# The Qualitative Study on Assessing Supply Side Constraints Affecting the Quality of Adolescent Friendly Health Services and the Barriers for Service Utilization in Nepal

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***The Study Team***

## The Study Team

### The Core Team

| | |
|---|---|
| Dr Elissa Kennedy | *International Consultant* |
| Anand Tamang | *Study Coordinator* |
| Dinesh Dhungel | *Research Associate* |
| Romi Giri | *Research Officer* |
| Achala Shrestha | *Research Officer* |

### Field Researchers

| | | |
|---|---|---|
| Kamala Karki | Laxmi Bhandari | Jiban Kharel |
| Punam Shrestha | Sirjana Poudel | Surya Prasad Yadav |
| Poonam Sharma | Anustha Mainali | Prabin Dhakal |
| Santoshi Thapa | Sabitri Chaudhary | Man Bhahadur Rai |
| Hemu Khadka | Sony Maharjan | Khagendra Prasad Bhatta |
| Saraswoti Shrestha | Maiya Koirala | Dipak Bhahadur Ayer |
| Chanda Singh Tharu | Reshma Adhikari | Kamal Prasad Ghimire |
| Laxmi Bhusal | Sita Sapkota | Nirajan Khadka |
| Shreeshti Uchai | Naveen Prasad Bhatt | Diwakar Shrestha |
| Gita Poudel Chhetri | Sita Ram Darlamee | Jay Lal Paudel |
| Nirmala Kumari Sigdel | Madhu Bilas Neupane | Kripa Thapa |
| Nisha Sharma | Shyamendra Jha | Rameshwor Karki |
| Nani Kumari Maharjan | Pramod Kumar Yadav | Krishna Bhahadur Chand |
| Gita Ghimire | Surya Narayan Adhikari | Umesh Adhikari |
| Rojeena Shrestha | Kamal Shrestha | Rammani Lamsal |
| Babita Adhikari | Dhurba Koirala | Ramesh Dhungel |

### Project Support Unit

| | |
|---|---|
| Sabina Tamang | *Administration & Finance* |
| Dev Chandra Maharjan | *Data Management Officer* |
| Radhika Singh | *Word Processor* |
| Priyanka Vaidhya | *FES Data Manager* |

## Abbreviations and Acronyms

| | |
|---|---|
| AFHS | Adolescent-Friendly Health Services |
| ANC | Antenatal Care |
| CREHPA | Center for Research on Environment Health and Population Activities |
| DHO | District Health Office |
| DoHS | Department of Health Services |
| FCHV | Female Community Health Volunteer |
| FES | Focus Ethnographic Study |
| FGD | Focus Group Discussion |
| FHD | Family Health Division |
| FPAN | Family Planning Association of Nepal |
| FPC | Family Planning Contraceptive |
| GIZ | German Society for International Cooperation |
| GoN | Government of Nepal |
| HFOMC | Health Facility Operation and Management Committee |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome |
| HMC | Health Management Committee |
| HP | Health Post |
| IDI | In-depth Interview |
| IEC | Information Education Communication |
| KII | Key Informant Interview |
| MCH | Maternal and Child Health |
| MoHP | Ministry of Health and Population |
| NGO | Non-governmental Organization |
| NHRC | Nepal Health Research Council |
| OPD | Out-patient Department |
| PHCC | Primary Health Care Centre |
| PMTCT | Prevention of Mother to Child Transmission |
| PNC | Postnatal Care |
| SHP | Sub-health Post |
| SRH | Sexual and Reproductive Health |
| SSI | Semi Structured Interview |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| VCT | Voluntary Counseling and Testing |
| WHO | World Health Organization |
| YP | Adolescents |

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# CHAPTER 1
# INTRODUCTION

## 1.1 The health of adolescents in Nepal

Adolescents (10-19 years old) account for nearly a quarter (approximately 6.4 million or 24.2%) of Nepal's population.This developmental stage marks the critical transition from childhood to adulthood, during which physical, emotional, cognitive and social changes expose adolescents to new health needs and risks. It is also a period when opportunities to modify health risks and behaviours are great, with implications for health and wellbeing in later life as well as for health of future generations.[2]

While generally considered a healthy time of life, adolescents in Nepal face a number of challenges including harmful gender norms and practices including early marriage, dowry and Chaupadi* trafficking, negative peer pressure, limited economic opportunities, and limited youth participation within family, community and at national level. Consequently, adolescents suffer from preventable poor health, especially related to mental health, substance use, poor nutrition and injury and, in particular, poor sexual and reproductive health (SRH).

The mean age of menarche in Nepal is 13.5 years, and semenarche 14.5 years,[3] heralding the onset of puberty. This period brings significant physical and emotional changes and with it a need for SRH information and services. Available data suggest that many adolescents are not well prepared for this transition. While most adolescents are aware of some of the physical changes of puberty, comprehensive knowledgeabout SRH is low and only half of adolescents have discussed puberty with parents or received information through school.[3, 4] A 2007 study of adolescent girls aged 13-15 years reported that only 41% had adequate knowledge about menstruation and only 13% practiced good menstrual hygiene.[5]

Onset of sexual activity is common during this age group. The 2010/11 Nepal Adolescents and Youth Survey (NAYS), the first nationally representative household survey focusing on adolescents, reported that 38% of boys and half of girls aged 15-24 years had ever had sexual intercourse.[3] According to the 2011 Demographic Health Survey (DHS), 7% of girls and 3% of boys of this age have had sex before the age of 15.[6]

Sexual activity among girls occurs almost universally within the context of marriage. While the age of first marriage is increasing, 60% of girls are married by the age of 20 and 7% before the age of 15.[67-9]Early marriage is associated with early pregnancy and can also increase the risk of other adverse outcomes such as sexually transmitted infections (STIs) and gender-based violence. Despite strong socio-cultural disapproval of premarital sex, one in five unmarried boys

*It is a traditional practice in which girls are forced to stay outside home in a cowshed during their menstruation as they are

aged 15-24 years report having had sex[6], and some studies have suggested that the prevalence of premarital sex among males, particularly in urban areas, is increasing.[10-13] Boys are also more likely to report higher risk sexual behaviours, as adolescents are key affected populations, including adolescents living with HIV.[14] With the rising age of marriage, premarital sex is also increasing among girls: a 2006 study of urban factory workers aged 14-19 years reported that one in eight unmarried females had ever had sex.[15]

Available data indicate that adolescents have a significant unmet need for comprehensive SRH information and services. Awareness of HIV and STIs is high, however less than a third of adolescents have comprehensive understanding of HIV prevention, girls more so than boys.[16-19] Comprehensive knowledge about family planning, reproduction and pregnancy is also low and misconceptions are common.[3, 20] Adolescents, females, particularly adolescent girls, are also less likely than adult women to have discussed family planning with a health worker either at a facility or through outreach services.[6]

In addition to inadequate knowledge, many adolescents also lack self-efficacy and life skills in relation to safer sex and prevention of HIV.[17, 21, 22] Use of condoms at first sex,[23] last sex,[24] and consistent use[15, 19, 25] is low among this age group: NAYS reported that only a third of sexually active adolescents males used a condom at last sex.[6] Use of modern methods of contraception has increased in the last decade, however only 21% of currently married girls aged 15-24 years use a modern method of contraception and more than a third have an unmet need for family planning – the highest of any age group.[6]

Subsequently, adolescents suffer a disproportionate burden of poor SRH. Key indicators are summarised in Table 1.1. According to the 2011 DHS, more than 11% of girls aged 15-24 years who have ever had sex report having had an STI or STI symptoms in the previous 12 months. Seven percent of boys report the same, with the prevalence of STI or STI symptoms in this age group more than double that of all other ages.[6] The majority of key populations, including people who inject drugs, women who sell sex, and men who have sex with men, are aged less than 25 years and/or initiate high risk behaviours during adolescence. These key affected populations account for a significant proportion of new HIV infections and also suffer high rates of STIs.[26-29]

While adolescent fertility rates have declined in Nepal over the past two decades, 2011 estimates indicate that 39% of girls have commenced childbearing by the age of 19 years.[6] Early pregnancy is associated with poorer health and socioeconomic outcomes for girls and also higher rates of preterm birth, low birth weight and neonatal mortality.[31-33] While the majority of adolescent pregnancies occur within marriage, many are unintended.

Other health risks affecting adolescents in Nepal are less well described in published literature, but include: injury due to road traffic accidents;[43] high prevalence of iron deficiency anaemia, particularly among girls;[44] and substance use, including tobacco smoking, alcohol and cannabis.[45, 4647] Poor mental health is also an important health concern among this age group:

11% of adolescents in the NAYS reported that they had felt sad or depressed for several days in the previous 12 months, but 80% did not seek care for these problems.[3]

**Table 1.1 Proportion (%) of adolescents aged 15-19 years with selected SRH indicators**

| Indicator | Female | Male |
|---|---|---|
| | 15-19 | 15-19 |
| Ever had sex | 29.0 | 20.7 |
| Ever married | 29.0 | 7.1 |
| Ever experienced physical or sexual violence | 12.3 | - |
| Current use of modern contraception (married) | 14.4 | - |
| Unmet need for family planning (married) | 41.5 | - |
| Commenced childbearing | 16.7 | - |
| Comprehensive knowledge HIV | 25.0 | 32.7 |
| Used a condom last sex | - | 44.8 |
| Ever had an STI or symptoms of STI | 9.6 | 13.6 |
| Ever been tested for HIV and received result | 5.1 | 10.5 |

*Source: 2011 DHS*[30]

## 1.2 The role of adolescent friendly health services

Health services play an important role in reducing preventable ill health among adolescents and supporting a healthy transition into adulthood. In addition to providing essential curative care for common adolescent health complaints, health services are also a crucial source of preventive services related to SRH, nutrition, substance use, mental health and other risk factors for poor health later in life. Health facilities can also be an important entry point for broader health promotion interventions: around half of all adolescents in Nepal report accessing a health facility in the previous 12 months, 43% of these from a government facility, representing a key opportunity to provide comprehensive health information and counselling.[3] Indeed a review of adolescent's SRH in Nepal reported that health services are an important source of sexuality education and counselling, although attention to provider attitudes and skills and accessibility is key. [48]

The particular health needs of adolescents, their rapidly evolving emotional and cognitive capacity, and the socio-cultural context in which they live have important implications for health systems and service delivery.[49] Facilities that are generally focused on maternal and child health and curative care need to be orientated and equipped to provide a comprehensive and integrated package of services, including preventative services that address the broad needs and risks of adolescents. Health providers also require additional knowledge and skills to effectively and sensitively deal with adolescents – including communication and counselling skills and an understanding of the developmental aspects of adolescent's health. Adolescent's increasing autonomy and need for privacy also have implications for the physical environment of facilities as well as policies related to confidentiality and consent. Services also need to be accessible and address the unique socio-cultural, financial and other barriers that prevent

adolescents accessing health facilities, particularly for sensitive issues such as SRH and substance use.[49, 50]

Adolescent friendly health services (AFHS) are those that provide quality care that is accessible, appropriate and acceptable to adolescents.[51] The recently developed World Health Organisation global standards for AFHS are summarised in Box 1.[50] Evidence from low and middle income countries in Africa and Asia has shown that where efforts have been made to incorporate these features into health services, use of services by adolescents has increased, particularly when linked with other strategies to generate demand and create an enabling environment for adolescents.[49, 52]While much of the global literature around AFHS focuses on provision of SRH services, the principles of AFHS apply to other adolescent health concerns such as mental health, substance use, nutrition, and injury and AFHS should have the capacity to effectively respond to these needs. Such issues not only contribute substantially to the short and long-term health burden impacting on adolescents, they also increase risks associated with SRH.

**Box 1: World Health Organisation, global standards for quality services for adolescents**

**Standard 1.** Adolescents are knowledgeable about their own health, and know where and when to obtain health services, and use them.

**Standard 2.** Parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents. They support such provision, and utilization of services by adolescents.

**Standard 3.** The health facility provides a package of information, counseling, diagnostic, treatment and care services that fulfill the needs of all adolescents. Services are provided in the facility, through referral linkages and outreach.

**Standard 4.** Health care providers demonstrate technical competence required to provide effective health services to adolescents. Both health care providers and support staff respect, protect and fulfill adolescents' rights to information, privacy, confidentiality, non-judgmental attitude and respect.

**Standard 5.** The health facility has convenient operating hours, a welcoming and clean environment, and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.

**Standard 6.** The health facility provides quality[2] services to all adolescents irrespective of their ability to pay, age, sex, marital status, schooling, ethnic origin, sexual orientation or other characteristics.

**Standard 7.** The health facility collects, analyzes and uses data on service utilization and quality of care disaggregated by age and sex to support quality improvement. Health facility staffs are supported to participate in continuous quality improvement.

**Standard 8.** Adolescents are involved in the planning, monitoring and evaluation of health services, in decisions regarding their own care as well as in certain appropriate aspects of service provision.

## 1.3 National adolescent friendly health services policy and guidelines

The Government of Nepal has identified adolescents as an important and underserved population, and critical to achieving national health and development goals.[53] In the past two decades, there have been increasing intersectoral collaborative efforts to develop and implement strategies to improve adolescent's health, with an emphasis on SRH, which is reflected in several national policies, plans and strategies.

Following commitments made at the 1994 International Conference on Population and Development, ASRH was identified as an integral part of the **1998 National Reproductive Health Strategy** and included as a core component of the essential reproductive health services package. To support implementation, the Family Health Division (FHD) developed the **National Adolescent Health and Development (AHD) Strategy in 2000**, which included AFHS as a key objective and detailed activities required to improve access to and utilisation of counselling and services.[53] Subsequently, the **2007 Implementation Guideline for ASRH** was developed to assist district level managers to implement the National AHD Strategy, emphasising youth participation, equity, and linkages with other youth health and development initiatives.[54] These guidelines provided the first national standards for AFHS, consistent with WHO global guidance on delivery of adolescent-friendly services. They detailed comprehensive SRH services to be provided at each health facility level and specific actions, roles and responsibilities to effectively organise services to ensure quality, acceptability and accessibility.

In **2010 the National Adolescent Sexual and Reproductive Health Program** was developed by FHD, outlining the health sector response to adolescents' SRH needs. The Program drew on lessons learned from a review of activities conducted as part of the Reproductive Health Initiative for Youth in Asia (RHIYA) program, and a pilot of the ASRH program in 26 health facilities in Baitadi, Bardiya, Surkhet, Dailekh and Jumla districts. The National ASRH Program was included as a key component of the National Health Sector Program (NHSP) II, with the major focus on the provision of AFHS through the public health system. The NHSP II includes a target to deliver the National ASRH Program in 1000 public health facilities by 2015.[55] Key elements of the Program include:

- Upgrading 13 facilities (from sub-health post to district hospital) in each district to provide AFHS and generate demand in communities
- Equipping facilities with basic equipment to provide private and confidential services
- Providing health workers with an adolescent job aid, counselling flipchart, and IEC materials
- Involving adolescents in decision-making regarding adolescent issues through Health Facility Operation and Management Committees (HFOMC)participation
- Providing appropriate SRH services (including family planning, abortion, safe motherhood, HIV and STI services) and recording service utilisation

Following a review of national and global evidence and experience, lessons learned from pilot programs, and consultation, the **National Adolescent Sexual and Reproductive Health Program Implementation Guide** was finalised in 2011.[56] Building on the 2007 guidelines, this document

provides specific guidance on national AFHS standards and actions required at programmatic, facility and provider level to support delivery of the ASRH Program.

