Adolescent Girls Access to Primary Health Care Services in Lebanon: **Barriers and Facilitating Factors**

Research Brief

AUB American University of Beirut
Faculty of Health Sciences
Center for Public Health Practice

REPUBLIC OF LEBANON
MINISTRY OF PUBLIC HEALTH

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AUB research team:
Principle Investigators

Aline Germani	Director of the Center for Public Health Practice, Faculty of Health Sciences, AUB
Tamar Kabakian	Associate Professor, Health Promotion and Community Health Department, Faculty of Health Sciences, AUB
Béatrice Khater	Clinical Instructor, Family Medicine Department, AUBMC
Martine Najem	Instructor of Public Health Practice, Center for Public Health Practice, Faculty of Health Sciences, AUB

Co-Investigators

Rachel Bteiche	Public Health Consultant
Thurayya Zreik	Public Health Researcher and Consultant for the Center for Public Health Practice

Supported by
Jihane Bou Samra
Dana Jumaa

Ministry of Public Health (MoPH) Team:

Randa Hamadeh	Director of PHC & Social Health Department, UHC 2030 National Coordinator -MoPH
Wafaa Kanaan	PHC Chief Central Coordinator-MoPH.

UNICEF Team:

Farah Hammoud	Child Protection Officer
Joelle Najjar	Health Officer
Lama Ghanem	Research and Evaluation Officer
Jamil El Khoury	Research and Evaluation Officer

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Background

Adolescent girls globally, and in Lebanon specifically, form a particularly vulnerable demographic group, and face disproportionate risks when compared with the rest of the population, including higher risk of exposure to early marriage, violence and abuse, and poor sexual and reproductive health outcomes (Amin et al., 2013). Adolescent girls' vulnerability is often compounded by social determinants such as gender norms that limit girls' decision-making power and exclude them from access to healthcare and other rights as well as economic determinants such as poverty and the need for disposable income (Amin et al., 2013), all of which affect access to health care. Reaching girls during the adolescence age group is thus key for interventions avoiding and mitigating the risks that girls may face later on (ibid.). Among the youth population in Lebanon, adolescent girls constitute a high proportion which is particularly diverse, including by nationality, with the main divisions being Lebanese, Syrian and Palestinian.

This qualitative study explores the perceived barriers and facilitating factors facing Lebanese, Syrian, and Palestinian adolescent girls aged 10-18 in accessing Primary Healthcare services in Lebanon - including clinical management of rape (CMR), mental and reproductive health services - with a focus on adolescent girls at high risk for GBV. The findings will be used to inform programmes and interventions targeting adolescent girls, and the broader areas of work in health, nutrition and prevention of gender - based violence (GBV), and to provide evidence that will support the MoPH in the development of health strategies that address the needs of adolescent girls.

It is worth noting that the data collection for this study was conducted during the period of November 2019 till February 2020, prior to the COVID-19 pandemic beginning in March 2020 and to the exacerbation of the economic crisis in Lebanon that had started in October 2019.

The objectives of this study were to:
• Identify specific priorities for enhancing adolescent girls' access to primary healthcare and GBV services across Lebanon.
• Generate evidence to be used to design services that better address the needs and gaps in healthcare provision and policies for adolescent girls.

Findings

The findings of the study are analyzed using the lens of the Behavioral Drivers Model; thus, the various factors and dimensions affecting girls healthcare seeking behavior are divided into psychological, social and environmental factors; gender dynamic cross-cut all factors.

1

Psychological factors that were found to affect adolescent girls' service seeking behavior include:

- Fear
- Low self-efficacy and limited decision-making
- Lack of awareness about services, including specialized services

2

Sociological factors that were found to affect adolescent girls' service seeking behavior include:

- The role of the gendered family structure
- Family roles
- Social influences
- Socioeconomic and political context

3

Environmental factors, structural factors that may drive behavior, include:

- Major barriers
- Poor communication and relationship with health care providers
- Wide lack of resources and a pervasive political and sectarian system

Findings

Key informant at a PHC.

*"They have fear. There is hmmm a certain group of people that is afraid for example of going to a mental health specialist, or they worry that society will consider them to be ill, or to be... for example crazy… **Socially these girls are being affected.**"*

Findings

1 Psychological factors that were found to affect adolescent girls' service seeking behavior include:

- **Fear** on the individual level as a main barrier, resulting from, among other things, lack of information about services and fear of family members' reactions. In other instances, fear of **stigma** associated with seeking health services, whether on SRH, mental health, or disclosing and seeking support for harassment, was also described.

- **Low self-efficacy and limited decision-making** as a result of overarching and governing social norms around gender roles and expectations.

- **Lack of awareness about services, including specialized services** such as CMR services, which affected their healthcare seeking behavior, and also the belief that PHC services are of lower quality.

18-19 year old Syrian girls discussed the way traditions and norms could impact the access to healthcare particularly when seeking care from male doctors.

"They say why are you going to a male doctor, the first thing we hear is that it's shameful, it's shameful for him to examine you, so if she wants to go to the doctor she would be disheartened and would just remain home instead."

