		
3. Does the health centre/ facility partner with other organizations to build staff skills and expertise?	KII Validation		
4. Doesthe health centre/ facility have health care providers trained in all aspects of basic health care services?	KII Validation required		
i) Syndromic management of STI's			

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
ii) Voluntary counseling and testing for HIV			
iii) Contraceptive information, counseling, and provision			
iv) Pregnancy testing and counseling			
v) Antenatal and postnatal care			
vi) Referral			
vii) Nutrition			
viii) Dental Health			
5. Does the health facility have ongoing activities to prepare and strengthen staff members as adolescent friendly providers?	KII Validation required		
Total Yes = **Total Yes + No** = **Level of compliance** =			
Standard 6.3 All staff receive supervisory support on an ongoing basis, to ensure the provision of quality adolescent reproductive health care			
2.Do supervisors have a set time for staff to participate in service improvement for adolescent care?	KII – Facility manager		
4. Is teamwork encouraged (explanation) at the health centre/ facility?	KII Interview (staff)		

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
Total Yes = **Total Yes + No =** **Level of compliance =**			
Standard 7.1 The health centre is clean, comfortable, and with basic amenities.			
1. Are there sufficient (every patient has a seat) seats in the waiting room for clients awaiting services?	Obs		
2. Does the physical environment accommodate persons with disabilities (ramps, hand rails, bathrooms with rails?	Obs		
3. Is safe (chlorinated or boiled) drinking water available?	Obs		
4. Is the health centre well ventilated (fresh air, no smoking or bad odors)?	Obs		
5. Has an effort been made to make the physical environment of the healthcentre/ facility environment bright and cheerful as possible?	KII – Facility manager Obs		
6. Does the waiting room have sufficient light for reading?	Obs		
7. Are all areas clients use clean?	Obs		

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
8. Are all clients' toilets available and in working condition?	Obs		
9. Are client's toilets clean?	Obs		
10. Is there adequate water for cleaning and washing equipment?	Obs		
Total Yes = **Total Yes + No** = **Level of compliance** =			
Standard 7.2 Privacy is maintained during consultation, exam and procedures			
1. Are there systems to decrease waiting times for clients?	I – Facility manager/ Sn nurse		
2. Does the consultation take place in an area that assures confidentiality?	Obs		
3. Does the health centre/ facility consultation take place in a manner that ensures the client's confidentiality is respected?	Obs		
Total Yes = **Total Yes + No** = **Level of compliance** =			
Standard 8.2 A system to ensure effective referrals and counter-referrals is used by health providers.			
1. Does the centre/ facility have an established referral procedure?	KII – Facility manager with validation		

STANDARD/ CRITERIA	DATA SOURCE	YES/NO/NA	COMMENTS
2. Is there a mechanism to facilitate feedback from referrals?	KII – Facility manager – Validation		
Total Yes = **Total Yes + No =** **Level of compliance =**			
Standard 9.6 Adequate staff for managing health care to adolescents available			
1. Does the health centre/ facility have amedical practitioner assigned?	KII – Facility manager		
2. Does the health centre/ facility have a nutritionist?	KII– Facility manager		
3. Does health centre/ facility havean emergency managementplan?	KII – Facility manager Verification needed		
4. Are all staff (clinical, clerical, ancillary) trained in emergency management?	KII – Facility manager Verification needed		
5. Does the health centre/ facility have staff that can communicate effectively with persons/ adolescents with hearing disabilities	KII – Facility manager		
Total Yes = **Total Yes + No =** **Level of compliance =**			

Attachment 4

Pilot Site: _____ Services available to adolescents (10-19 years)

Skill Assessment

Service area	# providers per service area								# providers with specialised training[19] in adolescent service delivery							
	PHN	RN	Nurse/ midwife	Midwife	MD	CHA	CI	Other (Specify)	PHN	RN	N/ M	Mwf	MD	CHA	CI	Other (Specify)
Clinical																
Ante-natal																
Delivery																
Post natal																
STI (not HIV)																
HIV																
TB																
Family Planning																
Mental health																
Drug abuse																
Dental																
Dermatology																
Immunization																
Dressing																
Surgical																
Other																
Non-clinical																
Education																
Individual counselling																
Group counselling																
Other (Specify)																

[19] Indicate type of training (degree/ certificate programme, special workshop, on-line course(s), on-site in-service training, etc.) on reverse side of this form.