The national standards for AFHS include:

1. Service delivery packages responding to adolescents' health needs should be provided at service delivery points and developed by the district health manager with participation of adolescents
2. Health services should be organised to effectively deliver services, ensuring availability of trained providers, equipment and supplies
3. Conducive facility environment is provided that identifies and addresses the barriers that adolescents face accessing services
4. Service providers have the capacity and motivation to address the needs of adolescents (includes clinical and support staff)
5. An enabling community environment exists for adolescents to access services
6. Adolescents are well informed about services
7. Adolescents and youth are provided with skills-based SRH education
8. Protection of sexual and reproductive health and rights of adolescents and removal of stigma and discrimination
9. Health management systems are in place to support planning, implementation and monitoring

The prescribed characteristics of AFHS are summarised in Box 2, providing a comprehensive set of standards consistent with global guidance concerning provision of services to adolescents.

Importantly, the guidelines also provide direction on the selection of facilities to implement AFHS. Considerations include: having male and female providers available (preferably under the age of 30 years); availability of interested and motivated providers; adequate infrastructure to ensure privacy confidentiality and comfort (such as safe drinking water and toilet facilities); provide a range of SRH services on site; motivated HFOMC and Village Development Committee (VDC); availability of civil society and non-government organisations and other adolescent programs; located near schools; and located close to adolescents vulnerable to STIs, HIV and unwanted pregnancy.

The guidelines also outline comprehensive SRH services to be provided to adolescents. These include counselling services, provision of family planning (including emergency contraception), maternal health care, comprehensive abortion care (including medical abortion), HIV and STI prevention, testing and treatment, management of sexual and gender-based violence, and information, education and services for general health concerns. Outreach services through Female Community Health Volunteers (FCHV) are also included in the program, which includes referral and promotion of AFHS and provision of contraceptives and condoms.

The National ASRH Program is also supported by the **National Adolescent Sexual and Reproductive Health Communication Strategy 2011-2015.**[57]The strategy was developed by the National Health Education, Information and Communication Center (NHEICC), with the goal of

increasing adolescents' knowledge and skills related to SRH, increasing demand for and utilization of health services (to be phased in line with the scale-up of AFHS), and promoting an enabling environment for ASRH at household, community and facility levels through advocacy, social mobilization and behavior change communication.

**Box 2: Characteristics of AFHS**

**Programmatic:**

- Involvement of adolescents in program development and implementation
- Male and female adolescents welcomed and treated equally
- Unmarried clients welcomed and served without prejudice
- Parental involvement encouraged but not compulsory
- Adequate supply of contraceptives
- Short waiting time
- Availability of IEC materials at facility
- Services in locations frequented by adolescents and AFHS details promoted in the community
- Coordination with schools, youth clubs and other institutions
- Provision of alternative ways for adolescents to access information, counseling and services outside routing health care delivery system

**Facility**:

- Convenient opening hours for adolescents
- Convenient location
- Adequate space
- Appropriate place for registration and waiting
- Ensure sufficient privacy (visual and auditory)
- Welcoming environment (quiet, availability of drinking water, toilet facilities)
- Availability of IEC and BCC materials

**Health service providers**:

- In-depth knowledge and skills concerning counseling, examination and referral
- Trained on ASRH issues (through National Health Training Centre)
- Shows respect without prejudice
- Ensures privacy and confidentiality
- Spends adequate time with clients
- Trained and capable of providing counseling on ASRH issues

The National ADH Strategy, National ASRH Program and Implementation Guidelines, and the National ASRH Communication Strategy affirm the rights of adolescents to comprehensive, non-judgmental and confidential counselling and services related to SRH. They also provide specific guidance to support the delivery of AFHS, including standard operating procedures, based on both national and global evidence and best practice. Recognising the broad needs and challenges adolescents face, these strategies also include actions to increase adolescent's knowledge and skills and create a community and policy environment that supports adolescent health and development. This includes generating demand for AFHS through branding (AFHS logo), promotion through peer educators, youth organisations and media, linkages with schools, and interventions to increase community and parental support.

# CHAPTER 2
# METHODOLOGY

## 2.1 Objectives of the study

The aim of this study was to explore the supply and demand side barriers impacting on access to and utilization of adolescentfriendly health services (AFHS) by adolescents aged 10-19 years across diverse socio-cultural and geographical settings in Nepal.

The specific objectives were to:

1. Assess the extent to which existing AFHS are meeting national and WHO guidelines
2. Assess current utilization of services by adolescents aged 10-19 years and identify service provision gaps
3. Assess the availability, comprehensiveness and quality of service provider training and job aides
4. Explore providers' and facility mangers' perceptions about the challenges providing AFHS and how these might be overcome
5. Explore adolescents' perceptions of current AFHS
6. Identify the barriers that limit adolescents' access to AFHS
7. Explore perceptions of adolescents about how to improve access to AFHS
8. Explore the perceptions and attitudes of community gatekeepers (including parents) regarding AFHS

## 2.2 Study design

A mixed methods study was conducted to explore current utilization of AFHS, barriers and enablers impacting on provision of services and accessibility from the perspectivesof adolescents, community gatekeepers and service providers. Qualitative methods, including focus group discussions, focused ethnographic study tools, in-depth interviews and key informant interviews were used to explore experiences, barriers and enablers related to AFHS access and provision. Quantitative methods included a standardized facility observation checklist and secondary analysis of facility client records. Primary data collection was supplemented by a desk-based review of existing policies, guidelines and evaluations of AFHS in Nepal. A detailed data collection tools are included as Annex 1.

## 2.3 Study sites and population

This study was conducted in 12 districts of Nepal (Table 2.1) purposively selected from 38 districts where AFHS had been initiated prior to June 30, 2012(16 Asad, 2069). Eligible districts were initially stratified into three categories based on the major support of the AFHS program:

1. Government supported
2. UN agency supported
3. NGO supported

Districtsin each of these categories were then further stratified by ecological zone (Mountain, Hill and Terai). Twelve districts were purposefully selected in consultation with FHD, UNFPA and UNICEF to capture facilities across the range of ecological zones and development regions, and also to capture those supported by government, UN agency and NGOs.

**Table 2.1 Geo-ecological representation of 12 districts selected for the proposed assessment**

| Ecological zone | Development Regions | | | | |
|---|---|---|---|---|---|
| | ***Eastern*** | ***Central*** | ***Western*** | ***Mid Western*** | ***Far Western*** |
| ***Mountain*** | - | Dolakha (GoN) | - | Jumla (GFA) | Bajura (UNICEF) |
| ***Hill*** | Udayapur (GoN/UNICEF) | Bhaktapur (WHO/GoN) | Kaski (GoN),) | Pyuthan (SCF/UNFPA) | Doti (GFA) |
| ***Terai*** | Jhapa (GoN) | Mahotari (UNFPA) | Kapilvastu (SCF/UNFPA) | - | Kailali (GFA) |

Seventy-two AFHS facilities were then selected, representing around 10-15% of the total number of AFHS facilities nationally. Six AFHS facilities were purposively selected from each district in consultation with the District Public Health Office (DPHO) to represent one public hospital, one primary health care centre (PHCC), two health posts (HP) and two sub-health posts (SHP) (Table 2.2). Selection was based on the presence of a trained AFHS provider and included facilities located both near to and remote from the district health office to capture urban, peri-urban, rural and remote settings. In some districts the selected facility did not have an AFHS provider available. In these cases the facility was replaced with a higher or lower facility located in the same area. In two districts, AFHS facility run by Family Planning Association of Nepal (FPAN) was also included in consultation with FHD/MoHP.

### Table 2.2 Health facilities covered for the study for each of the study districts

| District / # of Health Facility | Hospital | PHC | HP | SHP | FPAN | Total |
|---|---|---|---|---|---|---|
| Jhapa | - | 2 | 3 | - | 1 | 6 |
| Mahottari | 1 | 1 | 2 | 2 | - | 6 |
| Udayapur | 1 | 1 | 3 | 1 | - | 6 |
| Dolakha | 1 | 1 | 4 | - | - | 6 |
| Bhaktapur | - | 2 | 2 | 2 | - | 6 |
| Kaski | - | 1 | 4 | 1 | - | 6 |
| Pyuthan | 1 | 1 | 2 | 2 | - | 6 |
| Kapilvastu | - | 2 | 2 | 2 | - | 6 |
| Kailali | 1 | 1 | 3 | 1 | - | 6 |
| Doti | 1 | 1 | 2 | 1 | 1 | 6 |
| Bajura | 1 | 1 | 2 | 2 | - | 6 |
| Jumla | - | 1 | 3 | 2 | - | 6 |
| **TOTAL** | **7** | **15** | **32** | **16** | **2** | **72** |

Adolescents aged 10-19 years, parents and community gatekeepers were purposively selected from communities serviced by the participating AFHS facilities. Communities were sampled to capture the diversity of socio-cultural, ethnic and geographicalcontexts.Within each selected community, adolescents, including adolescents living with a disability, and community gatekeepers (parents, teachers, local leaders, religious leaders and peer educators) were identified in consultation with the local Female Community Health Volunteer (FCHV) or other community leader.

Young adults aged 20-24 years were also selected to participate in the qualitative component of the study. There were a number of reasons for including this age group:

- While the National ASRH Program particularly targets ages 10-19 years, it is noted that a number of national policy documents related to SRH and HIV refer to the needs of youth (aged 15-24 years) including their need for appropriate and acceptable health services and the need to engage youth in consultation and research.

- Many young adults have similar SRH needs and face similar barriers accessing health services as adolescents. With changing socio-cultural norms in Nepal, many of the social transitions usually associated with adolescents (including completing education, marriage and parenthood) increasingly occur in early adulthood. Therefore unmarried young adults may face similar challenges to unmarried adolescents when trying to access health services. In addition, recent neurocognitive studies have demonstrated that cognitive development continues until around the age of 24 years, indicating that the developmental stage of adolescence extends into early adulthood.

- Finally, young adults many be more likely to have independently accessed a health service than younger adolescents, and therefore can provide important user perspectives on the quality, accessibility and acceptability of health services.

## 2.4 Data collection

The study included the following qualitative methods:

- Facility observation checklist and key informant interviews(KII) with the facility in-charge and AFHS provider at all 72 facilities to explore implementation progress, challenges and supply-side barriers

- Exit interviews with adolescents aged 10-19 years at AFHS facilities in five districts (Jumla, Bhaktapur, Pyuthan, Jhapa, and Kailali) to explore satisfaction with services and quality of care

- Focused ethnographic study tools (FES) including free-listing and rating with males and females aged 10-24 years in one community in all 12 districts to explore perceived health needs/concerns, barriers and enablers to health service utilization. FES tools were facilitated in groups of 10 participants (separated into male and female groups) but individual responses recorded for each participant

- Focus group discussion (FGDs) with adolescents (one male FGD, one female FGD) and parents of adolescents in three districts (Jumla, Kaksi and Kapilvastu) to explore in depth AFHS barriers and enablers and features of an AFHS

- In-depth interviews (IDI) with adolescents aged 10-19 years living with a disability in three districts (Dolakha, Kaski and Mahotari) to explore barriers that limit access to AFHS

- Key informant interviews (KII) with community gatekeepersin ten districts (Dolakha, Jumla, Udayapur, Bhaktapur, Pyuthan, Doti, Jhapa, Mahotari, Kapilvastu and Kailali) to examine community-level attitudes, barriers and facilitating factors

The study tools were developed in English and based on the WHO *Quality Assessment Guidebook: a guide to assessing health services for adolescent clients,* the Pathfinder International *Clinic Assessment of Youth Friendly Services,* and the Nepal national AFHS standards outlined in the *National Adolescent Sexual and Reproductive Health Program Implementation Guide*. The draft tools were further adapted in consultation with UNFPA, UNICEF and FHD. All approved tools were then translated into Nepali and pre-tested.A summary of the tools and participants is provided in Table 2.3.

Data collection was carried outfrom May 12, 2014 to June 3, 2014 simultaneously in all the study districts. In each district one team comprising two trained male and two female researchers were responsible for collecting data. The quality of information collected was ensured by team supervisors in the field and by monitoring visits by the core team members of CREHPA.

### Table 2.3 Summary of data collection tools

| Tool | Population | Number completed | Number of participants |
|---|---|---|---|
| Facility observation checklist and interview with facility in-charge | Health facilities and facility in-charge | 72 | 72 |
| Key informant interview | AFHS providers | 72 | 72 |
| | Community gatekeepers | 10 | 10 |
| Exit interview | Adolescents 10-19 years | 8 | 8 |
| Focused ethnographic study tools | Young females aged 10-24 years | 12 Groups | 123 |
| | Young males aged 10-24 years | 12 Groups | 118 |
| Focus group discussions | Adolescent girls aged 10-19 years | 3 Groups | 28 |
| | Adolescent boys aged 10-19 years | 3 Groups | 28 |
| | Parents of adolescents | 3 Groups | 33 |
| In-depth interview | Adolescents living with a disability 10-19 years | 3 | 3 |
| | **Total** | **198** | **495** |

## 2.5 Data analysis

Where possible all data were disaggregated by age to identify similarities and differences between young adolescents (10-14), older adolescents (15-19) and young adults (20-24). Qualitative data (FES, interviews and FGD) are reported for adolescents aged 10-19 years unless otherwise indicated.

Quantitative data collected through observation checklists and facility client records data were entered into a purpose-built database and analyzed to determine simple frequencies disaggregated by sex, marital status and service types and transformed into cross tabulations and graphs. Qualitative data from interviews and FGDs were analyzed thematically using an inductive approach. Audio-recorded data from the FGDs and IDI was transcribed verbatim into Nepali, and interviewer-recorded responses from KIIs were compiled into interview transcripts.These were read and re-read by two researchers to develop a provisional coding framework that related to the study objectives. This was then used to code all transcripts and interview records. Matrices were created to summarize the coded data and determine the frequency and salience. Similar codes were grouped into sub-themes and verbatim quotes recorded to illustrate themes. Codes and themes were examined to determine differences and similarities between sub-groups of adolescents (age, sex, and marital status), socio-cultural and geographical setting, and type of health facility.

Free-listing and rating data from the FES groups were entered into 'Anthropac' software and analyzed to determine the frequency, average rank and salience of responses to the four key domains (health needs, sources of SRH counseling and services, barriers, and enablers). Data were disaggregated by gender and age to compare needs, barriers and enablers between males and females. The study findings are presented using the global and national AFHS standards as a guiding framework.

For the data validation, we shared the findings of the study with stakeholders through presentations, discussions at workshops and detailed feedback on the report.