Key informant interview with governmental entity.

*"**No one addresses this age group with appropriate sexual awareness**. Information from peers and the internet is wrong and inaccurate."*

2 Sociological factors that were found to affect adolescent girls' service seeking behavior include:

• The role of the **gendered family structure**, which can be either supportive or unsupportive and thus could be either a facilitator or a barrier to accessing care.

• **Family roles**, which are also tied into gender norms and roles, and which come into play with young girls being under the guardianship of their parents and thus being subjected to an added dimension of protectiveness beyond gender alone.

• Social norms also add to the **social influences** that drive healthcare seeking behavior, as concern about reputation is often a barrier to seeking healthcare or disclosing harassment.

• **Socioeconomic and political context** also play a significant role in access to care. The refugee status of some girls may make them more vulnerable to harassment. In addition, socioeconomic factors including poverty constitute a main barrier to accessing care and was one of the most salient barriers expressed in the findings.

3 Environmental factors, structural factors that may drive behavior, include:

• Major barriers are found on this level in terms of **accessibility - distance** (additionally concerns about transportation), **opening hours** (as many girls are at school or work), **safe locations, physical, infrastructure** (for example as a barrier to girls with physical disabilities) **and perceived quality** of PHCs (including overcrowding and privacy concerns).

"They are shy and afraid that suddenly someone opens the door and see them while they're being checked, these affect adolescent girls very much to the extent that once a girl started crying when we were doing an EKG (...) there was crowding and there was no privacy, when she entered the examination room with the physician they kept opening and closing the door."

Key informant at a PHC.

• Barriers pertaining to poor communication and relationship with health care providers were often a deterrent to seeking care.

• These barriers currently exist against the backdrop of **country wide lack of resources and a pervasive political and sectarian system**. Mentioned as a concern among girls and caregivers where it was expressed that nepotism or connection (political or sectarian) may play a role in provision of services and access.

Moreover, adolescent girls with disabilities face additional burdens in accessing appropriate care due to both physical and cognitive disabilities that affect mobility and communication, as well as increased exposure to harassment.

Emerging Findings

In addition to barriers and facilitating factors mentioned above, adolescent girls along with caregivers expressed very clearly health needs of this population. Very notably, mental health needs were highlighted as being of primary importance, both as a health need in and of itself, as well as a consequence of ill physical health. Moreover, caregivers specified the need for adolescent friendly sexual and reproductive health services. Also, in terms of health seeking behaviours, adolescent girls described seeking support from peers, family, schools, and pharmacies, while mentions of PHCs was largely absent.

10-13 year old Palestinian girls in Beirut.

"She was mentally ill and she was lonely and she hated going to school."

Emerging Findings

Key informant at a PHC.

"The Gynecologist only treats pregnant women. Do you see what I mean? This is a major problem for us, so if she has any infections, she's scared thinking how can this happen to me? I'm not pregnant, ***I'm not married, how can I go to a gynecologist to be examined?****"*

Recommendations

Referring to the analysis of the triangulated data gathered from all levels of stakeholders, and to the insights provided by the Behavioural Drivers Model on the main barriers faced by adolescent girls in accessing care as well as potential entry-points and points of intervention, and given the fact the access of all adolescents girls to quality services available in PHCs depends on several elements that need to work together including:

1) appropriate regulations, guidance and equitable financial coverage; 2) well-defined benefit package and adequate resource allocation for the provision of the package (quality and supply of services) and
3) supportive social norms and effective promotion, prevention and protection actions (enabling environment); below are preliminary recommendations that would contribute to strengthening these elements.

*"**She endured pain and didn't say anything** so that she would not be a burden."*

10-13 year old Lebanese girls in reference to the financial burden of healthcare on families.

14-17 year old Lebanese girls.

*"I can't pay (for healthcare), I can't drive, and I can't pay transportation costs. **The money barrier is a humanitarian barrier.**"*

Recommendations

At the Governance Level

1. Institutionalization of **collaboration and coordination mechanisms** between MoPH, MEHE and MoSA at the national and field levels, through signature of MoUs.[1] Within this framework, **establish clear referral pathways between these ministries at the national and field level**, to ensure the improved, and timely access of the target population to the needed services (particular between CMR, MHPSS, and SRH available in PHCs, and case management services available in some SDCs).

2. Develop guidance on the package of the services that need to be included in the adolescent friendly services for girls.

3. Ensure inclusion of adolescent girls friendly criteria, as elaborated in the guidance, in the PHC accreditation system within MOPH; and to have a minimum number (quota) of adolescent friendly facilities (PHCs or SDCs) available in each governorate with accommodation for adolescents with disabilities (accessibility for girls with disabilities and ensuring that staff are trained not to stigmatize).

4. Engaging with NGO partners on identification and optimization of resources needed to ensure needed health services (including physical, mental, nutrition, CMR, and sexual and reproductive) are made available to adolescent girls with the required quantity and quality, including married girls and adolescent girls with disabilities.

