



ADOLESCENT EXPERIENCE OF CARE IN MATERNAL HEALTH, REPRODUCTIVE HEALTH, AND FAMILY PLANNING

A Scoping Review

MOMENTUM Knowledge Accelerator



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ABBREVIATIONS

AMELP	Activity Monitoring, Evaluation, and Learning Plan
FP/RH	Family planning/Reproductive health
IL	Innovations and learning
IR	Intermediate result
KII	Key Informant Interviews
KM	Knowledge management
MCSP	Maternal Child Support Program
M&E	Monitoring and evaluation
MEL	Monitoring, evaluation and learning
MKA	MOMENTUM Knowledge Accelerator
MNCH	Maternal, newborn, and child health
PIRS	Performance Indicator Reporting Sheets
PY	Project year
SC	Strategic communications
STIR	Science, Technology, Innovation, Research
USAID	United States Agency for International Development

BACKGROUND

Quality of care is “the extent to which health care services provided to individuals and patient populations improve desired health outcomes,” according to the World Health Organization (WHO). In order to achieve this, health care must be safe, effective, timely, efficient, equitable, and people-centered” (WHO, 2006). Quality of care is comprised of provision of care, which focuses on health systems and service delivery, and experience of care (EOC), the patient’s perception of whether the care they received was of high clinical quality (WHO, 2018). Both aspects are important outcomes among all populations, including adolescents.

Adolescents are unique in their needs, particularly those related to maternal health, reproductive health, and family planning care. Adolescence is the phase of life between childhood and adulthood, spanning ages 10 to 19 (WHO, 2018). It is important to distinguish between young adolescents (ages 13 to 17) whose parents may still be involved in their care, and older adolescents (ages 18 to 19), who may be married, legal adults, or have children. The needs of these different subpopulations vary considerably, as do their EOC.

Older adolescents may need care without informing their parents, may be reluctant to access care due to the social stigma of sexual activity at their age, may not have resources to access care, and may receive poor treatment from providers. They may also be more independent, are more likely to be sexually active and in need of contraception and other reproductive and maternal health services, navigating these issues with their spouse, and may be parents. Younger adolescents face barriers to accessing these types of health care because the services are sometimes deemed sensitive or inappropriate for young people based on cultural norms (Byczkowski et al., 2010).

We focus on patient EOC in this review to build upon recent work by the WHO. The WHO Patient Reported Experience of Care Measures (PREMS) broadly define important domains of EOC for all ages (WHO, 2022; see box).

Box 1: EOC Domains

- Prompt attention
- Dignity (physical privacy, compassion, courtesy, respect)
- Confidentiality
- Autonomy and shared decision-making
- Choice (facility-provider)
- Access to social support networks
- Quality of basic amenities
 - Sufficient time
 - Trust

However, the WHO standards for EOC for children and young adolescents are slightly different from PREMS in that they include families and caregivers in the domains (WHO, 2018). These WHO standards include the following:

- Standard 4: Communication with children and their families is effective, with meaningful participation, and responds to their needs and preferences.
- Standard 5: Every child’s rights are respected, protected, and fulfilled at all times during care, without discrimination.
- Standard 6: All children and their families are provided with educational, emotional, and psychosocial support that is sensitive to their needs and strengthens their capability.

Reviewing age-appropriate domains for measurement of adolescent EOC is important to distinguish the unique needs of this population compared to children and adults. Measurement of adolescent EOC is also paramount for improvements in health care quality efforts for adolescents.

Framing adolescent EOC using a positive youth development (PYD) perspective can also help with the understanding of adolescent EOC. According to U.S. Agency for International Development (USAID), PYD “engages youth along with their families, communities, and/or government so that youth are empowered to reach their full potential. PYD

approaches build skills, assets, and competencies; foster healthy relationships; strengthen the environment; and transform systems” (Youth Power, 2023). PYD is designed for youth ages 10 to 29 but accounts for the developmental stages of youth and their social, emotional, and cognitive skills at various ages. Therefore, considering the developmentally appropriate domains of adolescent EOC using a PYD approach can help to focus the aspects EOC that are most relevant to adolescents at different ages.

