

Adolescent access to and utilization of health services in the Gbêkê and Hambôl regions of Côte d'Ivoire: A qualitative study exploring the perceptions of adolescents, caregivers, and health care workers

Chantal Donahue

A thesis

Submitted in partial fulfilment of the

Requirements for the degree of

Master of Public Health

University of Washington

2018

Committee:

James Pfeiffer

Julia Robinson

Samuel Adam Granato

Program Authorized to Offer Degree:

Global Health

©Copyright 2018

Chantal Donahue

University of Washington

Abstract

Adolescent access to and utilization of health services in the Gbêkê and Hambôl regions of Côte d'Ivoire: A qualitative study exploring the perceptions of adolescents, caregivers, and health care workers

Chantal Donahue

Chair of the Supervisory Committee:

James Pfeiffer

Department of Global Health

Adolescence is a critical time for physical, cognitive, social and emotional development, yet adolescents are prone to unique barriers and unmet needs for receiving proper health care services and information. This study explored barriers and facilitators to adolescent (15-19 years) access to and utilization of health services in two regions of Côte d'Ivoire. Focus group discussions were conducted with adolescent females and males, caregivers, and health care workers at eight health facilities. Barriers and facilitators emerged within three themes: cultural, structural, and “*accueil*,” a French word that translates to “welcome” but also encompasses overall feelings and experiences of a situation. Cultural barriers included community beliefs and stigma, and adolescent knowledge, while caregiver support and medical preference were both barriers and facilitators. Structural barriers included financial costs, distance to health facilities, waiting times, and lack of supplies and medications. Feelings of fear, shame and discomfort were barriers related to “*accueil*” while interactions with health care workers were both barriers and facilitators. Similarities and differences in perspectives between adolescents, caregivers, and

health care workers were present. Future work to increase adolescent access to and utilization of health services should take into consideration both recommendations from adolescents and the interconnectedness of the barriers they face to create multidimensional approaches that improve health outcomes for this priority population.

Introduction

With an estimated 1.8 billion people aged 10 to 24, the world is currently experiencing the largest generation of adolescents in human history.¹ Adolescence is a critical time for physical, cognitive, social and emotional development and sets the trajectory for future health behaviors and outcomes. Adolescents are especially prone to unique barriers and unmet needs for receiving proper health care services and information.¹⁻⁴ Several factors have emerged in studies examining perceived barriers to adolescents accessing health services, including financial costs, stigma, community attitudes, inconvenient operating hours, distances to health facilities, and fears regarding confidentiality and mistreatment by health care workers.⁵⁻¹³ Despite the health needs particular to this age group, adolescents are largely ignored in health policies and interventions and have not made the same health gains over the years that have been documented in other priority populations.^{1,2}

For the first time, the World Health Organization's (WHO) Global Strategy for 2016-2030 includes a focus on adolescents, bringing attention to the pervasive gap in knowledge on adolescent health and a pressing need for targeted, in-country research to create and implement effective, equity-focused, and evidence-based interventions specific to the unique needs of adolescents.² While there has been an increasing amount of research conducted on adolescent health, the focus of these studies tend to be on sexual and reproductive health (SRH) or HIV-related services.⁶⁻¹⁰ Fewer studies examine health-seeking behaviors and health needs of adolescents through a broader lens that goes beyond SRH.¹⁰⁻¹³ Furthermore, limited research on adolescent health behaviors has been conducted in West Africa.^{6-8,11}

In Côte d'Ivoire, half of the population is 18 years or younger.¹⁴ In this multi-burden country, adolescents face exacerbated health needs due to poverty, weak health systems, higher risks of infectious disease, and inadequate adolescent health services.¹⁴⁻¹⁶ Côte d'Ivoire's youth (15-29) mortality rate is nearly quadruple the world rate, with 33% of deaths attributable to infectious diseases and 32% to non-communicable and chronic disease.¹⁷ Education outcomes are poor; only 47% of boys and 45% of girls continue on to secondary school and much lower rates are seen in rural and low-income households.^{17,18} Child marriage is a common practice and 8% of girls are married by age 15 and 35% by age 18.¹⁸ One of three young married women are subject to domestic violence and 80% of married youth report not having a final say on their health care.^{17,19} Regardless of marital status, rates of early sexual debut in Côte d'Ivoire are among some of the highest in the region with 19% of women and 15% of men reporting being sexually active by age 15. Rates of pregnancy before age 18 are on the rise, increasing from 19.6% to 31.9% between 2005 and 2012.¹⁷ Furthermore, 28% of adolescents 15 to 19 in Côte d'Ivoire are affected by female genital mutilation. Interestingly, while HIV prevalence is low for adolescents 15 to 19 (0.4% for females and 0.2% for males), prevalence jumps to 4.5% in females 20 to 24 years while remaining almost stagnant for males the same age.¹⁸

These data signal important gaps in adolescent access to health services and information in Côte d'Ivoire. Studies and guidelines increasingly show that adolescents need differentiated care services that are tailored to their individual needs and health seeking preferences.^{5,20-23} To our knowledge, no studies have been focused on adolescent perceptions or utilization of general health services in Côte d'Ivoire. Country-specific information is needed to create or adapt multidimensional approaches to improve health outcomes in this population.

This study was conducted jointly by the University of Washington Department of Global Health and Health Alliance International (HAI), with the support and partnership of Côte d’Ivoire’s Ministry of Health and Public Hygiene. The purpose of this study was to understand the barriers and facilitators to adolescent access to and utilization of health services in the north-central regions of Gbêkê and Hambôl in Côte d’Ivoire. Adolescents, caregivers, and health care workers were included in the study to see if and how their roles and viewpoints may differ or influence adolescent access to health services. We expect the findings to be used to understand how adolescent access to health services in Côte d’Ivoire can be improved to better address the critical health needs of this priority population.