## 2.6 Ethical considerations

Ethics approval for this study was obtained from the Nepal Health Research Council (NHRC) ***(reference number 1173, 21 April 2014*)**. Verbal Informed consent was obtained from all adolescent participants. For this, the inform consent statement prepared for the purpose was read out to each participant and their consent to participate in the study was obtained verbally. Measures were taken during data collection, management and analysis to protect the privacy, confidentiality and dignity of all participants. All fieldworkers received intensive training in research ethics, including confidentiality. No personal identifying details were recorded. All files were securely stored and electronic data password protected, and accessible only to authorized members of the research team.

## 2.7 Study limitations

This study has a number of important limitations. Firstly, the lack of data, and lack of disaggregated data, available from health facility records limited the extent to which data could be analyzed to determine equitable access (such as by marital status, age, ethnicity). Secondly, adolescent's key affected populations and other underserved / marginalizedadolescents were not specifically targeted in this study, but are likely to face additional barriers and have unique health needs. This is an area requiring further research. Thirdly, key informant interviews with district level (DPHO and focal persons) and national level policymakers would have provided additional insights into the challenges and opportunities to strengthen AFHS, but were not included in this study. Finally, while we included 72 facilities in 12 districts across a diverse range of geographical and socio-cultural contexts, these findings may not generalizable or applicable to other districts.

# CHAPTER 3
# FINDINGS

## 3.1 Demand for and use of AFHS by adolescents

### 3.1.1 Sexual and reproductive health needs

#### *SRH related health problems of adolescent boys*

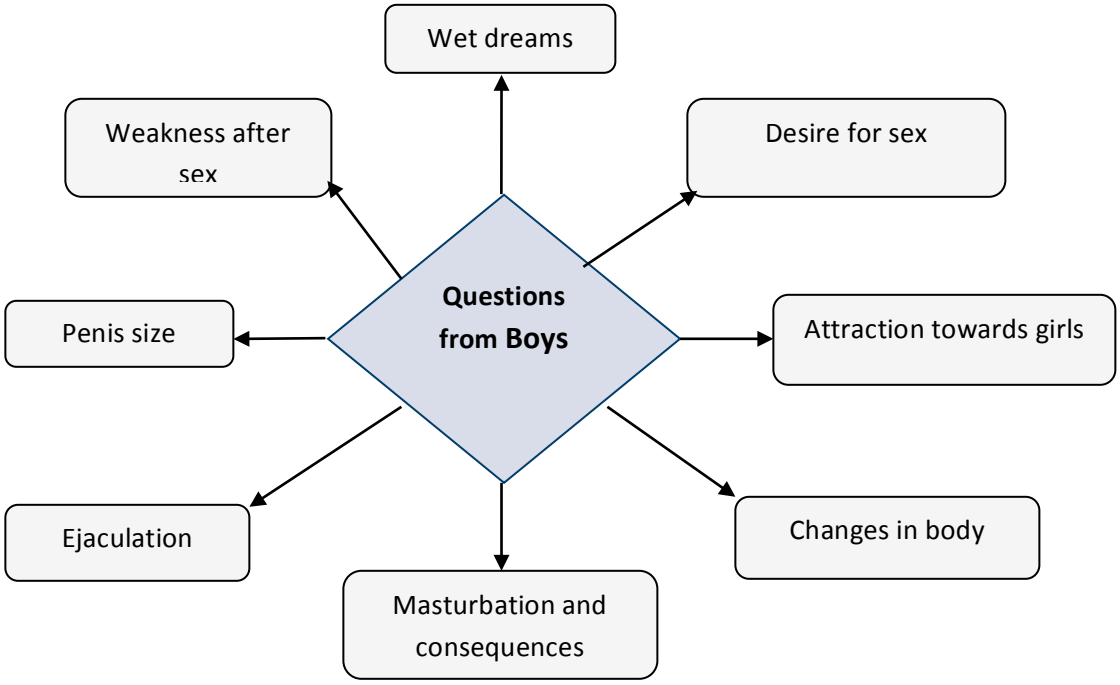
Adolescent boys participating in FGDs and FES identified a number of SRH concerns, ranging from issues related to puberty, relationships, and sexuality / sexual functioning to specific concerns about genitourinary infections and conditions (Figure 3.1). Most of these concerns were related to why these changes occur, what they mean, and what are their consequences. During free-listing, boys listed 23 SRH related problems with the top six problems (10% and above frequencies) including: wet dreams (36%); rash/wounds of genital area (29%); itchiness of genital area (21%); STIs (16%); HIV/AIDS (14%) andpre-ejaculation (12%). The top most concern was wet dreams (salience value of 0.30) (Table 3.1).

**Table 3.1 Freelists of SRH related problems faced by adolescent boys**

| S.N | Item | Frequency (%) | Salience |
|---|---|---|---|
| 1. | Wet dream/ Night fall | 36.4 | 0.297 |
| 2. | Rashes and/or wound in genital area | 28.6 | 0.16 |
| 3. | Itchiness in genital area | 20.8 | 0.117 |
| 4. | STI (Syphilis) | 15.6 | 0.121 |
| 5. | HIV/AIDS | 14.3 | 0.054 |
| 6. | Pre ejaculation | 11.7 | 0.062 |
| 7. | Penile discharge (offensive genital discharge, white discharge) | 9.1 | 0.047 |
| 8. | UTI (Burning micturition, Urinary tract infection) | 7.8 | 0.055 |
| 9. | Swelling of genital | 6.5 | 0.037 |
| 10. | Irregular size of genital | 6.5 | 0.034 |
| 11. | Hydrocele | 6.5 | 0.043 |
| 12. | Have only one testis | 5.2 | 0.039 |
| 13. | Erection problem | 5.2 | 0.034 |
| 14. | Curvature/ bending of genital | 5.2 | 0.025 |
| 15. | Masturbation | 5.2 | 0.03 |
| 16. | Bleeding from penis | 3.9 | 0.024 |
| 17. | Incomplete/ under-developed genitals | 3.9 | 0.023 |
| 18. | Foreskin problem (Phimosis,Paraphimosis) | 2.6 | 0.004 |
| 19. | Swelling in nipple | 1.3 | 0.002 |
| 20. | Burning sensation in genital | 1.3 | 0.009 |
| 21. | Burning sensation in genitalia during sex | 1.3 | 0.002 |
| 22. | Insomnia | 1.3 | 0.005 |
| 23. | Lump in nipple (Girkha) | 1.3 | 0.004 |

There was little difference in SRH concerns by age group, with the exception of wet dreams which was more commonly reported by older adolescents (15-19 years) than young adolescents who may have been less likely to have experienced this previously (see Annex table 3.1). Concerns about normal development and penis size, masturbation and STIs were common across all age groups, including young adults and adolescent boys living with a disability.

**Figure 3.1: Concerns of adolescent boys**

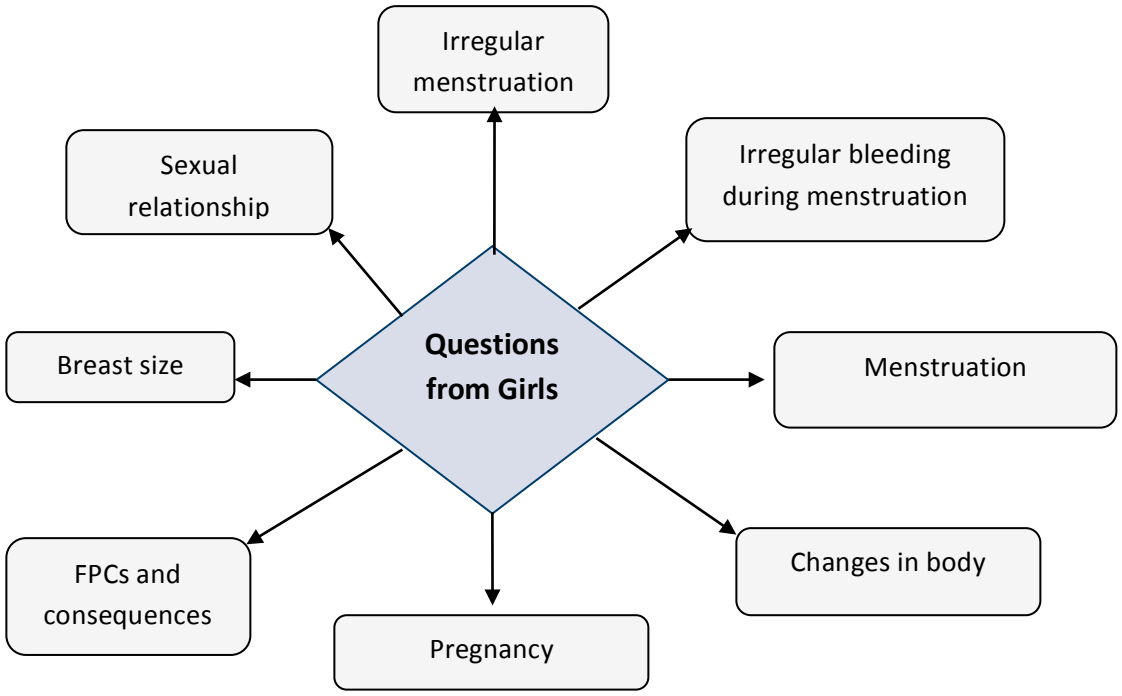



## *SRH related health problems of adolescent girls*

Adolescent girls participating in FGDs and FES reported a wide range of health concerns related to puberty and menstruation, relationships and pregnancy (Figure 3.2). Menstruation was the most commonly identified SRH issue among girls. Of the top ten problems identified by the adolescent girls participating in the FES, seven were menstruation related, such as abdominal pains during menstruation (80%); irregular bleeding (52%); irregular menstruation (42%); pains in limbs and back during menstruation (36%), dizziness/nausea during menstruation (18%); pain in breast before during and after menstruation (16%) andweakness and loss of appetite during menstruation (11%). White discharge (59%), prolapsed uterus (24%) and miscarriage (19%) were other problems falling within top ten frequently identified problems for adolescent girls (Table 3.2). Similarly to adolescent boys, many of these concerns related to why physical

changes occurred and what was normal, as well as the consequences of puberty and puberty-related concerns. As for adolescent boys, SRH concerns among girls were similar across age groups and for adolescent girls living with a disability.

**Figure 3.2: Concerns of adolescent girls**



## Table 3.2 Freelist of SRH related problems faced by adolescent girls

| S.N | Item | Frequency (%) | Salience |
|---|---|---|---|
| 1. | Lower abdominal pain during menstruation | 80.2 | 0.707 |
| 2. | White discharge | 59.3 | 0.392 |
| 3. | Irregular bleeding during menstruation (Less, Heavy) | 51.6 | 0.287 |
| 4. | Irregular menstruation | 41.8 | 0.251 |
| 5. | Pain in different parts of body during menstruation (back, limbs and head) | 36.3 | 0.232 |
| 6. | Prolapsed uterus | 24.2 | 0.123 |
| 7. | Miscarriage | 18.7 | 0.098 |
| 8. | Dizziness/Nausea/vomiting during menstruation | 17.6 | 0.086 |
| 9. | Pain in breast (before, during and after menstruation) | 16.5 | 0.084 |
| 10. | Weakness & Loss of appetite during menstruation | 11 | 0.06 |
| 11. | HIV/AIDS | 9.9 | 0.076 |
| 12. | Postpartum hemorrhage& maternal death due to early motherhood | 8.8 | 0.036 |
| 13. | Itchiness in genital area | 8.8 | 0.03 |
| 14. | Rashes and/ or wound in/around genital area | 7.7 | 0.034 |
| 15. | Body swells during pregnancy | 6.6 | 0.028 |
| 16. | Cervical cancer | 6.6 | 0.04 |
| 17. | STI (Gonorrhea) | 5.5 | 0.04 |
| 18. | Body changes in unusual way | 5.5 | 0.015 |
| 19. | Lower abdominal pain during pregnancy | 5.5 | 0.027 |
| 20. | Swelling of genital during pregnancy | 4.4 | 0.009 |
| 21. | Heavy bleeding after use of FPCs | 4.4 | 0.013 |
| 22. | Weakness after use of FPCs | 4.4 | 0.009 |
| 23. | UTI (Burning sensation) | 4.4 | 0.009 |
| 24. | Prolonged bleeding during menstruation | 4.4 | 0.022 |
| 25. | Dizziness/Nausea/vomiting during pregnancy | 2.2 | 0.009 |
| 26. | Infertility | 2.2 | 0.011 |
| 27. | Uterus related diseases | 2.2 | 0.019 |
| 28. | Feeling of having short leg/s during pregnancy | 1.1 | 0.004 |
| 29. | Itchiness in body due to use of pills | 1.1 | 0.001 |
| 30. | Anemia | 1.1 | 0.007 |
| 31. | Breast cancer | 1.1 | 0.007 |
| 32. | Amenorrhea after FPCs | 1.1 | 0.001 |
| 33. | Delay in onset of menarche | 1.1 | 0.008 |
| 34. | Depression during menstruation | 1.1 | 0.002 |
| 35. | Pain in genital after delivery | 1.1 | 0.004 |
| 36. | Pain in breast during pregnancy | 1.1 | 0.001 |
| 37. | Unsafe abortion | 1.1 | 0.009 |
| 38. | Problem with breast-feeding | 1.1 | 0.003 |
| 39. | Aminiotic sac breaks earlier than it should break/ before normal time | 1.1 | 0.002 |
| 40. | Prolonged labor | 1.1 | 0.005 |
| 41. | Itchiness in different body parts | 1.1 | 0.004 |
| 42. | Itchiness/Rashes and/ or wound around breast | 1.1 | 0.004 |
| 43. | Neonatal death because of delivery in early age | 1.1 | 0.003 |

### 3.1.2 Health-seeking behaviour

The most preferred place/person (in terms of frequency of free-listing) that both adolescent boys (82%) and girls (78%) would seek advice/treatment for their SRH problems was a government health facilities (PHCC/HP/SHP). These facilities were also listed first by both boys and girls more often than other sources of care, indicating high salience (0.68 for boys and 0.78 for girls) and an imperative to improve the delivery of AFHS through these facilities. Government hospitals were also identified as preferred sources of SRH services by over half of boys and girls (Table 3.3 and 3.4). Government facilities were preferred because they were perceived to be accessible, free, and able to provide a range of services delivered by skilled providers:

> *"In PHCC, along with the counseling, we are provided with free medicines. Because of the friendly environment, we do not feel uncomfortable to tell our SRH problems."*
> *- 14yrs, Dalit girl, Class 8 student, Unmarried, AFHS not taken, FES Bhaktapur*

> *"We do not feel shy to ask for condom because of the easy environment in hospital."*
> *- 15yrs,Chhetri boy, Class 10 student, Unmarried, AFHS not taken, FES Dolakha*

> *"Treatment of all types of health problems is provided in hospitals."*
> *- 14yrs, Chhettriboy,Class 5 student, Unmarried, AFHS not taken, FES Bajura*

> *"In hospitals, there are more efficient and skilled doctors and they are more reliable person for us to tell our health problems. It is easy for us to get treatment from the hospital."*
> *- 12 yrs, Brahmin girl, Class 6 student, Unmarried, AFHS not taken, FES Jhapa*

> *"More resources and doctors with more knowledge are available in hospital."*
> *- FGD, adolescent boys*

> *"Health facilities (hospital, PHCC, HP, SHP) are the places where the health problems are treated"*
> *-FGD, adolescent girls*

Pharmacies were a preferred source of SRH advice and treatment, particularly among boys (60% versus 41% for girls). For girls, FCHVs were also an important provider of SRH advice and information:

> *"There are skilled providers in private pharmacy shops, so it is easy and more reliable to take health services from there."*
> *- 19 yrs, Nath boy, +2student, Unmarried, AFHS not taken, FES Kailali*

> *"I feel more comfortable and reliable to tell my problems because Female Community Health Volunteer suggests us on SRH issues very clearly."*
> *- 15yrs, Chhettri girl, Class 7 student, Unmarried, AFHS not taken, FES Pyuthan*

Friends were also a preferred source of advice and care, with 60% of boys and 65% girls during free-listing. Friends were also described as an important source of advice during FGDs, including as a preferred source of information before seeking formal health services and because adolescents were more comfortable discussing sensitive issues with them:

*"For the first time, I was having menstruation in school. I was very scared to tell my teacher so I told my best friend about my problem and she helped me to go home."*
*- 16yrs, Newar girl, Class 9 student, Unmarried, AFHS not taken, FES Dolakha*

*"If we have any RH problems, we seek advice from the friend first and we go to either private or government health facility as per their advice"*
*- FGD, adolescent boys*

*"Friends are of same age and same level, we can share personal and private things with them and we do not feel shame to talk with friends"*
*-18 yrs,Brahmin boy, Bachelors in Education student, Unmarried, AFHS not taken, IDI with disable Mahottari*

Interestingly, two third girls (65%) listed their parents/family/relatives as the person they would prefer to seek advice from,in contrast less than a quarter of the boys mentioned this source (23%).