Through this review, we sought to understand current definitions of patient-reported EOC for adolescents; identify important theoretical domains to measure adolescent EOC; and identify measures of EOC for adolescents in maternal health, reproductive health, and family planning.

METHODS

We conducted a scoping review of peer-reviewed and grey literature on the domains relevant to the measurement of EOC and the range of measures currently in use for adolescents in maternal, reproductive, and family planning health care. Reproductive care included HPV vaccination and prevention, care, and treatment of sexually transmitted infections (STIs), including HIV/AIDS. We used key search terms (see box).

Box 2: Search Terms

- patient-centered care
- client-centered care
- respectful care
- experience of care
- adolescents
- youth
- teen
- adolescent maternal health
- adolescent reproductive health
- adolescent family planning, perceptions
- opinions
- maternal
- reproductive
- family
- health care
- perspectives

We searched for relevant published articles in the following databases: PubMed, Embase, Cochrane, WHO Regional Indexes, Ovid Global Health, JSTOR, POPLINE, CINAHL, African Journals Online, Scopus, Google Scholar, the USAID Development Experience Clearinghouse, and Web of Science. Our search parameters included literature from the last 10 years; from low- and middle-income countries (LMICs); available in English language; and related to EOC domains, or measurement of EOC, in adolescent maternal health, reproductive health, and family planning.

Our search using the above methods and criteria returned 82 articles. We excluded 31 articles for the following reasons: not adolescents (2), not EOC-related (19), not from an LMIC (9), and older than 10 years (1). We also reviewed 20 websites of adolescent reproductive health and family planning organizations (see Appendix A) for grey literature that met the same inclusion criteria we used in our search for peer-reviewed literature. We identified 8 relevant articles.

Next, we applied a modified Critical Appraisal Skills Programme (CASP) checklist to the 59 total articles that met our inclusion criteria (Critical Appraisal Skills Programme, 2023). Two researchers scored each article 1 to 9 points using the modified CASP checklist. Articles receiving scores of 7 to 9 points were considered high quality, 4 to 6 medium quality, and 1 to 3 low quality and excluded. After CASP review, 34 articles met our criteria for full review.

Ambresin et al. (2013) conducted a similar literature review to identify the domains most relevant to adolescent EOC; however, that review did not focus on LMICs. We build on their work to determine whether their identified domains and subdomains are also relevant in LMICs. The Ambresin et al. domains and subdomains (in parentheses) we used to assess the 34 articles included:

- **Accessibility** (location and affordability).
- **Staff attitudes** (respectful, supportive, honest, trustworthy, friendly).
- **Communication** (provision of information, active listening, communication tone).
- **Care** (confidential, autonomy, comprehensive, transition to adult services).
- **Environment** (flexibility of appointment times, separate physical space, teen health information, clean, waiting time, continuity of care, privacy).
- **Health outcomes** (involvement in care, pain management, quality of life).

We chose to apply these domains and subdomains to understand whether the same domains that were identified as important in developed countries were also deemed so in the LMIC literature, and whether additional domains were relevant in the LMIC context. Appendix C provides a comparison of the domains and subdomains identified by Ambresin et al. and the PREMS domains and WHO standards for EOC for children and young adolescents.

RESULTS

Identification of Theoretical Domains for Measurement Across Maternal Health, Reproductive Health, and Family Planning

We primarily identified articles exploring the theoretical domains of EOC; there were very few articles on measurement of adolescent EOC in maternal health, reproductive health, and family planning. Of the 34 identified articles, 23 were purely qualitative and 11 were quantitative or mixed-methods. Definitions of adolescent EOC were inconsistent across articles, and many of them overlapped with quality of care and provision of care. Therefore, we mapped the theoretical domains of EOC as defined by Ambresin et al. (2013) to ascertain their relevance in LMICs as evidenced in the literature.

Table 1 presents our findings by domain and subdomain.

Box 3: Modified Critical Appraisal Skills Programme (CASP) Checklist

- Section 1: Are the results valid?
 - Research aims: Was there a clear statement of the aims of the research?
 - Methodology: Is the methodology appropriate?
 - Research design: Was the research design appropriate to address the aims?
 - Recruitment: Was the recruitment strategy appropriate to the aims of the research?
 - Data collection/setting: Were the data collected in a way that addressed the research issue?
 - Data analysis: Were the data sufficiently rigorous?
- Section 2: What are the results?
 - Ethical considerations: Have ethical considerations been taken into account?
 - Findings: Is there a clear statement of findings?