Materials and Methods

This exploratory study grounded in qualitative methods was conducted across eight study sites in the north-central regions of Gbêke and Hambôl in Côte d’Ivoire from December 2017 to March 2018. The purpose of this study was to understand the perceived barriers and facilitators to adolescents accessing and utilizing health services, based on the perceptions of adolescents (age 15-19), caregivers, and health care workers (HCWs).

Site selection

A total of 8 health facilities were included in this study. Study sites were purposefully selected to take into account accessibility to the study team and to include a variety of key variables (rural/urban, private/public, etc.) and to represent facilities at different levels of the health system. The selected study sites included two general hospitals (public and private), one regional hospital, two urban health centers, two rural health centers, and one student health center. See Table 1 for site descriptions.

Table 1. Study sites

Type of Facility	District	Region	Primary Reasons for Consultations of 15-24 Year Olds*
Hôpital General (<i>Private General Hospital</i>)**	Bouaké Sud	Gbêkê	Psychiatric (n=40) Conjunctivitis (n=31) HIV (n=17)
Hôpital General (<i>Public General Hospital</i>)	Beoumi	Gbêkê	Malaria (n=238) Childbirth (n=87) Abdominal/pelvic pain (female) (n=27) Vaginal discharge/discomfort (n=19) Road injury (n=17) Moderate anemia (n=16)
Centre Hospitalier Regional (<i>Regional Hospital</i>)	Katiola	Hambôl	Childbirth (n=302) Malaria (n=244) Road injury (n=66) Typhoid fever (n=35)

Centre de Santé Urbain (<i>Urban Health Center</i>)	Bouaké Sud	Gbêkê	Malaria (n=497) Childbirth (n=242) Pneumonia (simple) (n=63) Dermatosis (n=34) Vaginal discharge/discomfort (n=29) Moderate anemia (n=23)
Centre de Santé Rural (<i>Rural Health Center</i>)	Bouaké Nord Est	Gbêkê	Malaria (n=62) Moderate anemia (n=19) Childbirth (n=12)
Centre de Santé Rural (<i>Rural Health Center</i>)	Bouaké Nord Est	Gbêkê	Malaria (n=73) Childbirth (n=36)
Centre de Santé Urbain (<i>Urban Health Center</i>)	Bouaké Nord Est	Gbêkê	Malaria (n=260) Abdominal/pelvic pain (female) (n=64) Vaginal discharge/discomfort (n=33) Pneumonia (simple) (n=16)
Service de Santé Scholaire et Universitaire (<i>Student Health Center</i>)	Bouaké Sud	Gbêkê	Malaria (n=135) Dermatosis (n=14) Vaginal discharge/discomfort (n=13)

*Total recorded visits from July through September 2017. Data collected is for 15-24 year olds; disaggregated data for 15-19 year olds was not available.

** This health facility is the only study site that offers psychiatric consultations.

Focus Group Discussions

Thirty-two focus group discussions (FGDs) were conducted. Four FGDs were conducted at each study site with four separate populations: adolescent girls, adolescent boys, caregivers, and HCWs. FGDs followed a semi-structured discussion guide and lasted approximately one hour (30–105 min). Questions explored adolescent knowledge of available health services, perceived barriers and facilitators to adolescents accessing health services, and recommendations to improve adolescent access to health care.

Adolescents aged 15 to 19 who had previously used a health service at the study site were recruited to participate in this study. Adolescents were recruited when they visited the health facility to access available health services. Health care workers explained the study to the adolescents and compiled a list of those who were interested in participating over a one- to two-week period before the FGDs were held. A total of 99 adolescents (58 female, 41 male) were purposefully selected to include a maximum variety of services being utilized (e.g. general medical consultations, HIV services, prenatal consultations, family planning services, dental and ophthalmology visits). Participants were recruited to represent a balanced perspective from both genders, across the age range, and from varying educational backgrounds. Demographic information is displayed in Table 2. FGDs had a range of 4-10 adolescents present.

Caregivers of adolescents participating in the study (no more than one per adolescent) were recruited and could include parents, grandparents, and guardians. A total of 24 caregivers participated in this study; demographic characteristics are displayed in Table 2. FGDs included 3-4 caregivers.

HCWs were purposefully selected to include those who worked directly with adolescents and to represent a variety of positions (doctors, midwives, community counselors). A total of 52 HCWs were included in this study, see Table 2 for demographics. FGDs included 4-11 HCWs; the number of participants depended on the size of the site and the number of staff available.

Table 2. Participant demographics

Adolescents	n	% of Total	Caregivers	n	% of Total	Health Care Workers	n	% of Total
Total	98*	100	Total	24	100	Total	52	100
Sex			Sex			Sex		
Female	57	58.2	Female	15	62.5	Female	22	42.3
Male	41	41.8	Male	9	37.5	Male	30	57.7
Age			Age			Age		
15-17	66	67.3	< 40	10	41.7	25-34	20	38.5
18-19	32	32.7	40 +	14	58.3	35-44	17	32.7
Religion			Number of children			45-54	13	25.0
Muslim	27	27.6	< 3	8	33.3	55+	2	3.8
Christian	64	65.3	3-5	12	50.0	Highest level of schooling completed		
Animiste	6	6.1	6+	4	16.7	Middle school	7	13.5
Other	1	1.0	Highest level of schooling completed			High school	6	11.5
Number of children			None	8	33.3	Technical school	5	9.6
0	96	98.0	Primary school	4	16.7	University/Medical school	34	65.4
1	2	2.0	Middle school	4	16.7	Position		
Current level of schooling			High school	4	16.7	Physician	9	17.3
None	5	5.1	Trade school	2	8.3	Nurse	18	34.6
Primary school	18	18.4	University	2	8.3	Midwife	8	15.4
Middle school	48	49.0	Employment			Nurse's Aide	2	3.8
High school	26	26.5	Salaried work	2	8.3	Community Counselor	4	7.7
Trade school	1	1.0	Self-employed	9	37.5			
Distance from home to health center			Cultivator	3	12.5			
0-5 km	84	85.7	Housekeeper	4	16.7			
5-10 km	10	10.2	Unemployed	3	12.5			
10+ km	4	4.1	Other	3	12.5			
Typical means of transportation to health center								
Walking	57	58.2						
Communal Taxi	19	19.4						
Moto	22	22.4						
Personal Vehicle	0	0.0						