*"I am very close to my sister so I do not hesitate to tell my health problems openly with her."*
*- 13 yrs, Chhettri girl, Class 9 student, Unmarried, AFHS not taken, FES Jumla*

Teachers were also a source of SRH information and counseling for some adolescents.

*"I understand more clearly when my teacher gives counseling on health problems."*
*- 18yrs, Chhetri boy, Class 9 student, Unmarried , AFHS not taken, FES Bajura*

While government facilities were overwhelming the preferred source of SRH services, some adolescents, including those living with a disability, identified private facilities as a source of care, particularly as they were perceived to provide more private and high quality services:

*"Though the service is costly, private clinics have all the facilities; they have good doctors as well and maintain privacy"*
*-16 yrs, Dalit girl, Passed 8$^{th}$class, Unmarried, AFHS not taken, IDI with disable Kaski*

Some adolescents reported that they would not seek SRH advice or treatment from anyone as these were not accessible:

> *"If we have any problems, we prefer to stay in house. Because, there is no such place to go for the adolescent girls like us and take advice. Even if we go there (health facility) they may ask lots of unnecessary questions"*
>
> *- FGD, adolescent girls*

Health-seeking behavior was similar for young adolescents and those aged 15-19 years (see Annex table 3.3 and 3.4). Young adults aged 20-24 years also reported similar preferred sources of SRH advice and treatment compared to adolescents aged 10-19 years.

### Table 3.3 Freelists of health care seeking behaviour of adolescent boys

| S.N. | Item | Frequency (%) | Salience |
|---|---|---|---|
| 1. | PHCC/Health Post/Sub health post | 81.8 | 0.679 |
| 2. | Friend/partner | 59.7 | 0.389 |
| 3. | Medical hall/Clinic/Pharmacy | 59.7 | 0.354 |
| 4. | Hospital | 54.5 | 0.294 |
| 5. | Teacher/Health teacher | 37.7 | 0.254 |
| 6. | FCHV | 36.4 | 0.211 |
| 7. | Health worker | 33.8 | 0.153 |
| 8. | CSO(red cross society, peacewin, worldvision,shovaaids,giftbajura,INF) | 29.9 | 0.144 |
| 9. | Doctor | 27.3 | 0.155 |
| 10. | Family/Parents/Relatives | 23.4 | 0.102 |
| 11. | Elderly people | 23.4 | 0.099 |
| 12. | Brother | 18.2 | 0.078 |
| 13. | Clinic run by NGO(FPAN,mariestopes) | 15.6 | 0.078 |
| 14. | Traditional faith healer | 11.7 | 0.052 |
| 15. | Mobile camp | 9.1 | 0.046 |
| 16. | Homeopathy | 7.8 | 0.038 |
| 17. | Peer educator | 6.5 | 0.051 |
| 18. | Media (TV,radio,paper,book,website) | 3.9 | 0.017 |
| 19. | Will not visit anyone/anywhere | 1.3 | 0.013 |
| 20. | Astrologist | 1.3 | 0.002 |
| 21. | Community leader | 1.3 | 0.006 |

### Table 3.4 Freelists of health care seeking behaviour of adolescent girls

| S.N. | Item | Frequency (%) | Salience |
|---|---|---|---|
| 1. | PHCC/ Health Post/ Sub Health Post | 78 | 0.593 |
| 2. | FCHV | 67 | 0.436 |
| 3. | Family/ Parents/ Relatives | 64.8 | 0.429 |
| 4. | Friend | 64.8 | 0.353 |
| 5. | Hospital | 63.7 | 0.378 |
| 6. | Health worker | 42.9 | 0.219 |
| 7. | Medical hall/ Clinic/ Pharmacy | 40.7 | 0.164 |
| 8. | Traditional faith healer | 26.4 | 0.138 |
| 9. | Health specialist/ Doctor | 22 | 0.133 |
| 10. | Teacher/ Health teacher | 20.9 | 0.091 |
| 11. | Clinic run by NGO (FPAN, Marie Stopes) | 20.9 | 0.135 |
| 12. | INGO (UNICEF, Luthren World Federation) | 11 | 0.086 |
| 13. | Ayurvedicaushadhalaya | 11 | 0.034 |
| 14. | Doctor | 11 | 0.04 |
| 15. | Homeopathy | 11 | 0.053 |
| 16. | Elderly people | 11 | 0.043 |
| 17. | CSO (Red Cross Society, Restless Development, Theater for Development, Community awareness development (CWF)) | 5.5 | 0.049 |
| 18. | Clubs at local level (Youth, Female, Community development service center) | 5.5 | 0.02 |
| 19. | Mobile camp | 4.4 | 0.023 |
| 20. | Pregnant women | 2.2 | 0.003 |
| 21. | Will not visit anyone/ anywhere | 2.2 | 0.012 |
| 22. | Mother's group | 2.2 | 0.012 |
| 23. | Married women | 1.1 | 0.003 |
| 24. | Volunteer | 1.1 | 0.005 |
| 25. | Other person who face same problem | 1.1 | 0.005 |
| 26. | Media (book, newspaper) | 1.1 | 0.002 |
| 27. | Sexual awareness development group | 1.1 | 0.003 |

## 3.1.3 Knowledge and awareness of AFHS

Lack of knowledge and information about health services, including AFHS, was one of the most commonly reported barriers impacting on access to services noted by both adolescent boys and girls during free-listing.

Despite government facilities being the most commonly identified and preferred source of SRH care, awareness of AFHS provided through these facilities was very low. No adolescent girls participating in FGDs or in-depth interviews, and very few adolescent boys, were aware of AFHS even though these programs had been initiated in their communities prior to 2012. Adolescents living with a disability were also not aware of AFHS available to them.

*"There is no such services especially targeted for adolescents like us in our community"*

*- FGD, adolescentgirls*

*"There are ANC, PNC and delivery services but we are not aware of the especial services for adolescents"*

*- FGD, adolescent girls*

*"Is there any program in the facility? We do not know. There is no notice in the facility and no one has told us about such program"*

*-*

*- 16 yrs, Dalit girl, Passed 8th class, Unmarried, AFHS not taken, IDIwith disable Kaski*

*"In our village, most of the people are still unaware about the AFHS because there is no such awareness program are performed in our community. Adolescents don't know how and from where the AFHS can be taken."*

*- 14yrs, Brahmin girl, Class 9 student, Unmarried, AFHS not taken, FES Jhapa*

Even among the boys (4) and girls (4) who participated in exit interviews, only 2 males and none of the four females had knowledge about AFHS, despite having just accessed a facility providing AFHS.

Promotion of AFHS is a key role of the AFHS facility as per the national guideline. While 53 out of 72 facilities reported having conducted awareness raising activities at the community level and through schools (49/72) in the initial phase of AFHS, but most had not conducted any awareness or promotion activities through schools, youth clubs or community groups since then.

Where efforts had been made to promote AFS and improve access to SRH information, Facility-in-Charge and providers noted that more adolescents were accessing services and had better understanding of their needs and rights:

*"Now the adolescents are aware of sexual and reproductive rights. They even know the ways to have safe sex life and safe abortion services. Not only that, every Friday, adolescents from youth group are made to make the other adolescents aware of the AFHS. Maybe because of this, number of adolescents is found to gradually come and seek the service and most importantly; they feel at ease. They seek services including counseling services on sexual and reproductive health, HIV/AIDS, safe abortion and such."*

*- Incharge Doti*

*"I think since we undertook 'DautariSathiSikchyaKaryakram' and AFHS program together, it has been very effective and beneficial. Students from school and Population teacher were trained first and after they were trained, they started raising awareness among other people and refer to health facilties. It has also become a means of marketing of health facilities to seek care. It has enabled lots of adolescents to seek AFHS and share their problems openly."*

*- ANM Doti*

### 3.1.4 Utilization of SRH counselling and services

Service statistics from all the 72 health facilities of 12 districts were analyzed to examine the extent of utilization of the health services by adolescents in the past six months preceding the study. Efforts were made to collect age and sex disaggregated data by marital status and nature of health problems for which counseling was sought and services received. In the majority of facilities, separate AFHS records were not maintained or were incomplete, therefore most utilization data were obtained from OPD and ANC/PNC registers. A number of limitations were noted. Firstly, uniformity of record-keeping and reporting systems was lacking across the districts making any detailed comparisons difficult. In some districts (Udaypur, Kapilbastu and Mahottari) only consolidated data on the total number of male and female adolescent clients provided such that disaggregation by age and service-type was not possible. As most data were drawn from OPD and ANC registers it is not clear whether the services that young clients received through these programs were linked to, or attributable to, AFHS.

The limited available data indicate that SRH counseling and services are being accessed by some adolescents, particularly those aged 15-19 years (Table 3.5)

**Table 3.5: Total number of adolescents receiving AFHS counselling and services by sex and age in the previous six months**

| Service | Male | | Female | | Total |
|---|---|---|---|---|---|
| | 10-14 | 15-19 | 10-14 | 15-19 | |
| **Counseling (all)*** | 630 | 802 | 656 | 920 | 3008 |
| **Service utilization (total)** | 74 | 140 | 73 | 4333 | 4620 |
| STI testing and treatment | - | 3 | 4 | 20 | 27 |
| VCT | 36 | 57 | 37 | 111 | 241 |
| PMTCT | - | - | 3 | 578 | 581 |
| HIV treatment | - | - | 2 | - | 2 |
| Contraception (married only) | - | 4 | - | 374 | 378 |
| Condom | 38 | 76 | - | - | 114 |
| Pregnancy test | - | - | - | 754 | 754 |
| Medical abortion | - | - | - | 53 | 53 |
| Post abortion care | - | - | - | 66 | 66 |
| ANC | - | - | - | 692 | 692 |
| Delivery care | - | - | - | 993 | 993 |
| PNC | - | - | - | 714 | 714 |
| Other | - | - | - | 5 | 5 |

*Source: Observation checklist*

** The counseling data includes from Jumla (3 facilities), Mahottari (1 facility),Bajura (3 facilities), Kailali (2 facilities), Pyuthan (2 facilities), Kapilvastu (1 facility), Dolakha (4 facilities) and Kaski (3 facilities) only*

*** The service data of some category only includes from Jumla (3 facilities), Mahottari, Doti,Bhaktapur, Bajura, Kailali,Pyuthan, Kapilvastu, Dolakha and Kaski (6 facilities each), Jhapa (2 facilities), and Udayapur (3 facilities) .*

Over 3000 adolescents received counseling in the past six months, with a similar number of adolescent girls (1576) and boys (1432) having accessed these services. A greater number of older adolescents aged 15-19 years were provided with counseling compared with young adolescents. While a similar number (4620) had received SRH services in the previous six months, these were overwhelming provided to adolescent girls, the majority of whom were married (data not shown). Over 95% of adolescent clients were adolescent girls, and of these, over two-thirds had accessed services related to pregnancy, delivery and postnatal care. Service utilization data for 20-24 year olds (not shown) demonstrated that use of SRH services such as STI care, VCT and contraception was higher among young adult males and females than for adolescents.

Some providers reported that they had seen an increase in adolescent clients, particularly for services related to contraception, and that this had had a significant impact in their community:

> *"Adolescents have access to various kinds of family planning contraceptives. Their health problems have been given priority at health facilities. Not only that, we used to hear and deal with so many suicidal cases because of pre-marital pregnancies, but its not the case now. It seems a dream to me! It's because contraceptives such as pills and condom prevents pregnancy. Even if one gets pregnant, they have safe abortion services. Now people have organized family members and do not bear many children. Also, the maternal and infant mortality rate has also reduced."*
>
> *- Supervisor Kaski*

It is noted that, over 80 percent of the adolescents participating in FES and FGD had never attended AFHS.

### 3.1.5 Barriers impacting on SRH service access

Adolescents participating in FES groups, FGDs and interviews identified a number of barriers impacting on access to SRH services. The main barriers for boys and girls are summarized in Box 3.

### Box 3. AFHS barriers reported by adolescents

Barriers impacting an SRH service access reported by adolescents:

**Individual–level:**

- Shyness / embarrassment
- Lack of knowledge / information about AFHS
- Lack of time / other responsibilities

**Socio-cultural and community-level**

- Fear of parents
- Negative attitudes of community gatekeepers / fear of being seen by community
- Restrictions on girls' ability to leave the house alone

**Facility-level**

- Distance / physically inaccessible / lack of transport
- Provider unavailable, judgmental, unfriendly, not trustworthy
- Lack of privacy and separate space
- Poor quality care / lack of sufficient commodities and medicines
- Inconvenient opening hours
- Costs associated with medicines or transport
- Long waiting time

While lack of information about AFHS was one of the main barriers reported by adolescents, shyness was the most commonly reported reason for not accessing health facilities among adolescent boys (69%) and the second most common reason for adolescent girls (47%) participating in the FES and was also noted during FGDs (Table 3.6 and 3.7). This included reluctance to discuss sensitive issues related to SRH and embarrassment associated with physical examination / genital examination. This was particularly the case if there was only a provider of the opposite sex present and/or if the provider was someone known to their family.