Table 1. EOC Domains and Subdomains Identified in LMIC Literature Scoping Review

ARTICLE	ACCESSIBILITY		STAFF ATTITUDES					COMMUNICATION			CARE						ENVIRONMENT						HEALTH OUTCOMES					
	LOCATION	AFFORDABILITY	RESPECTFUL	SUPPORTIVE	HONEST	TRUSTWORTHY	FRIENDLY	PROVISION OF INFORMATION	ACTIVE LISTENING	COMMUNICATION TONE	CONFIDENTIAL	AUTONOMY	COMPREHENSIVE	INTEGRATED SERVICES	PROVIDER DEMOGRAPHICS	PROVIDER COMPETENCE	TRANSITION TO ADULT SERVICES	OPENING HOURS / FLEXIBILITY OF APPOINTMENT TIMES	SEPARATE PHYSICAL SPACE	TEEN HEALTH INFORMATION	CLEAN	WAITING TIME	CONTINUITY OF CARE	PRIVACY	INVOLVEMENT IN CARE	PAIN MANAGEMENT	QUALITY OF LIFE	
MATERNAL HEALTH																												
Ambresin et al. (2013)	x	x	x	x	x	x	x	x	x	x	x	x					x	x	x	x	x	x	x	x	x	x	x	x
Bohren et al. (2019)		x	x																									
Bwalya et al. (2019)			x				x				x							x	x					x				
Chikalipo et al. (2018)																												
Cumber et al. (2022)		x	x																					x				
Decker et al. (2021)			x					x		x																x		
Dutta et al. (2022)										x																		
Erasmus et al. (2020)			x	x						x																		
Habib et al. (2023)																						x						
Moucheraud et al. (2022)									x	x																		
Sewpaul et al. (2021)			x																									
Total articles (n)	1	3	7	2	1	1	2	2	2	5	2	1	1	0	0	0	1	2	2	1	1	2	1	3	2	1	1	
HIV																												
Adhiambo et al. (2022)													x	x	x				x									
Edwards et al. (2021)						x	x	x						x								x			x			
Lawrence et al. (2021)				x				x																				
Mavodza et al. (2022)			x											x														
Smith et al. (2018)			x					x	x		x									x								
Woollett et al. (2021)			x	x		x		x										x	x									
Total articles (n)	0	0	3	2	0	2	2	4	1	0	1	0	1	3	2	0	0	1	2	1	0	1	1	1	0	0	0	

Table 1. EOC Domains and Subdomains Identified in LMIC Literature Scoping Review (Continued)

ARTICLE	ACCESSIBILITY		STAFF ATTITUDES					COMMUNICATION			CARE							ENVIRONMENT					HEALTH OUTCOMES				
	LOCATION	AFFORDABILITY	RESPECTFUL	SUPPORTIVE	HONEST	TRUSTWORTHY	FRIENDLY	PROVISION OF INFORMATION	ACTIVE LISTENING	COMMUNICATION TONE	CONFIDENTIAL	AUTONOMY	COMPREHENSIVE	INTEGRATED SERVICES	PROVIDER DEMOGRAPHICS	PROVIDER COMPETENCE	TRANSITION TO ADULT SERVICES	OPENING HOURS / FLEXIBILITY OF APPOINTMENT TIMES	SEPARATE PHYSICAL SPACE	TEEN HEALTH INFORMATION	CLEAN	WAITING TIME	CONTINUITY OF CARE	PRIVACY	INVOLVEMENT IN CARE	PAIN MANAGEMENT	QUALITY OF LIFE
REPRODUCTIVE HEALTH																											
Bell et al. (2020)	x																	x			x						
Espinoza et al. (2020)						x				x																	
Godia et al. (2014)				x			x			x	x							x			x						
Kennedy et al. (2014)	x	x	x			x	x			x					x												
Mchome et al. (2015)			x														x				x		x				
Newton-Levinson et al. (2016)		x	x							x		x					x				x						
Pandey et al. (2019)	x		x							x		x		x										x			
Sychaureun et al. (2018)		x					x								x									x			
Tilahun et al. (2022)		x				x				x							x	x									
Total articles (n)	3	4	4	1	0	3	3	0	0	1	6	0	2	0	1	2	0	3	3	0	0	4	0	3	0	0	0
Family Planning																											
Calhoun et al. (2022)		x	x					x		x	x						x	x		x	x			x			
Castle et al. (2023)			x				X	x		x											x		x		x		
Darney et al. (2016)								x		x																	
Gebreyesus et al. (2019)	x		x					x							x					x	x						
Jayachandran et al. (2016)			x					x												x	x			x			
Slater et al. (2018)			x				x	x							x						x						
Tobey et al. (2023)								x																x			
Walker et al. (2021)			x					x	x	x																	
Total articles (n)	1	1	6	0	0	0	2	8	1	3	2	0	0	0	0	2	0	1	1	0	3	5	0	4	0	1	0