*Data included for 98 of 99 adolescent participants - one participant did not submit demographic data

Data Collection and Analysis

Data on adolescent consultations during the months of July to September 2017 was collected at each study site (Table 1). Each study participant filled out a short demographic survey (Table 2). A team of two researchers (CD and FT) conducted all FGDs to ensure consistency across sites. FGDs were conducted primarily in French; a translator was used when participants felt more comfortable communicating in a local language. All interviews were audio-recorded with permission and detailed notes were taken from the recordings by CD and FT. A codebook was developed to conduct a thematic analysis using Atlas.ti software version 8.1.3 (522) by CD, with agreement on themes and interpretations checked by FT. Original recordings were revisited to confirm themes and directly and accurately transcribe quotations.

Ethics

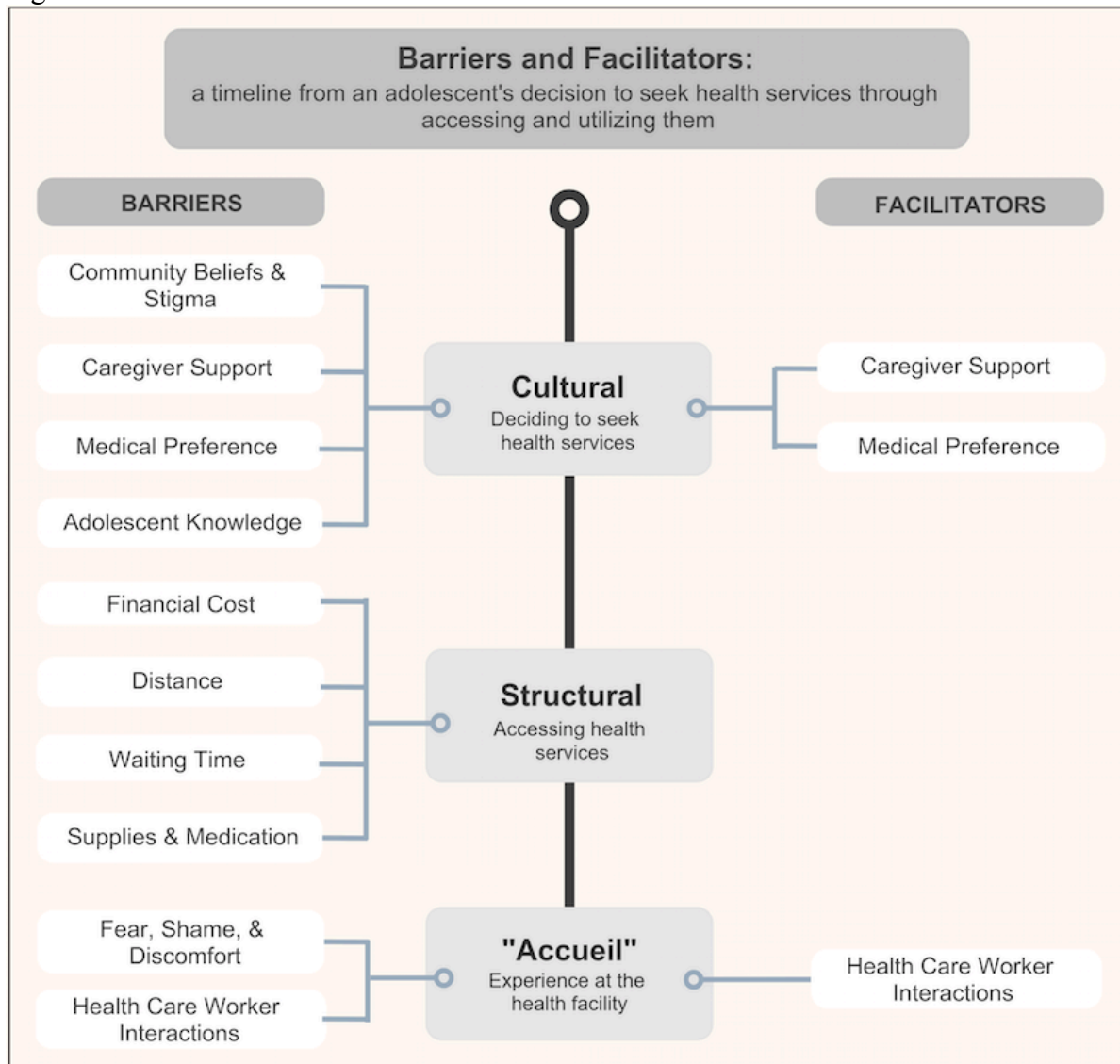
Informed, written consent was obtained by all participating HCWs, caregivers, and adolescents aged 18 or older. Adolescents aged 15 to 17 required informed assent in combination with caregiver consent. This study was approved by the University of Washington Institutional Review

Board and the *Comité National d’Ethique et de la Recherche* (National Ethics and Research Committee) of Côte d’Ivoire.