*"Many of us don't know about adolescent friendly health services. And when we don't know about it, we too can not seek services that are meant for adolescents like us."*

- *18 yrs, Newar girl, Class 10 student, Unmarried, AFHS taken, FES Mahottari*

*"Nurses ask about our health problems in front of other patients and those patients will be listening to what I say. They even tease me. So, I feel shy to go health post."*

- *19 yrs, Chhetri girl, +2 student, Unmarried, AFHS taken, FES Udayapur*

*"One of the main problems is; we feel shy when we have to put off our clothes in front of the doctors for our internal (private parts) checkup."*

- *19 yrs, Nath boy, +2 Student, Unmarried, AFHS not taken, FES Kailali*

*"I feel shy to put my clothes off and show my private parts that have rashes or wounds in them. Its really embarrassing."*

- *15 yrs, Dalit boy, Class 6 student, Umarried, AFHS taken, FES Jumla*

*"It is difficult for the adolescent girls to take the services especially in rural areas as they feel shy in telling their SRH problems with outsiders. They feel weird in telling such problems even with their friends".*

*- FGD, adolescent girls*

*"Since a doctor is male and I too feel shy to tell my health problems, I don't like doctors and taking services from them."*

- *13yrs, Chhetri girl, Class 8 student, AFHS taken, Unmarried, FES Jumla*

*"I do not like to visit a hospital where there are no nurse because there will be male doctors. I feel shy to talk with those doctors. They even charge us more money but don't give proper medicine. I don't feel good about all these, so I prefer not going there."*

- *10 yrs, Chhetri girl, Class6 student, AFHS not taken, Unmarried, FES Jumla*

*"It is really difficult and embarrassing to express our problems in front of male doctors. We feel comfortable to tell our health problems including internal problems to female doctors."*

- *13 yrs, Brahmin girl, Class 8 student, AFHS not taken, Unmaried, FES Dolakha*

Lack of time to visit facilities was also noted by some adolescents, particularly girls who reported household duties and restrictions from parents as a reason for not being able to access services:

*"My parents have never allowed me to go health facility because I have to look after my younger brother. So, I do not have any information about AFHS."*

*- 16yrs, Sada (musahar) girl, Class 4, Unmarried, AFHS not taken, FES Mahottari*

*"Most of the villagers are engaged in agriculture, so they cannot take out the time for their treatment."*

*- 18yrs, Newra boy, Appeared SLC, Unmarried, AFHS not taken, FES Doti*

Reported barriers were similar for both boys and girls, with some important exceptions. Girls noted that discrimination on the basis on gender and restrictions placed on girls that prevent them leaving the home alone significantly impacted on their ability to access facilities. Such factors were not reported by adolescent boys. Many of the reported barriers were also similar across the age groups, however older adolescents (and young adults) less commonly identified shyness and fear of parents as the main reason why they did not access services when compared with those aged 10-14 years. In addition to lack of privacy and confidentiality, adolescents living with a disability also reported that a lack of good quality services for disabled people limited their access to SRH care.

The barriers related to parents and community, providers and facilities are discussed in more detail in the subsequent sections.

## Table 3.6 Freelists of demand side barriers: Adolescent Boys

| S.N. | Item | Frequency (%) | Salience |
|---|---|---|---|
| 1. | Shy nature | 68.8 | 0.489 |
| 2. | Lack of information regarding AFHS | 41.6 | 0.258 |
| 3. | Distant location | 32.5 | 0.243 |
| 4. | Lack of privacy | 31.2 | 0.207 |
| 5. | Unsatisfactory treatment | 29.9 | 0.15 |
| 6. | Lack of medicines | 27.3 | 0.141 |
| 7. | Lack of time to visit health facility | 22.1 | 0.149 |
| 8. | Absence of service providers | 20.8 | 0.143 |
| 9. | Due to fear of parents | 20.8 | 0.116 |
| 10. | Fear of being exposed by villagers | 18.2 | 0.126 |
| 11. | Service provider is female | 11.7 | 0.082 |
| 12. | Service provider is not available on time | 11.7 | 0.053 |
| 13. | Facility remains closed | 11.7 | 0.059 |
| 14. | Poor financial condition | 9.1 | 0.069 |
| 15. | Lack of separate treatment room | 9.1 | 0.037 |
| 16. | Lack of medical equipment for treatment | 7.8 | 0.021 |
| 17. | Unfriendly behavior of service provider | 6.5 | 0.042 |
| 18. | Unnecessary time spent to receive service | 6.5 | 0.042 |
| 19. | Condom box is not kept outside | 6.5 | 0.032 |
| 20. | Lack of trust towards health facility/provider | 5.2 | 0.031 |
| 21. | Service provider scolds | 5.2 | 0.019 |
| 22. | Lack of temporary FPCs | 3.9 | 0.015 |
| 23. | Negative thinking when receiving FPC | 2.6 | 0.009 |
| 24. | Discriminatory practice towards poor people | 2.6 | 0.009 |
| 25. | Do not feel need of visiting HF | 2.6 | 0.026 |
| 26. | Friends can solve sexual health problem | 1.3 | 0.004 |
| 27. | Service provider do not work full time | 1.3 | 0.004 |
| 28. | Dirty environment of HF | 1.3 | 0.005 |
| 29. | Lack of trained counselor | 1.3 | 0.013 |
| 30. | Lack of suggestion box at facility | 1.3 | 0.008 |
| 31. | Lack of transportation facilities | 1.3 | 0.013 |
| 32. | Prescribe medicine without check-up | 1.3 | 0.003 |

## Table 3.7 Freelists of demand side barriers: Adolescent Girls

| S.N. | Item | Frequency (%) | Salience |
|---|---|---|---|
| 1. | Distant location | 47.3 | 0.345 |
| 2. | Shy nature | 47.3 | 0.295 |
| 3. | Lack of time to visit health facility | 39.6 | 0.285 |
| 4. | Lack of information regarding AFHS | 39.6 | 0.303 |
| 5. | Unsatisfactory treatment | 37.4 | 0.183 |
| 6. | Because of being a daughter, restriction to go outside home alone | 33 | 0.202 |
| 7. | Poor financial condition | 30.8 | 0.173 |
| 8. | Lack of trust towards health facility/ service provider | 23.1 | 0.105 |
| 9. | Unfriendly behavior of service provider | 22 | 0.125 |
| 10. | Service provider is male | 18.7 | 0.115 |
| 11. | Lack of transportation facilities | 17.6 | 0.109 |
| 12. | Lack of medicines | 16.5 | 0.067 |
| 13. | Fear of being exposed by villagers | 14.3 | 0.088 |
| 14. | Service provider do not work full time | 13.2 | 0.086 |
| 15. | Lack of education preventing one from attending health facilities | 12.1 | 0.053 |
| 16. | Lack of separate treatment room | 12.1 | 0.045 |
| 17. | Lack of privacy/ Fear of being exposed | 11 | 0.061 |
| 18. | Absence of service providers | 11 | 0.07 |
| 19. | Health facility charges high fees for treatment | 9.9 | 0.042 |
| 20. | Due to fear of family | 9.9 | 0.074 |
| 21. | Prescribe medicine without check-up | 8.8 | 0.053 |
| 22. | Afraid to visit health facility alone | 7.7 | 0.038 |
| 23. | Unnecessary time spent to receive service | 7.7 | 0.035 |
| 24. | Unavailability of emergency services | 5.5 | 0.02 |
| 25. | Lack of medical equipment for treatment | 4.4 | 0.023 |
| 26. | Negative views of society towards health facility | 4.4 | 0.016 |
| 27. | Service provider is not available on time | 3.3 | 0.016 |
| 28. | Lack of proper waiting area | 2.2 | 0.009 |
| 29. | Suggested not to visit health facility by others (relatives, friends, villagers) | 2.2 | 0.011 |
| 30. | Because of being physically challenged, can not have access to AFHS | 2.2 | 0.017 |
| 31. | Health facility remains closed | 2.2 | 0.009 |
| 32. | Family does not trust | 2.2 | 0.017 |
| 33. | Dirty environment of Health facility | 2.2 | 0.005 |
| 34. | Do not feel need of visiting health facility | 2.2 | 0.01 |
| 35. | Health facility remains crowded that prevents one from attending health facilities | 2.2 | 0.014 |
| 36. | Discriminatory practice on the basis of gender | 1.1 | 0.004 |
| 37. | Due to loose/ bad character of service provider | 1.1 | 0.003 |
| 38. | Restriction from home to discuss personal matters | 1.1 | 0.009 |
| 39. | Due to Patriarchal society | 1.1 | 0.01 |
| 40. | Discriminatory practice towards poor people | 1.1 | 0.011 |
| 41. | Different culture preventing one from attending health facilities | 1.1 | 0.004 |
| 42. | Lack of health security | 1.1 | 0.005 |
| 43. | Due to violence in society | 1.1 | 0.009 |
| 44. | Negative view of society if visited a health facility | 1.1 | 0.002 |
| 45. | Health facility does not provide free medicine | 1.1 | 0.006 |

### 3.1.6 What does 'adolescent friendly' mean to adolescents?

The key features of an adolescent friendly health services identified by adolescents during FES and FGDs are summarized in Box 4.

**Box 4. Features of an AFHS identified by adolescents**

Features of an AFHS:

**AFHS providers**

- Gender-friendly / male and female providers available
- Friendly and non-judgmental
- Skilled

**Privacy and confidentiality**

- Separate space for counseling and treatment
- Confidentiality is ensured
- Separate hours for adolescents

**Quality and comprehnseive services**

- Appropriate treatment and care provided
- Availability of medcines, commodities and equipment
- A range of services provided
- Referral mechanisms

**Accessible and comfortable environment**

- Close to communities
- Clean environment and toilet facilities / drinking water
- Free services
- Open 24 hours / convenient opening hours
- Information provided about the services

Encouragingly, many of the features identified by adolescents themselves are reflected in current national AFHS standards. Among both boys and girls, the most important features of an AFHS related to the AFHS provider, privacy, and quality of care. During free-listing, gender-friendly providers were the most commonly reported feature by adolescent girls (51%) and the second most important feature among boys (47%) behind privacy (table 3.8 and 3.9). Girls and boys noted that both male and female providers must be available as adolescents were not comfortable seeking SRH services from a provider of the opposite sex:

> *"We feel easy to tell our personal health problems without any hesitation to male service provider and sometimes it is also easy to ask for condom."*
>
> *- 15yrs, Karki boy, Class 10 student, Unmarried, AFHS not taken, FES Dolakha*

*“Only male can share his health problems to male health service provider because he feels shy and hesitate to tell his problems to female health service provider”*

*- 19 yrs, Chhettri boy, +2 student, Unmarried, AFHS not taken, FES Kailali*

*"After going to the facility staff should give counseling in detail and this should be provided to female by female provider"*

*-FGD, adolescentgirls*

*“Female health worker should be provided for female, this will help them share their problems without hesitation and can get proper health treatment.”*

*- 18 yrs, Magar girl, +2 student, Unmarried, AFHS not taken, FES Jhapa*

*“It would be very helpful for us if there are female service providers in the health facility. It will enable us to express our health problems openly. Even if we have wounds or rashes or even diseases in our private parts; then also we won’t be shy to share our problems or show our private parts to them (female service providers). That’s why it is important to have female service providers in facility.”*

*- 14 yrs, Dalit girl, Passed 8 class, Unmarried, AFHS not taken, FES Kaski*

In addition, the skills, attitudes and behavior of providers were also key aspects of adolescent friendly care and critical to overcoming barriers that limit adolescents’ access. In particular this related to providers’ attitudes towards adolescents:

*"Provider should attend facility in time, behavior of the provider should be friendly, maintain privacy and provide counseling without getting annoyed"*

*- FGD, adolescent boys*

*“If the providers come to the facility on time, then we will not have to wait for long. But they do not appear on time and it directly affects our study hours in school.”*

*-12 yrs, Dalit girl, Class 4 student, Unmarried, AFHS not taken, FES Jumla*

*"There must be a separate room for the adolescents as well as required medicine and providers should not get annoyed"*

*-FGD, adolescent girls*

*"There must be a separate room for AFHS and must have informative IEC materials, provider should attend in time, provider should give good counseling to the people like us without getting annoyed, the questions we have asked should answer politely and show good behaviors, should arrange time appropriate for adolescents."*

*- 16 yrs, Dalit girl, Passed 8$^{th}$ class , Unmarried, AFHS not taken, IDI with disable Kaski*

Providing a separate space for AFHS that ensured privacy was the most important feature noted by adolescent boys and the third most important reported by girls. This included a space that provided enough privacy to discuss sensitive issues as well as providing privacy during physical examination:

*“In front of others, we feel uneasy and shy to tell our personal health problems therefore, separate room should be provided for health checkup.”*

*- 17yrs, Dalit boy, class 8 student, unmarried, AFHS not taken, FES Jumla*

*"There must be a separate room so that no one could see us or hear us, provider should give all types of information, make such an environment that we can share our problems with full trust"*

*- 18yrs, Brahmin boy, Bachelors in Education student, Unmarried, AFHS not taken, IDIwith disable Mahottari*

Quality of care was also important to adolescents, particularly ensuring that facilities had adequate supplies of medicines and commodities, including contraceptives, provided appropriate and comprehensive care, and had sufficient referral mechanisms in place.

*"…..medicines and required equipment/materials should be available, there must be both the male and female provider and providers must give full attention"*

*- FGD, adolescent boys*

The key features of AFHS were similar across age groups, and similar also to the preferences of young adults.