Across all articles, we found the following domains and subdomains most important to measurement of positive adolescent EOC as follows:

- **Accessibility** (location and affordability).
- **Staff attitudes** (respectful, trustworthy, friendly).
- **Communication** (provision of information, active listening, communication tone).
- **Care** (confidential).
- **Environment** (flexibility of appointment times, separate physical space, waiting time, privacy).

The domains and subdomains and their relevance to adolescent EOC are outlined in more detail below. In addition to these domains, we identified two additional subdomains, namely gender and age, relating to **provider type**.

ACCESSIBILITY DOMAIN

LOCATION AND AFFORDABILITY SUBDOMAINS

The accessibility domain emerged as influencing adolescent EOC. Location and affordability were identified as components of this domain. The studies consistently highlighted long distances to health centers as a key barrier to adolescents' ability to access care. Affordability was also recognized as a barrier, with concerns about the costs of services, commodities, and transportation. Additionally, lack of services in rural areas and financial constraints were recurrent themes.

Several studies identify ways in which adolescent EOC in antenatal care could be improved. In one study in Malawi, participants suggested adolescent-specific instead of mixed-age antenatal classes (Ankomah & Konadu Gyesaw, 2013). In another study in Blantyre, Malawi, adolescent experience of antenatal care was positive when they had a specific day for care, were peers of the same age group, and were able to freely discuss their concerns (Chikalipo et al., 2018). In contrast, a specific day for antenatal care was considered negative in a study in Ghana and Tanzania because adolescents wanted care available every day (Hackett et al., 2019).

Across several reproductive health services, adolescents face barriers to access due to service location and affordability. Rural adolescents in Vanuatu (Kennedy et al., 2013) and Nepal (Pandey et al., 2019) noted a lack of reproductive health services and distance to existing services. Citing distance, adolescents in Nepal used a private pharmacy near their homes instead of traveling to their village health facility (Pandey et al., 2019). In addition to the long distance to services, adolescents cited the cost of transportation as another barrier (Kennedy et al., 2013). Once they reached reproductive health services, adolescents were often asked to pay for medicines or tests that they could not afford, creating additional barriers, limiting service utilization, and diminishing their EOC (Sychareun et al., 2018a; Tilahun et al., 2022a).

Only two of the reviewed family planning papers included assessment of accessibility as it pertains to location and affordability. Calhoun et al (2022a) notes that clients appreciated that family planning commodities are dispensed free of charge in Nigerian public health facilities, but that stockouts occasionally require women to purchase them at private sector pharmacies. Gebreyesus et al. (2019b) measured facility distance from clients' homes in Ethiopia and found that clients who traveled more than 30 minutes to reach a facility were more likely to report being satisfied with services than those who traveled less than 30 minutes.

STAFF ATTITUDES DOMAIN

RESPECTFUL, TRUSTWORTHY, AND FRIENDLY SUBDOMAINS

The reviewed literature show that the domain of staff attitudes plays a pivotal role in shaping adolescent EOC. Providers' level of respect for the client emerged as the most frequently cited characteristic within this domain.