Results

Three themes regarding the barriers and facilitators to adolescents accessing and utilizing health services emerged from participant responses: cultural factors, structural factors, and “*accueil*,” a French word that translates to “welcome” but also encompasses overall feelings and experiences of a situation (see Figure 1). These themes portray the process an adolescent goes through from the moment they start making decisions on whether or not to seek health services through the experience of accessing and utilizing them. New barriers and facilitators can be found along each step that can positively or negatively influence an adolescent’s ability and experience accessing health care. These factors are tied to the unique, semi-autonomous experience of being an adolescent, further shaping or constraining their health-seeking behaviors throughout this process.

Figure 1. Barriers and facilitators model



Cultural Factors: Deciding to seek health services

Cultural factors stem from an adolescent's community or family and have the ability to influence an adolescent's health-seeking behavior when deciding whether or not to utilize a health service. These factors include community beliefs and stigma, caregiver support, medical preference, and adolescent knowledge.

Adolescent Perspective

Community Beliefs and Stigma. Beliefs within an adolescent's community, often characterized as contributing to stigma, came up as a barrier in the majority of the adolescent FGDs. Adolescents often reported a fear of being seen at health centers by community members, believing it will be assumed that they were seeking HIV or SRH services and judge and gossip about them.

'People will start to say things to others about us, but [what they say] is not true. They might even say to our parents that they saw us [at the health facility], so we must have [certain] illnesses.' – Adolescent female

Adolescents also described situations where they were interested in seeking health services but heard negative experiences or opposing opinions from community members that dissuaded them from going to a health center.

Caregiver Support. Caregiver support as a barrier came up across all adolescent FGDs. Most adolescents expressed difficulties communicating with caregivers about health issues due to a fear of misunderstanding, being reprimanded, or being embarrassed about "taboo" health topics such as family planning and HIV or STI prevention. However, caregiver support also came up as a facilitator to care in about half of the adolescent discussions. In these cases, adolescents spoke of caregivers who were more informed and understood the importance of seeking health-related information.

'You are afraid to express yourself to [your parents] ... my mama will reject me, my papa will reject me, so it's better to hide it.' – Adolescent male

'There are parents who know the services, they will say to you "You are sick, you need to go get treatment." But there are others who [aren't familiar with the services], they will not want to give their money for that.' – Adolescent male

Medical Preferences and Traditions. Preference for traditional medicine emerged as a main barrier for seeking biomedical health care in all adolescent groups. Reasons for this preference included family or community customs, accessibility, low cost, and belief in efficacy. Adolescents reported that it was common to seek care at a health center only when the illness became serious after first trying traditional medicine unsuccessfully. Adolescents also described negative associations toward biomedical interventions offered at health facilities as a barrier, citing distrust in services, and negative past experiences. However, some adolescents cited trust in biomedical interventions as a facilitator, describing a desire for information, a trust in medical diagnoses, and efficacious treatments. These cited positive past experiences (personal and others') receiving treatment and getting better after visiting health facilities.

‘There is someone who could say to you “I know the medicine [you need], don’t go to the hospital” . . . because our older brothers all know *Baoulé* [traditional] medicine’ – Adolescent female

‘The doctors who are [at the health facilities], they are ones who have studied... they know the illness that causes our suffering, and they know how to heal people.’ – Adolescent female

Adolescent Knowledge. While a desire for health information was cited by adolescents as a facilitator to care, a lack of knowledge came up as a barrier during more than half of adolescent FGDs. This was often referred to as “ignorance” surrounding illnesses that typically affect adolescents: adolescents not recognizing these illnesses, understanding their consequences, and knowing when and where to seek treatment. Many adolescents stressed their lack of understanding of preventative health, especially with issues related to HIV, STIs, and undesired pregnancies.

‘They stay at the house because they don’t know the real consequences of their illness. If they knew of the consequences, they would go to the hospital to be healed.’ – Adolescent male

Caregiver Perspective

All caregiver discussions cited their own support as a main facilitator for adolescents seeking care. Many expressed a recognition of the importance of seeking preventative services and support of adolescents reaching out to them to discuss “taboo” health subjects. Additionally, many caregiver groups mentioned the importance of caregivers accompanying adolescents to health facilities to orient them to the location and to alleviate any negative feelings. Only around half of the caregiver groups recognized their potential role as a barrier to adolescents seeking health services. Many groups expressed negative opinions surrounding adolescents accessing certain services (often family planning services), confirming fears cited in adolescent discussions.

‘Often, in certain families there is a certain distance between the father and the children. The child can be afraid to approach his father and say “Papa, I don’t feel well.” He prefers to hide that.’ - Caregiver

Caregivers also cited community beliefs and stigma as a barrier, although this topic emerged less frequently than among adolescents. Caregiver perceptions of traditional medicine and adolescent knowledge as barriers mirrored those of the adolescents.

‘It’s shame, they don’t want to sit with other people . . .the people in the village will look at a young girl when she comes in and they will say “she is too young, she must have fallen pregnant.”’ - Caregiver

Health Care Worker Perspective

Nearly all HCW discussions mentioned community beliefs, stigma, caregiver support, and adolescent knowledge as barriers to accessing care, citing similar reasons to what the adolescents expressed. Traditional medicine also emerged as a barrier among HCWs; however, neither negative nor positive adolescent beliefs towards biomedical interventions were discussed.

‘It’s ignorance – when I say ignorance what I mean is that they don’t see the importance of coming to the hospital. In our communities there is traditional medicine, and there are those who are prejudice, those who have already come to the health center will [give false information] and that could be why others don’t come.’ – Health care worker

Participant Recommendations

Among all these cultural themes, a need for increased access to adolescent-specific health information was highlighted as a priority across adolescents, caregivers, and HCWs. Suggestions to improve adolescent knowledge and access included: 1.) increasing outreach services; 2.) including caregivers and community members in community education campaigns; and 3.) creating information centers separate from health facilities.

Structural Factors: Accessing health services

Structural factors impact an adolescent’s ability to successfully access health services. These factors are associated with the facilities they are attempting to access and include financial costs, distance to facilities, long waiting times, and the availability of supplies and medication.