### Table 3.8 Freelists of overcome barriers at health facility level by adolescent boys

| S.N. | Item | Frequency (%) | Salience |
|---|---|---|---|
| 1. | Create separate room for counseling/treatment | 57.1 | 0.427 |
| 2. | Establish gender friendly service | 46.8 | 0.283 |
| 3. | Deliver quality services | 39 | 0.215 |
| 4. | Maintain/ensure confidentiality | 33.8 | 0.243 |
| 5. | Information dissemination regarding AFHS | 32.5 | 0.198 |
| 6. | Recruit skilled health care service providers | 31.2 | 0.209 |
| 7. | Appropriate behavior by service providers | 23.4 | 0.167 |
| 8. | Availability of medicines | 10.4 | 0.046 |
| 9. | Facility should be close | 10.4 | 0.049 |
| 10. | Ensure adequate medicines | 9.1 | 0.071 |
| 11. | Availability of FPCs | 9.1 | 0.054 |
| 12. | Need of hygienic environment | 9.1 | 0.05 |
| 13. | Deliver prompt services | 9.1 | 0.065 |
| 14. | Keep condom box outside | 6.5 | 0.04 |
| 15. | Availability of all types of medical/clinical instruments | 3.9 | 0.02 |
| 16. | 24 hour health care services | 3.9 | 0.016 |
| 17. | Need of ambulance service | 2.6 | 0.017 |
| 18. | Availability of clean drinking water facilities | 2.6 | 0.009 |
| 19. | Free services should not be charged fees | 2.6 | 0.013 |
| 20. | Run mobile camps | 1.3 | 0.013 |
| 21. | Make good roads to have easy access to bring medicines | 1.3 | 0.011 |
| 22. | Should not charge fees | 1.3 | 0.006 |
| 23. | Deliver free health care services | 1.3 | 0.004 |
| 24. | Condom box should be kept in secret place | 1.3 | 0.01 |
| 25. | Improve/introduce Counseling services | 1.3 | 0.009 |

### Table 3.9 Freelists of overcome barriers at health facility level by adolescents girls

| S.N | Item | Frequency (%) | Salience |
|---|---|---|---|
| 1. | Gender friendly service providers | 50.5 | 0.382 |
| 2. | Availability of adequate medicines | 39.6 | 0.292 |
| 3. | Need of separate room | 35.2 | 0.242 |
| 4. | Appropriate behavior of service providers | 30.8 | 0.181 |
| 5. | Need of all kinds of facilities | 27.5 | 0.169 |
| 6. | Information dissemination regarding services availed | 22 | 0.128 |
| 7. | Availability of medicines/services at free of cost | 22 | 0.108 |
| 8. | Appropriate treatment services | 20.9 | 0.137 |
| 9. | Proper counseling services | 19.8 | 0.123 |
| 10. | Hygienic environment/clean toilets | 18.7 | 0.085 |
| 11. | Availability of skilled service providers | 15.4 | 0.09 |
| 12. | Availability of safe drinking water | 12.1 | 0.045 |
| 13. | Prescribe medicines after proper diagnosis | 12.1 | 0.063 |
| 14. | Non discriminatory practice and treat everyone equally | 11 | 0.047 |
| 15. | Need of ambulance | 9.9 | 0.073 |
| 16. | Deliver health care services round the clock | 9.9 | 0.078 |
| 17. | Maintain confidentiality | 8.8 | 0.054 |
| 18. | Service providers should be available on time | 7.7 | 0.053 |
| 19. | Availability of adequate human resource | 6.6 | 0.028 |
| 20. | Deliver prompt services | 5.5 | 0.025 |
| 21. | Should deliver quality services | 4.4 | 0.031 |
| 22. | Availability of adequate medical equipment | 4.4 | 0.035 |
| 23. | Separate services hours for adolescents | 3.3 | 0.019 |
| 24. | Availability of temporary methods of FPCs | 2.2 | 0.009 |
| 25. | Should have good referral mechanism | 2.2 | 0.007 |
| 26. | Services should be availed at free of cost | 1.1 | 0.002 |
| 27. | Health facility should be nearby | 1.1 | 0.005 |
| 28. | Services available should be monitored regularly | 1.1 | 0.009 |
| 29. | Easy access to services | 1.1 | 0.006 |

In addition to improving AFHS, adolescents also identified a number of opportunities to overcome community-level barriers. The two most important strategies were increasing awareness of AFHS among adolescents and communities, and creating an enabling environment for adolescents in communities (Table 3.10 and 3.11).

Adolescents identified a number of methods to increase awareness of and promote AFHS, including mass media, community-based activities such as drama and workshops, education in schools, dissemination of information through youth clubs and through household visits:

*"Conduct awareness program at community level through different activities like, group meetings, street drama and other suitable activities"*

*- FGD, adolescent boys*

*"Give information about AHFS through television and local FM radio"*

*- FGD, adolescent boys*

*"Provide information about the activities of AFHS through posters, pamphlets, newspapers, FM radio and television"*

*- FGD, adolescent girls*

*"Conducting community based discussion sessions for adolescent girls will help everyone (adolescent girls) to understand about the AFHS and make us realize our needs. In discussions, we can confidently share our problems with everybody present in the discussion and understand that others too share similar problems."*

*- 20yrs, Sarki girl, Illiterate, Married, AFHS not taken, FES Bajura*

Adolescents noted that awareness activities needed not only to increase adolescents' knowledge about what services were available, but also information that reinforced the private and confidential natur of AFHS, encouraged adolescents to seek care, and increased theirconfidence. This was particularly important for girls, who were noted to have less access to information than boys:

*"If information on AFHS is not provided to adolescents then how they will know from where to get the health facilities therefore, it is most important to provide information to the adolescents."*

*- 19 yrs, Chhettri boy, Appeared SLC, Unmarried, AFHS not taken, FES Kailali*

*"Adolescent girls should not have shame and fear and should be self-determined and confident and be able to explain others as well, so it is important to show street drama."*

*- 19 yrs, Chhettri girl, +2 student, Married, AFHS not taken, FES Doti*

*"Boys can go anywhere anytime but girls cannot go here and there like boys. So the boys have more information about SRH problems and are aware about the places where they can solve their problems. Girls do not have knowledge about such things. Therefore girls should be made aware about the SRH problems and they should make aware not to feel shy to tell their problems with the providers as the providers can solve their SRH problems"*

*- FGD, adolescent girls*

*"Increase awareness in the community and in school about AFHS from time to time, form the boys and girls group and discuss SRH issues in the group, encourage to visit the facility and make environment in the community to take the service without hesitation".*

*- 16 yrs, Dalit girl, Passed 8$^{th}$class, Unmarried, AFHS not taken, IDI with disable Kaski*

Awareness activities were also important to create a more enabling environment for adolescents by addressing negative traditional beliefs, increasing awareness and support among family members and increasing community members' understanding of the importance of AFHS. Adolescents also considered activities that addressed issues such as community gossip and discrimination based on caste, ethnicity, gender, socioeconomic status or disease status were important to create an enabling environment, were activities that promoted parents' and communities' role in encouraging and supporting adolescents to access health facilities:

> *"Visit house to house to inform the community people about the availability of services under AFHS, visit school and college to inform and educate the adolescents about AFHS, make them believe about the privacy and confidentiality of the services and not to hesitate to tell the problems to the providers as they are the one to solve their health problems"*
>
> *- 18 yrs, Brahmin boy, Bachelors in Education student, Unmarried, AFHS not taken, IDI with disable, Mahottari*

> *"If any adolescent goes to seek health services at the facility but cannot express his/her problem, then as a result he/she is prevented from getting the actual treatment services or counseling which was ought to receive. Thus, there needs to be an enabling environment where any adolescent can express their actual problems and receive needy services."*
>
> *- 18 yrs, Brahmin girl, +2 student, married, AFHS not taken, FES Jhapa*

> *"There should be establishment of enabling environment in the society where adolescent girls can express their problems without being shy and this can also prevent them from other forms of violence in the days to come."*
>
> *- 24 yrs, Brahmin girl, B. Ed.-teacher, married, AFHS taken, FES Kaski*

## Table 3.10 Freelists of overcoming community level barriers by adolescentboys

| S.N. | Item | Frequency (%) | Salience |
|---|---|---|---|
| 1. | Conduct various public awareness programs (through TV, radio, posters,streetdrama,door to door visit) | 75.3 | 0.66 |
| 2. | Creating enabling environment for adolescents with SRH issue to seek AFHS | 42.9 | 0.285 |
| 3. | Improve transportation facilities | 15.6 | 0.122 |
| 4. | RH education in school | 10.4 | 0.074 |
| 5. | Run clubs for adolescents | 9.1 | 0.044 |
| 6. | Run community SRH discussion center | 7.8 | 0.048 |
| 7. | Provide information to parents about AFHS | 7.8 | 0.053 |
| 8. | Educate everyone | 7.8 | 0.056 |
| 9. | Expand health services | 3.9 | 0.039 |
| 10. | By managing cost for visiting health facilities who can not afford | 3.9 | 0.028 |
| 11. | Demand skilled human resource for HFs | 1.3 | 0.006 |
| 12. | Organize health camps | 1.3 | 0.006 |
| 13. | Organize SRH programs | 1.3 | 0.013 |
| 14. | Organize mobile camps from time to time | 1.3 | 0.013 |

## Table 3.11 Freelists of overcoming community level barriers by adolescent girls

| S.N. | Item | Frequency (%) | Salience |
|---|---|---|---|
| 1. | Creating enabling environment for young with SRH issue to seek AFHS | 70.3 | 0.499 |
| 2. | Conduct various public awareness programs (through TV,radio,internet,posters,pictures,street dramas,hoardingboards,FCHVs,mother's group,songs,dance,door to door visit) | 67 | 0.564 |
| 3. | Educate everyone | 27.5 | 0.181 |
| 4. | Provide information to everyone (family,parents,adolescents and young people) about AFHS | 19.8 | 0.125 |
| 5. | Avoid discriminatory practices on the basis of gender, caste/ethnicity | 11 | 0.085 |
| 6. | Improve transportation facilities | 8.8 | 0.043 |
| 7. | By managing cost for visiting health facilities who cannot afford | 7.7 | 0.048 |
| 8. | Demand skilled human resource for health facilities | 6.6 | 0.035 |
| 9. | RH education in school | 6.6 | 0.033 |
| 10. | Organize SRH programs | 4.4 | 0.019 |
| 11. | Organize programs after school hours | 4.4 | 0.026 |
| 12. | Conduct SRH program at VDC level that will encourage adolescents to seek AFHS | 4.4 | 0.014 |
| 13. | Demand medicines for health facilities | 2.2 | 0.022 |
| 14. | Demand free distribution of medicines by health facilities | 1.1 | 0.011 |
| 15. | Demand for gender friendly service providers at health facility | 1.1 | 0.011 |

## 3.2 Parent and community support for AFHS

Knowledge of parents and community members on AFHS is equally as important as knowledge of adolescents in order to generate demand and support for AFHS. Acceptance and support for AFHS among parents, teachers, religious leaders, peer educators, FCHVs and HFOMC; plays a vital role in improving service utilization by adolescents.

As noted previously, negative attitudes and socio-cultural norms were highlighted by adolescents as important factors limiting their access to services. These contributed to a fear of ramifications from parents or community leaders, community gossip, or loss of reputation if they were found to be accessing SRH services. In addition, some traditional beliefs and practices actively prevented adolescents, particularly girls, from being able to access facility-based services:

> *"It is not easy to take the services to the Dalit girls like us. Because of our traditional society, people around us think negatively if we visit health facility with SRH related problems"*
> *- 16 yrs, Dalit girl, Passed 8th class, Unmarried, AFHS not taken, IDI with disable Kaski*

### 3.2.1 Gatekeepers' perceptions of adolescents' SRH needs and the value of AFHS

#### *Knowledge of AFHS*

Despite AFHS having been initiated in all participating communities prior to 2012, very few parents participating in FGDs were aware of the service. Those who were aware of the provision of special services to adolescents identified these as providing temporary FP methods, education and counseling, general health services and abortion services.

Awareness among other community gatekeepers was much higher. Of the ten community gatekeepers (teachers, FCHVs, HFOMC, peer educators and religious leaders) who participated in interviews, all but one (9 out of 10) were aware of AFHS – likely reflecting their engagement in orientation training and/or awareness activities conducted during program initiation.They noted a range of services provided through AFHS in their community (STI, safe abortion, counseling, family planning) and identified school and community-based activities that had been launched as part of AFHS, such as street dramas, community-based events, and peer education.

#### *Perception of AFHS and adolescents' health needs*

Parents identified a number of SRH needs of adolescents. These included informing adolescents about sexual and reproductive health in schools, counseling and provision of reversible methods of contraception, safe abortion services and counseling, general health services (including emergency care), STI services, and pregnancy-related care. The value of AFHS was

largely related to prevention of STIs and HIV as well as early pregnancy, and for providing adolescents with reliable information and counseling about SRH concerns:

> *"Adolescents should be informed about sexual and reproductive health issues in their school. They should also be taught about complications of bearing a child before the age of 20 and post-partum complications."*
>
> *- FGD with parents, Kaski*

> *"Counseling should be provided before the age of 20 years because among the districts Kaski district has the highest number of adolescents below the age of 20 year"*
>
> *- FGD with Parents, Kaski*

> *"There is a vast difference between the generations; now a day when adolescent girls and boys meet they may have sex. So, to get rid of the consequences of early sex, counseling is essential in this age"*
>
> *- FGD with parents, Jumla*

Many parents also supported the provision of SRH services such as condoms, contraception and safe abortion for adolescents:

> *"Adolescents should be able to receive ANC services, delivery services, especially safe abortion services for which adolescent girls are not being able to go seek service yet because they are not married, only married women go freely. They need to have enabling environment to have easy access to services available at the facility."*
>
> *- FGD with parents, Kapilvastu*

> *"Adolescents can easily share their health problems but when it comes to sexual and reproductive health issues, they feel shy though they have may have curiosity on such issues. Thus, both adolescent boys and girls need to have education on sexual and reproductive health. In addition, there is a need to create an enabling environment where they can go and ask for temporary methods of family planning. They may also be counseled on which methods of contraceptives they want to use."*
>
> *- FGD with parents, Kapilvastu*

Similar to parents, community gatekeepers also highlighted several needs of adolescents including counseling on marriage and pregnancy, HIV test and treatment, pregnancy test and counseling for pregnant women, FP services and counseling, safe abortion services, and services for people who inject drugs. Gatekeepers also stressed the need for services that provided a separate room to talk openly, good behavior of the provider, and gender friendly providers, and indicated that the establishment of youth information centres and organizing SRH related sessions once in a week as additional non-facility based activities that would improve the health of adolescents. Gatekeepers also emphasized adolescents' right to SRH services and the importance of services to prevent disease and adolescent pregnancy.

In contrast, some parents were concerned about, or disapproving of, SRH services being provided to adolescents. This was particularly the case for contraceptive services for unmarried girls.

> *"Unmarried adolescents also use temporary methods but we are afraid that they may spoil their lives by using it continuously"*
>
> *- FGD with parents, Kaski*

> *"Doctors say directly that contraceptives will be provided to unmarried adolescents but we are not in favor of this"*
>
> *- FGD with parents, Jumla*

> *"We prefer that our children should not be given temporary contraceptives until they get married"*
>
> *- FGD with parents, Jumla*

> *"Family planning are used after marriage and birth of the children but why they are used when adolescents are not married"*
>
> *- FGD with parents, Kaski*

### 3.2.2 Socio-cultural barriers

While many parents and all other gatekeepers interviewed were supportive of AFHS, they, like adolescents themselves, recognized that socio-cultural barriers were among the main barriers preventing adolescents' accessing services. Traditional beliefs, patriarchal structures and negative attitudes regarding adolescent sexual behavior contributed to fear and reluctance to seek SRH services, particularly if confidentiality and privacy were not assured. Such barriers included restrictions on girls leaving the house, negative attitudes concerning use of contraception by unmarried adolescents, and stigma associated with sexual behavior. Gatekeepers and adolescents recognized that girls were disproportionately impacted on by such attitudes, particularly in rural settings:

> *"Family members scold if a girl goes out of house without parental consent but they don't care if it's a boy in the family, he can go anywhere he wants."*
>
> *- FGD with parents, Kaski*

> *"If a married adolescent comes to seek service, then nobody cares at all. But if an unmarried adolescent comes to seek service, people in the community start backbiting about him/ her."*
>
> *- FGD with parents, Kaski*

> *"It is difficult for an adolescent to express his/her problems than compared to a married adolescent."*
>
> *- FGD with parents, Kapilvastu*

> *"For married it is okay but for unmarried ones, the society looks them with pessimistic eyes"*
>
> *- FGD with adolescent boys, Kaski*

### 3.2.3 Parents' and gatekeepers' role in AFHS

Parents and community leaders were asked about their role in supporting adolescents to have access to AFHS.Parents of adolescents saw their role primarily as informing their children about the services available, particularly the role of mother to inform daughter/s and father to inform son/s about AFHS because it will be easy to communicate. They also identified a need for community based programs to increase awareness and educating adolescents about AFHS in school.