Trustworthiness and friendliness were also noted as important factors influencing adolescent EOC. The significance of having respectful, trustworthy, and friendly providers was underscored by respondents' fear of encountering disrespectful or untrustworthy providers. Provider friendliness was often remarked on positively, as adolescents shared experiences of supportive interactions characterized by kindness and understanding.

Authors of several qualitative studies from sub-Saharan Africa explored important domains for adolescent antenatal care. Researchers in a study in Lusaka, Zambia, of adolescent antenatal EOC showed that they were motivated to use care when they were treated well by providers; however, deterrents included poor treatment by providers, long wait times, lack of adolescent-specific spaces, crowded environments, and inconvenient hours. Adolescents also reported discrimination by providers if they were not married (Ankomah & Konadu Gyesaw, 2013). In a different study in Cape Town, South Africa, researchers found that respectful treatment helped increase antenatal care attendance, whereas experiences of discrimination, lack of information, victimization, and client mental health issues reduced attendance. Similarly, in Ghana and Tanzania, uptake of antenatal care by adolescents was higher when providers did not discriminate against adolescents (Hackett et al., 2019). In a study in South Africa, adolescents felt the providers were rude toward them and considered them immature, promiscuous, and shameless due to their age. This treatment discouraged adolescents from attending care, leading them to drop out of care or change clinics (Sewpaul et al., 2021).

Habib et al. (2023) conducted a systematic review of respectful maternal care interventions to reduce poor treatment of adolescents. In 17 studies included in that review, adolescents described poor treatment during labor and delivery and uncompassionate, humiliating, judgmental, disrespectful, and abusive care. Adolescents desired nonjudgmental, adolescent-friendly, caring, supportive, unbiased, and dignified care. Five studies from that review showed that birth companionship, when requested and allowed, led to better maternal health outcomes. The authors also noted that interventions that used an adolescent-centered, multifaceted approach were often more successful (Habib et al., 2023). Bohren et al. (2019), in a study of labor and childbirth in Nigeria, Ghana, Guinea, and Myanmar, found that age was the most important factor associated with poor treatment, with younger women (ages 15 to 19) experiencing higher levels of verbal and physical abuse, stigma, and discrimination compared to older women. The authors also found that younger, unmarried women were more likely to have non-consensual vaginal exams.

Adolescents also cited the importance of respectful, trustworthy, and friendly care across several articles about reproductive health and HIV care. Similar to respectful maternal care, adolescents feared judgmental providers who shamed them for being sexually active or experiencing an unintended pregnancy or sexually transmitted infection (Kennedy et al., 2013). Of particular importance were the staff attitudes toward the adolescents. Two reproductive health studies showed providers had paternalistic attitudes toward adolescents (e.g., not trusting them to make decisions for themselves), were judgmental and rude, and provided unfriendly treatment (Arije et al., 2022; Newton-Levinson et al., 2016a). This was also true for adolescents accessing HIV services, who reported judgmental and negative attitudes due to their age and marital status and stigmatization for being sexually active (Mavodza et al., 2022; Smith et al., 2019; Woollett et al., 2021a). For adolescents living with HIV, providers friendliness was cited as particularly important to perceived support from the provider (Edwards et al., 2021; Mavodza et al., 2022).

Most family planning papers (six of eight studies) assessed client perception of staff attitudes. While substantial overlap exists across the subdomains included within the staff attitude domain (i.e., treated with respect, treated with kindness), the predominant focus (six of eight studies) was on client perception of the importance of respectful treatment and/or the extent to which staff treated them respectfully. The two qualitative studies explored broad perceptions of staff attitudes and the influence staff attitudes have on family planning service demand, use, and satisfaction among adolescents (Calhoun et al., 2022a; Castle et al., 2023a). Castle et al. (2023b) found that, in Burkina Faso, positive staff attitudes heavily influenced adolescent perceptions of family planning service quality, which in turn positively influenced their use of family planning services.

Notably, adolescents were more likely than older women to experience stigmatization by providers, but still reported pursuing family planning services despite the potential for negative interactions. Calhoun et al. (2022a) reported that three-quarters of adolescents in their study mentioned the importance of treatment by the provider, and that respondents considered respectful treatment very important to their overall satisfaction. Calhoun et al. (2022a) also highlight that adolescent women commonly cited the importance of warm and respectful greetings as well as friendliness as important to their EOC. The absence of mistreatment, such as being shouted at, was critical to women's satisfaction.