Adolescent Perspective

Financial Costs. Prohibitively expensive costs of consultations and prescriptions emerged unanimously as a top barrier to accessing health services in adolescent FGDs. Adolescents are often reliant on caregivers for money and frequently expressed fears of putting an additional burden on them by asking for money to go to a health facility.

‘...will I be able to buy the medicine that will heal me? Will my money be sufficient? So I think about all of that and it is hard to go [to the health facility].’ – Adolescent male

Distance to Health Center. Adolescents frequently cited long distances to health facilities as a barrier to accessing care. Typically, this was in relation to health facilities being far apart (especially in rural areas), specialized services only being available in urban facilities, and a lack of transportation options or financial means to afford transportation when available.

‘The distance between the hospital and the house, there isn’t transportation. You need to come to the hospital but since there are no means of transportation you have to stay home.’ – Adolescent male

‘We live I think 5 or 6 kilometers from the clinic. There is not a hospital there – so we are obligated to come to [a city], ... some people die in transit, there aren’t transportation options, it’s too expensive...’ Adolescent female

Waiting Time. Long waiting times at facilities came up as a barrier in all adolescent discussions, especially in health facilities with a low HCW to patient ratio. Many adolescents explained that they avoided going to health centers when they were sick because they knew it would take too much time and they had competing priorities including school and familial duties.

‘You come in the morning and they tell you to be patient, and you wait and wait, and then they tell you that you have to come back again the next day.’ – Adolescent male

‘Me, I don’t want to come to the hospital because I know it will take forever.’ – Adolescent male

Supplies and Medication. A frustration and fear of health facilities not having necessary supplies and medications, resulting in a lack of treatment or the need to return to the facility, came up as a barrier in about half of adolescent FGDs.

Caregiver Perspective

Caregiver perceptions of structural barriers aligned closely with those of the adolescents. Financial costs, distances to health facilities, long waiting times, and concerns regarding supplies and medications were all discussed as structural barriers to care.

‘Here it is a problem of means... when you don’t have anything ... you know that the hospital exists, but ... the prescription [cost is too high]. Voila, that is why people stay home. The sick person is there, we need to take care of them first, ... but it’s hard, it’s hard.’ – Caregiver

‘The waiting time is too long. When there are too many people, the nurses and the midwives do the consultations very quickly. We wait too long and then the consultations are too short.’ - Caregiver

Health Care Worker Perspective

Financial costs, lack of necessary supplies and medications, and distance to health centers also emerged as barriers among HCW discussions. However, HCWs also discussed ways in which financial costs and distances also acted as facilitators for adolescents. They described free or reduced services at student health centers, HCWs reimbursing or subsidizing costs for adolescents, or expressed the sentiment that health services are generally inexpensive in Côte d’Ivoire. Some HCWs also explained that health facilities are plentiful and geographically accessible. While waiting times were listed as a barrier in some HCW discussions, many groups spoke of the recognition that most adolescents are missing school when seeking health services and explained that adolescents are often given priority and seen before other waiting patients or are scheduled appointment times that take into consideration school schedules.

‘Often when they come here they are sitting from 8 until 12 or 13, and even into the night. So, when it is like that, you can’t let them go like that, you are obligated to do what you can do [for them] before you leave.’ – Health care worker

Participant Recommendations

Many facility-level changes were suggested to decrease the structural barriers adolescents face when accessing health services. Adolescents expressed a desire for more health facilities located near schools. Most adolescents and caregivers, but only some HCWs, suggested increasing the number of consultation rooms in facilities, building more facilities in general, and ensuring that supplies and medications are consistently available. Nearly all adolescents suggested decreasing or waiving the costs of consultations and medication for adolescents.

***“Accueil”:* Experience at the health facility**

Once an adolescent has successfully made it to a health facility they face further barriers and facilitators that shape their experience utilizing health services. “*Accueil*” describes this

experience, which is highly influenced by feelings of fear, shame, and discomfort as well as positive or negative interactions with HCWs. This experience can impact future decision making when an adolescent desires returning to a health facility.

Adolescent Perspective

Fear, Shame, and Discomfort. Negative feelings regarding adolescents' experiences at health facilities came up as a barrier to accessing care in all adolescent groups. Feelings of fear, shame, and discomfort were reported most frequently. Adolescents gave examples of delaying or avoiding going to health centers due to a fear of shots and medicine, fear of receiving a bad diagnosis, and feeling uncomfortable seeing other sick individuals. Adolescents frequently reported negative feelings during consultations associated with undressing, talking to adult HCWs, being asked a lot of questions, and experiencing difficulty expressing themselves due to feeling uncomfortable or experiencing language barriers.

'For some, it is their first time to come and they are scared . . . it's stressful . . . you know you will see other sick people.' – Adolescent male

'At [the health center] you might have to get your blood analyzed and you are scared, you think of AIDS.' – Adolescent male

Health Care Worker Interactions. Adolescents became the most passionate when talking about experiences with HCWs at facilities. It was a consensus across all adolescent groups that prior negative interactions with HCWs are a main barrier to utilizing health services. These experiences typically consisted of adolescents being yelled at or chastised by HCWs or being neglected while HCWs gave preferential care to other patients.

'When I come to the hospital . . . I wait for a long time sitting with old people. [The HCWs] take the others before me, but I came here first. I keep waiting and they take the others.' – Adolescent female

'There is also the *accueil* of [HCWs], when we come they tell us to wait, to sit over there. We are suffering and they do these things and it is tiring. They will yell and we don't like that.' – Adolescent male

'For example, you come in for an accident and they will say "You did this, you are not staying out of trouble.'" – Adolescent male

'The midwives are very difficult on the adolescents during childbirth. They insult them and they yell at them.' – Adolescent female

Positive experiences with HCWs also emerged as an important facilitator in half of the adolescent discussions. Interaction with friendly HCWs who made the adolescent feel comfortable was often cited as a catalyst for adolescents to begin seeking out health services more frequently, mitigating barriers related to negative feelings of fear and discomfort.