> *"All parents should behave very friendly with their children so that they can disclose their problems openly"*
>
> *- FGD with parents, Kaski*

> *"Parents should not stop their children if they are interested to know about sexual and reproductive health issues"*
>
> *- FGD with parents, Kapilvastu*

Other community gatekeepers cited various roles they could play in improving AFHS. This included increasing community awareness of AFHS through community meetings such as meetings of AamaSamuha (Mother's Group), encouraging adolescents to attend and participate in such community meetings, encouraging parents to support their children to seek AFHS, conducting community awareness campaigns on SRH issues, referring adolescents to seek AFHS and conducting mobile camps.

> *"If we were informed about the activities being carried out by the facility, we could tell the adolescents to attend/participate in such activities"*
>
> *- Religious leader, Kapilvastu*

> *"Inform adolescents about the AFHS available in the health facility in the community and send them"*
>
> *- Peer educator, Kailali*

> *"Make an enabling environment to take the services by adolescents"*
>
> *- Religious leader, Pyuthan*

> *"Invite adolescents in the ward level meeting, inform them about AFHS, listen to their concerns and make them believe about the confidentiality of the AFHS"*
>
> *- FCHV, Bajura*

As highlighted previously, adolescents also identified a role for the community in overcoming barriers to AFHS. They identified a need to provide education to everyone about AFHS including families and parents, running community SRH discussions, addressing gender/ caste discrimination and creating enabling environment:

*"Everyone in the community should be educated and made aware about problems that occur during adolescence and encourage them to take those problems as universal. They should further be made realize their role in addressing such problems by having adequate knowledge and taking them as normal issues that happen with anybody in their lifetime. Otherwise, the community will never help us in solving our problems"*

*- 21yrs, Brahmin boy, I. Ed. Student, Unmarried, AFHS not taken, FES Doti*

*"If public awareness programs are conducted, they will help to eliminate existing negative attitude of community towards sexual and reproductive health issues. It will further encourage adolescents to seek AFHS instead of discouragements."*

*- 18yrs, Brahmin girl, +2 Student, Married, AFHS not taken, FES - Jhapa*

*"If we establish a youth information centrein the village, everyone will be aware of issues relating to adolescents. They will know and understand things which they didn't previously. Discussions will also encourage us to share things and be confident; and might assist in resolving health issues of adolescents as well."*

*- 20yrs, Brahmin boy, B. Ed. Student, Unmarried, AFHS not taken, FES Jhapa*

*"The parents of adolescent girls should trust their daughters and from then only the daughters will be confident to share their problems. This will eventually encourage any girl to enjoy or fight for their rights be it from it society or from nation."*

*- 17yrs, Brahmin girl, SLC passed, Unmarried, AFHS taken, FES Kaski*

*"We daughters should not be made to sleep in cow shed otherwise we are; and will always be at risk of getting infected with many diseases. If we get sick, our parents will have to spend money to treat us in hospital. So, we must be supported by organizations to stop this."*

*- 13yrs, Dalitgirl, Class 7 Student, Unmarried, AFHS not taken, FES Jumla*

## 3.3 Provision of a comprehensive package of services

### 3.3.1 Range of AFHS services provided

The National AFHS Implementation Guide specifies a comprehensive range of services to be provided to adolescents, including counselling services, provision of family planning (including emergency contraception), maternal health care, comprehensive abortion care (including medical abortion), HIV and STI prevention, testing and treatment, management of sexual and gender-based violence, and information, education and services for general health concerns.

All of the 72 facilities included in this study provided a range of SRH and general health services, depending on the level of health facility, for the general adult population. All facilities indicated that these general services were also available to adolescent clients, irrespective of marital status, age, gender, ethnicity or disability. However, it was unclear how the AFHS program was integrated with general health services and other SRH programs – such as family planning, safe motherhood, safe abortion and STI/HIV services. Some facilities indicated that all adolescent clients would be seen by the trained AFHS provider; however in the majority of facilities the processes for managing adolescent clients who presented to the facility, particularly through OPD, were not clearly articulated. For example, it was not clear if a young client who presented through OPD for a general health complaint or routine care (such as pregnancy-related care) would be offered the same opportunities for education, counselling and SRH services as those who presented specifically seeking AFHS counselling and services.

Indeed some facilities reported that AFHS had not been implemented despite receiving orientation training and the budget for establishing of AFHS. Lack of trained provider, insufficient funds and lack of monitoring visits from the headquarters were cited as the reason for not implementing the program. In four facilities (one hospital, one HP and two PHCC) AFHS had ceased either due to transfer of the trained providers and non-replacement by another trained staff, or lack of supervision from district and national authorities.

About half of the facilities had a condom box either kept outside the facility or inside the facility itself. More than 60% of hospitals and PHCC had a condom box, compared with 43% of SHP and only 16% of HP. Some of these condom boxes were empty.

### 3.3.2 Sufficient equipment and supplies

Adolescents and their parents believed that the facilities they visit do not have 'sufficient medicines' which had discouraged them from accessing a government health facility. Lack of adequate equipment and supplies was also reported by facility In-charges and health providers and this impacted on the implementation of AFHS – including their ability to provide some key SRH services. This included shortages of furniture, IEC materials, audiovisual education aids, medicines and laboratory services.

*"As we do not have abortion services, VCT facility and other lab test facility we are not confident in providing required services to adolescents. Adolescents come to take these services and we are unable to provide"*

*-Provider, HP*

### 3.3.3 Availability of IEC materials

The National ASRH Implementation Guide specifies that eight set of IEC booklets provided by the NHEICC should be displayed in the waiting room of AFHS facilities and incounseling rooms. Around86 percent of the facilities had at least one type of IEC material, and three quarters of facilities had these materials on display. Others either had no materials or only produced materials when requested. One facility of 72 had materials specifically for adolescents living with disability. IEC materials were visible in 86% of hospitals, in three-quarters of HP and SHP and in only two-thirds of PHCC. In some facilities IEC were available in the waiting area where the adolescent could access them while waiting to see a provider, as required by the National Implementation Guide. In most of the facilities there are insufficient IEC materials and no materials available for adolescents to take home. Some of the facilities had televisions to display health promotion programs, but many of these were not currently in use.

A small number of facilities were effectively using IEC materials, and reported positive impacts of these on adoelscents' knowledge and health outcomes:

*"We have been able to run a Audio-visual (trying to mean TV) waiting room at 'Gol-ghar' for adolescents that was donated by IPAS."*

*-Incharge Kailali*

*"I think things are working well because adolescents are now aware of family planning contraceptives. They even know on when to perform pregnancy test. Many of them know about medical abortion services. They are known to how one conceives and a baby is born. They have been learning all these things after coming to our facility than they used to earlier. It was also possible because of the books we have here. They learn many things by reading them."*

*-Incharge Jumla*

### 3.3.4 Referral mechanisms

For services that are not available on site, mechanisms are in place to refer clients including adolescents to other service delivery centres of higher level. However, the process of referring a adolescent client is the same as for adult clients in all the facilities included in this study. Thisincludedregistering in the OPD register book first and then referral to other service delivery centres – with or without a referral card. It was not clear whether adolescent clients were referred to higher level facilities providing AFHS.

## 3.4 Competency of AFHS providers

### 3.4.1 Availability of AFHS provider

Since the selection of an AFHS facility was based on the presence of a trained AFHS provider, all 72 facilities had a trained provider available. Only in one instance in Kapilbastu, the team had to replace the selected facility because the facility had stopped providing AFHS due to the transfer of trained staff.

Eighty-three percent of facilities had two or more trained AFHS providers and at least one of them was female. Eleven facilities had only one trained AFHS provider. Of these eight facilities only had a male provider (4 HP, 3 SHP and 1 PHCC) and three had a female provider only (1 PHCC, 1 SHP and 1 hospital). The lack of both trained male and female providers was similar across all facility levels, impacting on around 16% of all facilities included in this study, irrespective of facility type. In only one facility, all staff had received AFHS orientation or training.

Unavailability of both male and female AFHS providers was a noted barrier by both adolescent girls and boys, and having male and female providers was one of the highest priorities for improving AFHS:

> *"Uneasy to tell problems openly to female doctors since there aren't any male doctors in the facilities."*
>
> *- 17yrs, Tamang boy, C lass 8 student, Unmarried, AFHS not taken, FES Bhaktapur*

### 3.4.2 Providers' perceptions about current training and training needs

The national ASRH Implementation Guide 2011 specifies that providers should receive at a minimum two days of orientation training related to AFHS, with a further four days of technical training in ASRH. Providers interviewed in this study were asked how many days of training they had received related to AFHS. Two providers had received one day and 30 had received two days of training, presumably referring to the orientation program, although not all providers specifically mentioned this. The remaining 40 providers reported that they had received three or more days of training (34 had three days training, two had four days, and four and five days). Some of the providers reported that AFHS training was combined with other training programs conducted by DPHO, which may explain the additional number of days of training (beyond orientation) reported by many providers.

Providers reported a number of benefits, including new skills and knowledge, from the AFHS orientation and training they had received. The most commonly reported benefit was "improving knowledge and skills to identify adolescent health issues" followed by skills and knowledge related to "youth friendly counseling" (see Box 5)

### Box 5. Self-reported impact of AFHS training

**Self-reported knowledge and skills gained by the providers from AFHS orientation and training**

- Knowledge about common adolescent health problems
- Knowledge and skills related to adolescent-friendly counseling
- Improved attitudes / understanding about how to communicate effectively with adolescents
- Knowledge about STI diagnosis and treatment
- Understanding about the importance of privacy and confidentiality
- Understanding of the management and delivery of AFHS, including recording and reporting requirements

*"It is very useful in my current work. The training helped me to provide SRH counseling to the adolescents"*

*- Provider HP, Mahottari*

*"The training is very useful. We learned new things and we can provide services from here, so the people need not to go far away to get the services. New information we have received helps in providing services effectively"*

*- Provider SHP, Doti*

*"It is very useful. Most of the adolescents are not comfortable to tell their problems in OPD. I have been able to give counseling to the adolescents according to their psychological behavior"*

*- Provider, HP, Kapilvastu.*

*"At this current situation, this training is useful. From the training we received information about the problems of sexual and reproductive health of adolescents and received knowledge on how to handle/solve the problems through appropriate counseling"*

*- Provider, HP, Kaski*

However, some providers reported that the orientation and training they had received to date was not sufficient because of the short duration and scope and/or because they faced other challenges that prevented them applying what they had learnt:

*"It is in average. There is no proper environment for providing services as per the training. There is lack of medicines and services are being provided from OPD. Need suitable environment for providing services to adolescents"*

*- Provider, PHC, Kapilvastu*

*"It was not so useful because the training had focused on counseling only".*

*- Provider, PHC, Udayapur*

*"Due to short time period of training, it is less useful. Training is insufficient so could not understand many things. But in some level, this training has helped in providing services easily"*

*-Provider, SHP, Bajura*

The majority of the providers expressed their desire to receive additional training to improve the provision of AFHS (Box 6). Training regarding the provision of separate AFHS was the most commonly identified need among the providers, in addition to refresher training to maintain knowledge and skills. Specific training on reproductive health, contraception, STIs, was also identified by providers. Some also noted a need for training to help them deal effectively with same sex attracted and transgender adolescents (LGBTI) and survivors of gender based violence (GBV).

**Box 6. Self-reported training needs**

**Self-reported training needs of AFHS providers**

- How to provide separate AFHS
- AFHS refresher training
- Reproductive health
- Family planning
- STIs and HIV
- Growth monitoring and nutrition
- Managing adolescents who are same-sex attracted and transgender
- Dealing with the survivors of gender-based violence

*"The two days orientation training we received on AFHS is not useful in dealing with SRH issues. We cannot treat adolescent boys and girls who come with signs and symptoms of STIs. To make us more effective providers, we need additional six days of clinical training on STIs management/treatment"*

*- Provider, HP, Jhapa*

*"We need additional training on sexual and reproductive health problems of adolescents, how to deal with those problems, about the behaviors of adolescents and providing education to them using various methods and materials".*

*- Provider, SHP, Doti*

### 3.4.3 Adolescent Job aids

Many providers reported using booklets and flipcharts related to safe abortion, family planning, maternal and child health and HIV/STIs when providing education and counseling to clients, including adolescent clients. However, only 6/72 facilities (3 HP, 2 SHP and 1 PHCC) had received the Adolescent Job Aid and of these all were locked in a cabinet and were not being used by providers. No providers reported using the WHO Adolescent Job Aid to assist them to

assess, manage and counsel adolescent clients – despite the National Implementation Guide outlining that this tool should be used to provide comprehensive assessment and care for all adolescents who present to the facility.

> *"Job aids are not provided tous. If I had job aids I would have used it"*
>
> *-Provider, HP*

> *We had posters which were kept outside were taken away by the clients, some were distributed in schools and recently we have nothing. We have not received job aids yet"*
>
> *- Provider, PHCC*

> *"I will use posters, pamphlets, brochures, flip charts, booklets etc. during counseling"*
>
> *- Provider, SHP*

### 3.4.4 Supportive supervision

As per the Implementation Guide, supervision of AFHS providers is to be provided primarily bythe District Public Health Office. The AFHS supporting organizations also provide supervision in their supporting districts. For example, UNFPA provides supervision in Bajura, Pyuthan, Mahottari and Kapilvastu, SCF provides supervision in Pyuthan and Kapilvastu, Giz provides supervision in Doti and Kailali and Ipas provides supervision in Kailali. Similarly FPAN provides supervision in its program districts Doti and Kailali.

Providers reported that supportive supervision for AFHS is inadequate. Nearly half of all providers reported that they had not received any supervision since initiation or since commencing their role at the facility. Even among those who reported receiving supervision 1-2 or 3-4 times a year, many were unsatisfied with the quality of supervision as it had not helped them address challenges they faced delivering AFHS nor provided feedback on performance. This contributed to low motivation and lack of accountability.

> *"Supervision is done 1-2 times in a year, but I am not satisfied with it, because, they have not shown the responsibilities to solve the problems. They just come to see the facility, no support for the AFHS management"*
>
> *- Provider, AFHS facility, Pyuthan*

> *"Not satisfied with the supervision because, they just come and see the formats only. They will not show interest on the AFHS, neither provide feedbacks nor provide any suggestions"*
>
> *-Provider, AFHS facility, Kailali*

> *"Not satisfied because, not only the AFHS but other program are also not supervised since last nine months. The DPHO should provide the supervision but no one has come for supervision"*
>
> *-Provider, AFHS facility, Kaski*

*"Not satisfied because, the program was started since last 4 years and I have received the AFHS training 2 years ago, but no one has come for supervision"*

*-Provider, AFHS facility, Udayapur.*

Those facilities located near to the district headquarters and those actively supported by non-government organizations were more likely to report having received supervision and monitoring visits related to AFHS.

Similarly, the facility in-charge at each facility noted that the lack of supervision hindered the implementation of AFHS.