The quantitative family planning studies (n=6) measured staff attitudes more narrowly while still allowing for overlapping characteristics of staff attitudes. Slater et al. (2018) measure the extent to which clients were treated "respectfully and kindly," while Gebreyesus (2019a) employed a survey that asking clients whether they were treated with respect and felt comfortable asking questions. Holt et al. (2021) employ the Quality of Contraceptive Counseling Scale, which includes a Disrespect and Abuse subscale, and identify that clients ages 19 to 24 are more likely to report experiencing disrespect and abuse than women in older age groups (Sychareun et al., 2018a; Tilahun et al., 2022a).

COMMUNICATION DOMAIN

PROVISION OF INFORMATION, ACTIVE LISTENING, AND COMMUNICATION TONE SUBDOMAINS

Although the communication domain was comparatively underrepresented in the reviewed literature, a notable finding was the impact of simple communication strategies on adolescents' comfort and experience. Adolescents appreciated health care staff engaging in simple acts such as greeting them, using facial expressions, and providing opportunities for self-expression. This highlights the potential of small communication gestures to contribute to a positive EOC for adolescents.

Moucheraud et al. (2022a) used Service Provision Assessment (SPA) surveys from 2012 to 2018 from several sub-Saharan African countries to assess adolescent experience of antenatal care—including satisfaction, wait time, discussion of problems, explanations, auditory and visual privacy, availability of services, availability of medicines, treatment by staff, cleanliness, and cost—to determine whether adolescents reported better or worse EOC compared to adults. The authors found that adolescents had fewer discussions with providers and were less likely to receive complete antenatal care compared to older women, especially among first-time mothers (Moucheraud et al., 2022b).

In a study by Decker et al. (2021) examining youth experiences of maternal care in Mexico, youth said they could not express their experiences of pain during delivery for fear of negative consequences from providers. The young mothers also felt they were unable to question clinical decisions or disagree with their providers. Youth in labor said they were turned away by providers who said it was too early to be admitted to the hospital, and one adolescent reported giving birth in the street as a result (Decker et al., 2021).

Several reproductive health studies cited lack of communication with younger adolescents (ages 10 to 14) when trying to integrate their care across primary care and specialized services for sexually transmitted infections (Newton-Levinson et al., 2016b) or lack of time to discuss issues in-depth with adolescents (Pandey et al., 2019). Even simple greetings and positive facial expressions to communicate support were important to adolescents in a study in Kenya, as was the opportunity to for adolescents to thoroughly explain their problems (Godia et al., 2014). For adolescents living with HIV, communication on the latest health information and provision of reliable, relevant, and tailored information were cited as important to their treatment (Smith et al., 2018; Woollett et al., 2021b).

All the family planning studies reviewed included assessment of the provision of information, a well-established indicator of the quality of family planning services (Bruce, 1990). Calhoun et al. (2022a) identified that while information provision was valuable to all adolescents, regardless of reason for their visit, their need and desire for information did vary. For example, adolescents who had never used family planning before valued information about several different methods, while resupply clients valued brief visits with limited exchange of information. Darney et

al. (2016) measured the extent to which adolescent and young women in Mexico felt that they were given sufficient time to receive all the information they needed. In the studies reviewed, the subdomain of communication tone overlaps conceptually with staff attitudes. In Niger, most women considered the provider's use of greetings and a courteous, calm, and warm demeanor as the most important attributes of a family planning visit. Through use of the Quality of Contraceptive Counseling tool, Walker et al. (2021) was the only study reviewed that measured the extent to which clients perceived active listening by their provider.

CARE DOMAIN

CONFIDENTIAL SUBDOMAIN

The care domain encompasses several key components, with confidentiality and provider demographics emerging as particularly significant. Confidentiality emerged as a central element of adolescent EOC across most of the reviewed articles. Adolescents expressed the need for their interactions with providers to remain confidential and sought assurance that shared information would not become known within their communities. Notably, provider age and gender were also key factors influencing adolescents' perceptions of care quality.