'Here at the student health center I feel like I am with my friends. I can say what I want to say and I can say how I feel.' – Adolescent female

‘I was scared before I came [to the health facility] because I was hurt... But when I arrived, I can tell you that she [HCW] did things that made me even forget my pain. She received me very well, she treated me very well.’ – Adolescent female

Caregiver Perspective

Most caregiver groups discussed the negative feelings described by the adolescents as barriers to accessing care. Occasionally there was a lack of consensus among caregivers, with some voicing strongly that fear and other negative feelings are not a barrier for adolescents; rather, a desire to receive treatment and get better acts as a facilitator overriding any negative emotions. Caregivers also considered negative and positive experiences with HCWs as a barrier and facilitator, respectively, to adolescents seeking health services.

‘When a young girl falls pregnant, at the house she does not feel ashamed. But when she comes here [health facility] she is now sitting with the tanties* and she is small and she feels ashamed.’ - Caregiver

‘There are health care workers who are conscientious . . . they treat all of the sick [patients] the same. On the contrary, there are health care workers, when it is a child [adolescent] who does not seem very sick, he neglects him... He is neglected because he is young.’ - Caregiver

‘I can say that the services take care of adolescents. They do good, they look after our children’ - Caregiver

Health Care Worker Perspective

Health care workers also cited adolescent fear, shame, or discomfort as potential barriers. Negative experiences with HCWs as a barrier to adolescent health came up infrequently. Generally, when discussed, it was distanced and acknowledged as something that happens in “other facilities.” Almost all HCWs perceived their interactions with adolescents to be a main facilitator and spoke in-depth about the importance of treating adolescents in a certain manner, citing numerous examples, to make them feel comfortable.

‘You need to put yourself in their skin. Speak the French at their level, [call them] “My son! My little brother!” Make them feel comfortable. Familiarize yourself with the patient so they are able to say [what is wrong].’ – Health care worker

Participant Recommendations

Multiple suggestions were made to improve the adolescent experience of going to a health facility. Most adolescents and caregivers suggested creating health centers specifically for adolescents. Some adolescent females expressed a desire for separate waiting rooms and consultations rooms for adolescents. HCWs recommended the implementation of differentiated services for adolescents. Training health care workers on best practices for working with adolescents was suggested by a majority of adolescent groups. This suggestion did not come up in any caregiver group; however, half of the HCW groups expressed a desire to be trained on working with adolescents.

* “Tantie” translates to “aunt” but is used in a broader sense as a term of endearment for older women.

Discussion

While the individual barriers and facilitators found in this study are compelling on their own, it is worthy to note the interaction that occurs across the cultural, structural, and “*accueil*” themes. These factors have the ability to exacerbate each other and are compounded by their relationship to the unique experience of being an adolescent – someone who is highly autonomous in many ways and yet still dependent on their caregivers and communities in others. These relationships, and the dynamic environment they create, can be seen in the progression of events that were commonly described by the adolescents, caregivers, and HCWs in this study.

Initially, an adolescent may not recognize the need to seek out health services, or if they do, they may be negatively influenced by beliefs or stigma within their community. Once deciding to access a health service, the adolescent is burdened by a financial dependence on caregivers and time commitments like school that conflict with clinic hours and long waiting times. If they are able to find the time and money to get to the health facility, the waiting times they experience, which are potentially lengthened if they are passed over by HCWs, may be exacerbated by feelings of fear or the perception that they are being judged by community members. Finally, this experience might culminate with HCW interactions perceived by the adolescent as scolding or demoralizing. This progression presents multiple opportunities for negative outcomes in an adolescent’s ability to access or experience of health care; additionally, one adolescent’s experience can start a cycle of reinforcement as they return to their community and share their negative experiences with others. Similar stories were told by adolescents accessing different health services across all study sites, including rural, urban, private and public facilities. Furthermore, while certain scenarios may be specific to the Ivoirian context, these cultural, structural, and “*accueil*” barriers are similar to those adolescents face numerous other settings.⁶⁻¹³

Another key finding of this study is the difference in perspectives that emerged between adolescents and their caregivers and HCWs. Not only does this highlight the fundamental importance of understanding the adolescent experience and including their voices in research, it elicits questions on what could be creating this dissonance. Caregiver support as a barrier to care was widely discussed by adolescents, yet caregivers were confident in their role as a facilitator. One possible explanation is that caregivers are more supportive and willing to discuss difficult health topics than adolescents believe, and the related fears adolescents describe may stem from misconceptions. Alternatively, caregivers might perceive themselves to be supportive while exhibiting contradictory behaviors that create a distance between themselves and the adolescents. Similar explanations can be said for HCW interactions. These contradictions raise an overarching question: how much do the actual experiences and interactions matter if the overall perceptions are negative? The results of this study demonstrate the power of support and positive experiences with caregivers and HCWs and their ability to act as a catalyst to adolescent health-seeking behaviors, often having the power to overcome multiple barriers and negative feelings associated with accessing health services.