5. Strengthen partnerships between municipalities and MoPH for successful implementation of adolescent girls friendly health services.

1. The collaboration between MoPH, MEHE and MoSA can be also institutionalized through a binding decision issued by the Council of Ministers in Lebanon.

Recommendations

Recommendations

At the Service Provision Level

6 Capacity building of health care professionals in PHCs, SDCs, and health counselors in education settings, that focus on communication skills with AG, prevention of sexual abuse and exploitation, safe identification of GBV and referrals, and being sensitive to risk of stigmatization and discrimination against girls with disabilities.

7 Establish adolescent friendly health services at the level of schools, since this is the preferred venue expressed by adolescent girls.

8 Pilot and implement the establishment of adolescent girls friendly PHCs[2] and SDCs at national and governate level which provides tailored adolescent health services particularly in the most vulnerable communities.

9 Enhancing mental health and psycho-social support services (MHPSS) within PHCs for girls including recruitment of additional human resources and building capacity of current workforce.

10 Promote PHC services for all segments of the population (including Lebanese, Palestinian, and Syrian) through mass media with a focus adolescent girls and girls with disability, while ensuring messaging clarifies services provided in PHCs, their inclusivity (nationality, age, disability) and confidentiality.

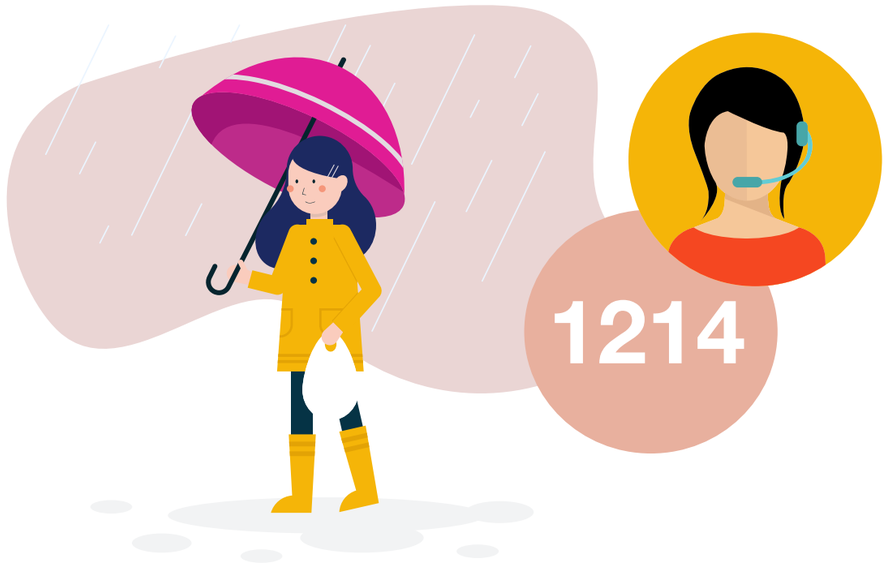
11 Continuous update of the service mapping and referral pathways in coordination between NGOs, PHCs, MOPH and relevant working groups.

12 Employ innovative tools and techniques (i.e. mobile applications, websites, social media, etc.) to share Health, SRH, MHPSS and GBV prevention information and services on adolescent girl's health with girls.

13 Continue to support life skills activities and program for adolescent girls, boys and caregivers and other gatekeepers (i.e. pharmacies), on topics related gender norms, GBV risks ad safety planning, interpersonal communication, negotiation skills, with emphasis on peer to peer approach.

2. Including PHCs that will be reconstructed after the Beirut Blast.

Recommendations



At the intersectoral level

14

Increase inter-sectoral collaboration between ministries and sectors to identify and address structural barriers, including:

a. Coordination on measures to address transportation barriers including coordination on subsidized transportation fees, including the possibility to implement unconditional cash programs in the most vulnerable areas.

b. Raising awareness on existing complaint mechanisms, such as the 1214 MOPH hotline, and ensure that complaint mechanisms on the level of PHCs currently exist and are safe, have strict information sharing protocols, and are accessible, effective, and properly promoted and well known by adolescent girls and their caregivers.

c. Inter-sectoral collaboration to ensure unified messaging around adolescent health services among frontline workers.

Recommendations

At the Community Level

15

Develop tools and activities that tackle or challenge harmful gender norms hindering access to SRH, MHPSS, CMR and general health services targeting both adolescent boys and girls, caregivers, and health care practitioners (i.e pharmacists).

16

Enhance awareness on MHPSS services to decrease stigma around seeking services for adolescent girls and their caregivers.

17

Maintain and update mapping and coordination with existing life-skills programs targeting youth and adolescents for capacity-building on self-efficacy, with an integrated approach focusing on health awareness.

18

Ensure and enhance GBV risk mitigation activities, while sharing with adolescent girls contextualized safeguarding measures, making sure to promote their leadership and participation.

19

Develop a community outreach/mobilization plan with local authorities such as municipalities in order to identify needs from the community, while ensuring that the plan includes the voices of adolescent girls' and highlights their requests and needs.

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