Adolescents were particularly afraid of providers breaching their confidentiality (Espinoza et al., 2020; Tilahun et al., 2022b). Specifically, they feared that due to lack of privacy, they would be seen by friends, relatives, or community members (Kennedy et al., 2013) or overheard (Newton-Levinson et al., 2016b). These fears were deterrents for adolescents to use reproductive health services. Godia et al. (2014) showed that when privacy was provided and respected, adolescents were better able to plan for their future lives and prevent unwanted pregnancies and early marriage, especially when parents were unable to educate their children about reproductive health. For adolescents living with HIV, trust established with a provider over time was important, especially in terms of preserving their confidentiality (Edwards et al., 2021) (Woollett et al., 2021a).

None of the six quantitative family planning studies specifically measured client perception of confidentiality, though privacy is commonly measured. Within the qualitative studies reviewed, the subdomains of confidentiality and privacy also overlap. In studies exploring perceptions of family planning service quality in Burkina Faso and Niger, women explained that they prioritize privacy and confidentiality as important drivers of satisfaction with services (Calhoun et al., 2022b; Castle et al., 2023b).

ENVIRONMENT DOMAIN

FLEXIBILITY OF APPOINTMENT TIMES, SEPARATE PHYSICAL SPACE, WAITING TIME, AND PRIVACY SUBDOMAINS

Within the environment domain, four components were identified as critical for adolescent EOC. Inflexible appointment times and long wait times were identified as procedural barriers that affected access to care. The physical environment, including the provision of separate spaces for adolescents, was emphasized as important for maintaining privacy and fostering a positive care experience. Furthermore, the design and layout of waiting areas were noted as important to adolescents' comfort and sense of privacy.

Flexibility of appointment times were of great importance to adolescent EOC. For example, in Ethiopia, adolescents could only access reproductive health care during weekday business hours, and when they were able to come in for services, providers were often absent or assigned to other units. Further, adolescents desired weekend and nighttime appointments, but none were available (Tilahun et al., 2022b). In another study, lack of service hours and inability to pre-book appointments created additional barriers to accessing care, thus making for a negative EOC (Mchome et al., 2015).

In several studies, physical space was cited as important, usually in regards to the proximity to other services or the confidentiality offered by a location. In Ethiopia, when HIV services (ART treatment and physical exams) were closer to each other, adolescents found them easier to use (Tilahun et al., 2022b). In another study in Kenya, adolescent boy

participants said that while the waiting area and services at the health facilities were amenable to girls, they did not meet the needs of boys (Godia et al., 2014). Another important aspect to adolescent EOC was wait time; many adolescents reported waiting long times for care (up to three hours), only to be told they were in the wrong place (Mchome et al., 2015).

A lack of privacy was common in public health facilities in Laos, Nepal, and Tanzania, with serious implications for breach of confidentiality. Providers often saw adolescents and discussed sensitive issues in open areas, when other patients were in the room, or close to waiting rooms where conversations could be overheard. Adolescents feared that their friends, neighbors, or other community members would see them and report back to their parents or others (Mchome et al., 2015; Pandey et al., 2019; Sychareun et al., 2018b). Concerns about privacy and confidentiality were especially important to adolescents living with HIV because of the potential for social stigma or public exposure of their HIV status (Edwards et al., 2021; Adhiambo et al., 2022).

DISCUSSION AND CONCLUSION

As part of this scoping review, we originally sought to understand definitions of EOC for adolescents in maternal health, reproductive health, and family planning; to determine domains relevant to adolescents in LMICs; and to identify any measurement of EOC in the literature from these countries in the last 10 years. In this review of LMIC-specific articles, we identified the most important measurement domains in adolescent EOC for maternal health, reproductive health, and family planning, namely staff attitudes, accessibility, communication, care, and environment (as defined by Ambresin and colleagues).