Recommendations

Cultural Factors

Drawing from adolescent, caregiver, and HCW recommendations, increasing access to information is a priority to increase knowledge on adolescent health topics and awareness of

available health services. Focus should be put on targeting rural areas, and per WHO guidelines, outreach efforts should include caregivers and community members to decrease stigma and communication barriers.²³

Structural Factors

Structural barriers need to be addressed at a health systems level. Changes regarding these barriers would have positive implications for all populations accessing health systems but are harder to implement in already strained systems and may not be an immediate solution to addressing adolescent health needs. The WHO recommends building on systems that are already in place to make them more adolescent-friendly.^{23,24} There is an opportunity to expand on the system of student health centers currently in place in Côte d'Ivoire by expanding their reach outside of urban areas. Rebranding and outreach can also be done to increase the access of non-student adolescents to these services. Adding maternity services would address the highly stigmatized needs of pregnant adolescents. Finally, in areas where a separate student health center may not be feasible or appropriate, it may be sufficient to create adolescent-specific areas in existing health facilities to decrease stigma and increase opportunities for health education.

“Accueil”

Addressing HCW interactions with adolescents has the potential to have the biggest impact on adolescent access to health services. HCW training alone has not been found to be effective in increasing adolescent use of health services; however, positive results have been seen when done in combination with adolescent-friendly facility-based improvements.²¹ According to the HCWs in this study, there is no distinction between adolescent and adult health services in Côte d'Ivoire; including a focus on adolescent health needs (biologically and emotionally) in medical school curricula may be appropriate. However, the potential impact of systematic factors, such as high patient loads and low HCW rates, on HCW interactions with adolescents should not be forgotten when developing interventions. Finally, including youth positions in health facilities to attend to and orient adolescents or act as a liaison between adolescents and HCWs could improve the environment and adolescent experience at health facilities.

Limitations

This study has several important limitations. First, only adolescents who had already accessed and utilized at least one health service were included in this study; their perceptions and experiences may be different from adolescents who have never used health facilities. However, the discussion guide was designed to ask about both the participants' experiences as well as those of their peers who do not frequent health centers; adolescent quotes posed in third person reflect this effort. Similarly, caregiver participants were those who were willing to accompany and wait with their adolescents for the FGDs and may have different perceptions than the caregivers who did not want to participate. Due to the variety of HCW positions represented in each FGD, there may have been cases where lower-level HCWs were not comfortable expressing opinions that differed from their supervisors. Furthermore, due to their busy schedules, HCWs would occasionally step out of the FGD to attend to a patient. As a result of time constraints, only one of the eight study sites was located in the region of Hambôl. Finally, both FGD facilitators are adult females (one of which is Caucasian and non-Ivoirian), which may have influenced participants' responses.

Strengths

This is the first study on the perceptions of adolescent access to and utilization of health services in Côte d'Ivoire. Unlike many studies that focus only on adolescent access to HIV or SRH services, this study did not limit the focus to specific health services. SRH services are a priority for this age group; however, they are not the only reasons adolescents access health facilities. While some of the top reasons for adolescent consultations at the study sites were related to SRH (childbirth, vaginal discomfort) most were not (malaria, pneumonia, road injuries, anemia). As a result, the implications from the study findings can be applied more widely to the health systems rather than focused on specific programs.

Additionally, a key element of this study is its inclusion of caregiver and HCW perceptions. The differences in perceptions brings forward questions of how the roles and perspectives of caregivers and HCWs, highly influential players in an adolescent's experience accessing health services, could be positively or negatively impacting this process. Furthermore, this disconnect highlights the importance of including adolescents in research, intervention development, and policy making.

Thus, the major strength of this study is that it creates a platform to elevate adolescent voices in research. Adolescents were able to share their experiences and perspectives as well as offer recommendations on how to best improve adolescent access to health services. If implemented correctly, such recommendations are able to address the barriers most important to the adolescents in a way that is acceptable and effective for this population.

Conclusion

Future work to increase adolescent access to and utilization of health services should take into consideration both adolescent recommendations and the interconnectedness of the barriers they face to create multidimensional approaches to effectively improve health outcomes for this priority population.

References

1. Das Gupta M, Engelman R, Levy J, Luchsinger G, Merrick T, and Rosen J. (2014). United Nations Population Fund, State of the World Population. The Power of 1.8 Billion: Adolescents, Youth and the Transformation of the Future.
2. World Health Organization (WHO). (2015). Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). Retrieved from http://www.who.int/pmnch/media/events/2015/gs_2016_30.pdf
3. United Nations Children's Emergency Fund (UNICEF). (2016). State of the World's Children: A fair chance for every child. Retrieved from https://www.unicef.org/publications/files/UNICEF_SOWC_2016.pdf.
4. Cisse, A. (2011). Analysis of Health Care Utilization in Côte d'Ivoire. University of Cocody; African Economic Research Consortium: Nairobi.
5. Patton, G., Coffey, C., Cappa, C., Currie, D., Riley, L., Gore, F., . . . Ferguson, J. (2012). Adolescent Health 4: Health of the world's adolescents: A synthesis of internationally comparable data. *The Lancet*, 379(9826), 1665-75.
6. Babalola, S. O., Tamashe, B., & Vondrasek, C. (2005). Parental factors and sexual risk-taking among young people in Côte d'Ivoire. *African Journal of Reproductive Health*, 9(1), 49-65.
7. Biddlecom, A., Munthali, A., Singh, S., & Woog, V. (2007). Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *African Journal of Reproductive Health*, 11(3), 99-110.
8. Briggs, L. (1998). Parents' viewpoint on reproductive health and contraceptive practice among sexually active adolescents in the Port Harcourt local government area of Rivers State, Nigeria. *Journal of Advanced Nursing*, 27(2), 261-6.
9. Hampanda, K., Ybarra, M., & Bull, S. (2014). Perceptions of health care services and HIV-related health-seeking behavior among Uganda adolescents. *AIDS Care*, 1-9.
10. Kabiru, Caroline W, Izugbara, Chimaraoke O, & Beguy, Donatien. (2013). The health and wellbeing of young people in sub-Saharan Africa: An under-researched area? *BMC International Health and Human Rights*, 13(1), *BMC International Health and Human Rights*, Feb 13, 2013, Vol.13(1).
11. Glozah, F. (2015). Exploring Ghanaian adolescents' meaning of health and wellbeing: A psychosocial perspective. *International Journal of Qualitative Studies on Health and Well-being*, 10(1), *International Journal of Qualitative Studies on Health and Well-being*, 01 January 2015, Vol.10(1).