Our main findings were a lack of consistency in the definitions of EOC and scant measurement of EOC in LMICs. There is a need to create a comprehensive definition of the components of EOC for adolescents in LMICs, and to develop a conceptual framework for how adolescent EOC influences health outcomes. Using these new tools, it would be feasible to develop and test a comprehensive measure of EOC for adolescents in LMICs; current tools only include some but not all of the Ambresin domains and subdomains. Furthermore, we need to test such measures with only adolescents (ages 15 to 19) and not with all women of reproductive age (ages 15 to 45), and between younger adolescents (ages 13 to 17) compared to older adolescents (ages 18 to 19). Afulani and colleagues (2023) also argue that a comprehensive scale of adolescent EOC in sexual and reproductive health is needed due to the paucity of measurement of EOC in LMICs. The application of scales developed in high-income countries may not be relevant to LMIC contexts, and current measures developed in LMICs are not comprehensive enough to capture all aspects of EOC. We also suggest a new domain (provider type) and two subdomains (provider gender and age) that may be relevant for the development of a comprehensive measurement tool for adolescent EOC.

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APPENDIX A: WEB CONTENT FROM ADOLESCENT HEALTH ORGANIZATIONS

- Advocates for Health: <https://www.advocatesforyouth.org/>
- EngenderHealth: <https://www.engenderhealth.org/>
- Family Planning High Impact Practices: <https://www.fphighimpactpractices.org/briefs/adolescent-responsive-contraceptive-services/>
- FP2030: <https://fp2030.org/ayfp>
- Guttmacher Institute: <https://www.guttmacher.org/>
- Institute for Reproductive Health: <https://www.irh.org/projects/passages/>
- International Center for Research on Women: <https://www.icrw.org/>
- International Center for Research on Women: <https://www.icrw.org/wp-content/uploads/2016/10/140701-ICRW-Family-Planning-Rpt-Web.pdf>
- International Planned Parenthood Foundation: <https://www.ippf.org/>
- Ipas: <https://www.ipas.org/>
- MSI Reproductive Choices: <https://www.msichoice.org/>
- PAI: <https://pai.org/>
- PATH: <https://www.path.org/programs/reproductive-health/youth/>
- Pathfinder: <https://www.pathfinder.org/>
- Population Council: <https://popcouncil.org/>
- PSI: <https://www.psi.org/>
- Save the Children: <https://www.savethechildren.org/us/what-we-do/health/adolescent-sexual-and-reproductive-health>
- UNFPA: <https://www.unfpa.org/resources/adolescent-sexual-and-reproductive-health>
- UNFPA: <https://www.unfpa.org/resources/contraception-adolescents-and-youth>
- Women Deliver: <https://womensdeliver.org/youth/strengthening-skills/youth-news-and-resources/youth-resource-center/>

APPENDIX B: CITATIONS FOR ALL REVIEWED ARTICLES

Maternal Health

- Ambresin, A.-E., Bennett, K., Patton, G. C., Sanci, L. A., & Sawyer, S. M. (2013). Assessment of youth-friendly health care: A systematic review of indicators drawn from young people's perspectives. *Journal of Adolescent Health, 52*(6), 670–81. <https://doi.org/10.1016/j.jadohealth.2012.12.014>
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APPENDIX C: COMPARISON OF AMBRESIN ET AL. DOMAINS AND PREMS DOMAINS AND WHO STANDARDS FOR EOC FOR CHILDREN AND YOUNG ADOLESCENTS

WHO PREMS	AMBRESIN
Prompt attention	Environment (waiting time)
Dignity (physical privacy, compassion, courtesy, respect)	Environment (privacy) Staff attitudes (respectful, supportive, honest)
Confidentiality	Care (confidential)
Autonomy and shared decision-making	Care (autonomy)
Choice (facility-provider)	Environment (separate physical space)
Access to social support networks	Environment (continuity of care)
Quality of basic amenities (Sufficient time, trust)	Care (comprehensive) Staff attitudes (trustworthy)
WHO EOC STANDARDS FOR CHILDREN	AMBRESIN
Standard 4: Communication with children and their families is effective, with meaningful participation, and responds to their needs and preferences.	Communication (provision of information, active listening, communication tone) Health outcomes (involvement in care, pain management, quality of life)
Standard 5: Every child’s rights are respected, protected, and fulfilled at all times during care, without discrimination.	Staff attitudes (respectful, supportive, honest, trustworthy, friendly)
Standard 6: All children and their families are provided with educational, emotional, and psychosocial support that is sensitive to their needs and strengthens their capability.	Staff attitudes (respectful, supportive, honest, trustworthy, friendly) Communication (provision of information, active listening, communication tone)