12. Mokomane, Mokhele, Mathews, & Makoae. (2017). Availability and accessibility of public health services for adolescents and young people in South Africa. *Children and Youth Services Review*, 74, 125-132.
13. Mmari, Blum, Sonenstein, Marshall, Brahmhatt, Venables, . . . Sangowawa. (2014). Adolescents' perceptions of health from disadvantaged urban communities: Findings from the WAVE study. *Social Science & Medicine*, 104, 124-132.
14. Demographic and Health Survey. (2013). Côte d'Ivoire: Enquête démographique et de Santé et à Indicateurs Multiples.
15. Ministry of Health and Public Hygiene. (2016). Politique Nationale de Santé des Adolescents et des Jeunes 2016-2020.
16. Organisation for Economic Co-operation and Development (OECD). (2017). Examen du Bien-Être et des Politiques de la Jeunesse en Côte d'Ivoire. Retrieved from <http://www.oecd.org/dev/inclusivesocietiesanddevelopment/Examen-du%20bien-etre-et-des-politiques-de-la-jeunesse-en-Cote-dIvoire.pdf>
17. United Nations Population Fund (UNFPA). (2012). Status Report: Adolescents and young people in sub-Saharan Africa. Retrieved from <https://assets.prb.org/pdf12/status-report-youth-subsaharan-Africa.pdf>
18. United Nations Programme on HIV/AIDS (UNAIDS). (2014). The Gap Report 2014: Adolescent girls and young women. Retrieved from http://www.unaids.org/sites/default/files/media_asset/02_Adolescentgirlsandyoungwomen.pdf
19. Chandra-Mouli, Venkatraman, Chatterjee, Subidita, & Bose, Krishna. (2016). Do efforts to standardize, assess and improve the quality of health service provision to adolescents by government-run health services in low and middle income countries, lead to improvements in service-quality and service-utilization by adolescents? *Reproductive Health*, 13(9), 10.
20. Denno, Hoopes, & Chandra-Mouli. (2015). Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support. *Journal of Adolescent Health*, 56(1), S22-S41.
21. United Nations Population Fund (UNFPA). (2013). UNFPA Strategy on Adolescents and Youth: Towards realizing the full potential of adolescents and youth. Retrieved from <https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA%20Adolescents%20and%20Youth%20Strategy.pdf>
22. World Health Organization (WHO). (2012). Making health services adolescent friendly: Developing national quality standards for adolescent-friendly health services. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/75217/9789241503594_eng.pdf?sequence=1

23. World Health Organization (WHO). (2017). Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation. Retrieved from <http://apps.who.int/iris/bitstream/handle/10665/255415/9789241512343-eng.pdf?sequence=1>
24. World Health Organization (WHO). (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. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/148354/9789241508315_eng.pdf?sequence=1
25. Geary, R., Gómez-Olivé, F., Kahn, K., Tollman, S., & Norris, S. (2014). Barriers to and facilitators of the provision of a youth-friendly health services programme in rural South Africa. *BMC Health Services Research*, 14, 259.
26. Geary, R., Webb, E., Clarke, L., & Norris, S. (2015). Evaluating youth-friendly health services: Young people's perspectives from a simulated client study in urban South Africa. *Global Health Action*, 8(1), 26080.
27. International Planned Parenthood Federation (IPPF). (2008). Provide: Strengthening youth friendly services. Retrieved from https://www.ippf.org/sites/default/files/inspire_provide.pdf
28. Nkala, B., Khunwane, M., Dietrich, J., Otwombe, K., Sekoane, I., Sonqishe, B., & Gray, G. (2015). Kganya Motsha Adolescent Centre: A model for adolescent friendly HIV management and reproductive health for adolescents in Soweto, South Africa. *AIDS Care*, 1-6.
29. World Health Organization (WHO). (2015). Technical consultation on indicators of adolescent health: Global reference list of health indicators for adolescents (aged 10-19 years). Retrieved from http://apps.who.int/iris/bitstream/handle/10665/204625/WHO_MCA_15.3_eng.pdf?sequence=1
30. Chandra-Mouli, Svanemyr, Amin, Fogstad, Say, Girard, & Temmerman. (2015). Twenty Years After International Conference on Population and Development: Where Are We With Adolescent Sexual and Reproductive Health and Rights? *Journal of Adolescent Health*, 56(1), S1-S6.
31. Dick, & Ferguson. (2015). Health for the World's Adolescents: A Second Chance in the Second Decade. *Journal of Adolescent Health*, 56(1), 3-6.
32. Fisher, C. (2004). Informed Consent and Clinical Research Involving Children and Adolescents: Implications of the Revised APA Ethics Code and HIPAA. *Journal of Clinical Child & Adolescent Psychology*, 33(4), 832-839.
33. Gates, M. (2016). Advancing the adolescent health agenda. *The Lancet*, 387(10036), 2358-2359.

34. Patton, Ross, Santelli, Sawyer, Viner, & Kleinert. (2014). Next steps for adolescent health: A Lancet Commission. *The Lancet*, 383(9915), 385-386.
35. Patton, Sawyer, Santelli, Ross, Afifi, Allen, . . . Viner. (2016). Our future: A Lancet commission on adolescent health and wellbeing. *The Lancet*, 387(10036), 2423-2478.
36. Patton, Viner, Linh, Ameratunga, Fatusi, Ferguson, & Patel. (2010). Mapping a Global Agenda for Adolescent Health. *Journal of Adolescent Health*, 47(5), 427-432.