*"No one will come for supervision, so how can I tell you that who comes for supervision. If the AFHS is implemented, someone should come for the supervision, so that we could know who comes for supervision. Providing training only will not fulfill the responsibilities of DPHO"*

*-In-charge, AFHS facility, Bhaktapur.*

*"No one will come for supervision"*

*-In-charge, AFHS facility, Bajura*

*"Official from DPHO had visited which has already been more than seven months"*

*-In-charge, AFHS facility Jumla*

*"No one has come for supervision since I came here one year ago"*

*- In-charge, AFHS facility, Mahottari .*

*About six months ago PHN (Public Health Nurse) had visited together with the representative from Ipas and Giz"*

*-In-charge, AFHS facility, Kailali*

*"Actually, it will make no different to say that no one has come for supervision. I have not seen anyone who came for supervision"*

*-In charge, AFHS facility, Kapilvastu*

### 3.4.5 Self-reported comfort and confidence providing AFHS

The majority of providers reported that they were confident providing SRH services to adolescents. More than half attributed this to the AFHS orientation/training they had received, with experience and availability of required materials also reasons for feeling confident.

*"I am confident in providing SRH services to adolescents. Though the training was short it was effective"*

*- Provider, SHP*

*"Due to my experience and the training I have received I am confident in providing services to adolescents. It is also my responsibility to provide services to adolescents."*

*- Provider, HP*

Around 20% of providers reported that they were not confident providing services to adolescents. This proportion was similar across all the facility types, indicating that providers at hospitals were as lacking in confidence as those in SHP. Inadequate training was the main reason for not feeling confident. The other reasons reported were inadequate knowledge for counseling, no laboratory facility and lack of materials.

*"I am not that much confident in providing services because of inadequate training"*

*- Provider, HP*

*"As we do not have abortion services, VCT facility and other lab test facility we are not confident in providing required services to adolescents. Adolescents come to take these services and we are unable to provide"*

*-Provider, HP*

Most of the providers reported that organizing regular refresher training would help increase confidence. Similarly, regular monitoring and supervision, feedback and creating a more enabling environment through provision of materials and a separate room for AFHS would also increase the confidence providing AFHS.

Providers were also asked if there are any types of counseling or services that they don't feel comfortable providing to adolescents. More than a third of providers reported feeling uncomfortable providing some counseling or services to adolescents. More than a quarter of providers were not comfortable providing safe abortion services to unmarried girls. Others reported discomfort managing adolescents who were same sex attracted, providing condoms to boys, or managing pregnant adolescent girls. Just as adolescents felt uncomfortable seeking SRH services from providers of the opposite sex, this also contributed to the discomfort of providers themselves:

*"When it comes to sexual and reproductive health problems and counseling, I feel discomfort. I am more at discomfort when clients have wounds/rashes in and around their genitalia and to be specific I am reluctant to serve adolescents unmarried boys."*

*- Female Provider, HP, Bajura*

*"I am uncomfortable to serve adolescent boys with lesser age and they are also very shy to express their problems because I am a female. They even don't open up besides several probes and this puts me into awkward situation. This does not end just here. They tend to hide their problems even more if they attend the facility with their relatives."*

*- Female Provider, PHCC, Bajura*

*"Adolescent girls as clients are very shy in nature and we too end having discomforts in delivering them services. Unmarried adolescent girls are even shyer when we try to counsel them and I don't feel comfortable doing so."*

*- Male Provider, HP, Dolakha*

As with confidence, inadequate training was the main reason for not being comfortable providing SRH services to young clients. Other reasons included if the adolescent client was a relative of the provider or being concerned about complications (including of abortion) among adolescent clients. Improving providers' knowledge about specific SRH concerns related to adolescents, such as STIs, HIV, and abortion, was identified as key to increasing comfort addressing these issues.

### 3.4.6 Adolescents' perceptions about the competency of AFHS providers

Adolescents' negative perceptions regarding the skills, attitudes and behavior of providers were noted as key reasons for poor access to SRH services by adolescents in this study. Boys and girls reported that unsatisfactory treatment, unfriendly providers, lack of trust in providers' confidentiality, lack of training (including in counseling), discriminatory attitudes and providers who were not punctual were factors that discouraged adolescents seeking services:

> *"Providers do not come in time and there is no friendly behavior among them"*
>
> *- FGD adolescent boys*

> *"Due to the rude behavior of the health facility staff adolescents do not want to go to take the services"*
>
> *- FGD, adolescent boys*

> *"Compared to other facilities, this facility does not provide proper treatment. Same medicines are provided for all types of health problems. Health service providers are also not friendly"*
>
> *- 15 yrs, Taman boy, Class 9 student, Unmarried, AFHS not taken, FES*

Adolescents who had participated in the exit interview had a mixed perception on the behavior and attitude of the providers. Majority of the adolescents reported that they were well treated by the providers, given adequate time and opportunity to share their problems with the providers and felt comfortable to discuss about their health problems and were satisfied with the service they received. However, some of the adolescents felt that the providers failed to ensure and maintain privacy and confidentiality. None of the adolescents were informed about the AFHS when they were being registerd in the OPD.

## 3.5 Accessibility and acceptability of AFHS

The majority of AFHS providers and facility-in-charge considered their service to be accessible to adolescents. Eighty-six percent felt that their services were 'easily accessible' because they provided a range of services in a friendly and private environment and had both male and female providers available at convenient times. Of those who did not think their services were easily accessible, the lack of adequate or separate space, insufficient staff, and lack of

monitoring were major contributing factors. Similarly adolescents themselves reported that facilities were often inaccessible to adolescents because of distance and inconvenient opening hours, or did not provide an acceptable or welcoming environment

### 3.5.1 Physical accessibility of facilities

Distance to a facility was one of the main barriers for adolescentsaccessing AFHS identified by adolescents as well as community gatekeepers. Distance was more prominent in rural area than in urban and peri-urban areas and more so for girls than boys. Indeed distance was the most commonly cited barrier reported by girls during free-listing. Adolescents living with a disability also reported distance as barrier because of difficulty reaching the facility. Lack of transport, including disability-friendly transport, were also commonly reported.

> *"Due to distant location, adolescent girls cannot tell their problems openly to health service provider"*
>
> *- 16 yrs, Dalit girl, Class 8 student, Unmarried, AFHS not taken, FES Pyuthan*

> *"Health facility should be nearer. If we are able to visit when required, we can get rid of a deadly disease, if there is a hospital nearby even small kids can visit easily."*
>
> *- 15 yrs, Chhettri girl, Class 7 student, Unmarried, AFHS not taken, FESPyuthan*

### 3.5.2 Opening hours

The Implementation Guide specifies that clinic timing should suit the needs of adolescents, including consideration of school hours. The majority of facilities only offered AFHS during regular clinic hours from 10:00 AM to 2:00 PM. Adolescents, providers and community gatekeepers noted that this was not convenient, particularly for in-school adolescents:

> *"The facility opens at the time when we have to go to school and when we come from the school it is already closed".*
>
> *- FGD, adolescent girls*

Twenty-three facilities had arranged separate time/days for AFHS, and of these more than half of the hospitals (4/7) and SHPs (8/16) had introduced separate time/days for AFHS but this was less common among the PHCC (3/15) and HP (13/32) included in the study.

### 3.5.3 Welcoming and comfortable environment

Many adolescents reported that the facility environment discouraged them from accessing services. Overcrowding, lack of a waiting area, long waiting times and dirty facility environments were noted barriers identified during FGDs and FES. The majority of facilities had satisfactory toilet and drinking water facilities during observation, although a small number were noted to be unhygienic.

Almost half of the facilities (34 out of 72) did not have an AFHS signboards indicating what services areavailable to adolescents and at what times. More than 70% of the hospitalsvisited had a visible AFHS signboard, compared with around 56% of HP and SHP and only 40% of PHCC. In some facilities the signboard was kept inside the facility, but not readily visible outside the clinic. FPAN facilities also had posted hoarding boards in some places in their project area informing about the adolescent friendly services

Similarly, information about the AFHS was not included in the citizen charter in most (78%) of the facilities. It may be due to the fact that the citizen charter was written in most of the facilities at the time when the AFHS initiative was not started. In 9 facilities there was no citizen charter.

### 3.5.4 Privacy

Privacy and confidentiality of the service were key concerns of adolescents. Lack of privacy was one of the most common barriers preventing use of services, particularly among adolescent boys, and the need for a separate space for counselling and treatment was the most important aspect of an AFHS reported by boys and the third most common reported by girls during FES. Providers and facility-in-charge also identified the lack of space or a separate room to deliver AFHS counselling and treatment as one of the main challenges they faced implementing AFHS. In most facilities, adolescents were served by health providers through OPD where they had to wait with adults and children. This contributed to adolescents' fear of being seen or recognised by relatives or other community members who might question their reasons for attending the service. In the majority of PHCC, HP and SHP facilities there was no separate space for counselling and treatment, and adolescents were seen by a provider in a room that did not offer adequate privacy. In other instances only a curtain was provided to offer some visual privacy, but insufficient auditory privacy.

> *"There is no privacy. You have to tell your problems in front of other people due to lack of separate room for the AFHS"*
> *- 15 yrs, Brahmin boy, Passed 9 class, Unmarried, AFHS not taken, IDI with disable, Dolakha*

> *'We feel uneasy to talk openly about personal matters (SRH) with provider because all kinds of services are being provided from the same room with other patients watching, as there is no separate room for us'*
>
> *- IDI Female, Kaski*

In those settings, were a separate space for AFHS was not available, separate adolescent-only opening hours were suggested by some adolescents to alleviate the concerns about privacy. However as noted only a minority of facilities were providing AFHS outside of regular facility hours.

### 3.5.5 Cost of services

Contraceptive and reproductive health care services and information are provided for free in all public health facilities (PHCC, HP, SHP) with the exception of a registration fee charged in some facilities ranging from 3 to 20 rupees. A service fee is charged for safe abortion care at some government facilities. Some of the PHCC and HP also charged for pregnancy test (30-80 rupees) and blood test for STIs (70-100 rupees). In addition, some medicines needed to be purchased by the client from outside (medical shop) at extra cost. Despite the free service for most SRH care, adolescents participating in FGDs believed that lack of money to pay the service charges/fee was a barrier to service access. Lack of money was also one of the important barriers noted by adolescents participating in FES, particularly younger adolescent girls (10-14 year olds).

## 3.6 Equitable access to quality AFHS

Equity is one of the key pillars of AFHS, defined by WHO as ensuring that all adolescents, not just certain groups are able to obtain the health services they need. This includes that:

a. No policies or procedures restrict the provision of health services to adolescents on the basis of age, sex, social status, cultural background, ethnic origin, disability or any other area of difference.
b. Health-care providers administer the same level of care and consideration to all adolescents regardless of age, sex, social status, cultural background, ethnic origin, disability or any other reason.
c. Support staff administers the same level of care and consideration to all adolescents regardless of age, sex, social status, cultural background, ethnic origin, disability or any other reason.

Equitable access is also reflected in the national AFHS standards:

***Adolescents and youth enjoy their sexual and reproductive health rights***

Many adolescents reported that some groups would be discriminated against or not provided certain information or services. For example, young unmarried girls are still facing difficulties to get safe abortion services, despite the legalization of abortion services. Similarly, some providers identified that they would not be comfortable seeing adoelscents who were same-sex attracted or transgender.

The Implementation Guide also requires facilities to ensure that male and female adolescents are welcomed and treated equally and that unmarried client are welcomed and served without prejudice. This was echoed by providers:

> *"We are here to provide service. There is no age bar for any service. We must give service to anyone who comes in the facility"*
>
> *- In-charge, HP, Mahottari*

The lack of sufficient and disaggregated facility utilization data makes it difficult to determine equitable access to and uptake of services. The limited data available indicate that SRH services (through AFHS or other health programs) are mainly being used by older married adolescent girls. This may reflect older married girls' increased need for some SRH services (such as pregnancy-related care), but may also indicate that boys, young adolescents and unmarried adolescents are currently underserved by AFHS. There are no disaggregated data by ethnicity, caste, or socioeconomic status and no data concerning utilization by adolescents with a disability or those who are same sex attracted or transgender.

While quantitative data are lacking, qualitative data from adolescents, community gatekeepers and providers would also suggest that there are particular groups of adolescents who have poor access to AFHS. Female providers noted that uptake of services among boys was low, particularly where no male provider was available:

> *"Most boys feel awkward to receive services from me and knowing this I send them to male service providers."*
>
> *- Female Provider, HP, Udaypur*

> *"I do not feel comfortable to deliver sexual and reproductive health services including counselling for boys because they are shy and do not express their problems openly. This makes counselling services even more difficult. I feel uncomfortable to deliver counselling services especially for unmarried boys."*
>
> *- Female Provider, HP, Bajura*

Unmarried adolescents were recognized as being particularly underserved because of community-level barriers and judgmental or discriminatory attitudes of providers. This was most evident for unmarried adolescent girls who were more likely to face negative attitudes from family, community and providers and face restrictions on their access to services:

> *"Because of our socio-cultural norms and traditions, I feel a bit uncomfortable in delivering sexual and reproductive health related counseling services. Its more discomforting when it comes to serve unmarried adolescent girls because I fear our existing social traditions, norms and values and the girls also belong to Muslim community and you too might know that there are various boundaries for people belonging to this community."*
>
> *- Male Provider, HP, Mahottari*

> *"It is more difficult for girls in accessing AFHS. On one hand because of our social practices, their mobility is restricted from their own family members and on the other hand, they are peril to lose their dignity and may even end being by-cut by the society and might shoulder accusation of being a witch if they try to seek health care."*
>
> *- Religious leader, Community gatekeeper, HP, Pyuthan*

*"It is obvious that girls are at higher risk of having barriers in accessing health care than that of boys because of our social structure where girls fear of being accused of many things by and in the society. The way a society looks at a girl is completely discriminatory than it looks at a boy. Take a simple example. If a boy walks naked nobody says anything but if a girl's dress is slightly torn, people make that an issue and start talking badly about her."*

*- FCHV, Community gatekeeper, SHP, Mahottari*

*"If a girl goes out somewhere, her own family member starts to doubt and scold her. The society also starts back biting and keeps an eye ("chiyocharchagarne") on the girl then onwards. Also if a girl visits a health facility, the providers themselves start keeping an eye on the girl as if she has done a crime. The society also starts having more interest on that girl to know why she went to the health facility and backbite about her."*

*- FGD with parents, Kaski*

*"Girls have to work more than boys especially at home. Boys have nothing to do and do not bother about the whereabouts and whatabouts at home and keeping roaming places. But the society is always keeping an eye ("chiyocharchagarne") on where and why; wherever girls go. I think it's an intense care of family and society for girls but it is not good to that extent."*

*- FGD with adolescent girls, Kapilvastu*

Adolescents living with a disability faced similar socio-cultural barriers, but also faced additional challenges particularly when physical disability made it difficult to access services alone:

*"I was accompanied by my mother to visit the health facility because I am a disable and I am not allowed to go anywhere outside home on my own. There is nobody at the facility at most of the times when I am taken there by my mother. Most of the providers are gone to attend trainings and there are fewer female service providers. Those who are female providers do not provide services properly; they look more of untrained ones. Also the providers do not ask why we had visited the facility rather they gather together and are busy chatting. They even do not bother about us. I wish they asked me like you are asking me. I feel like they come here just to receive their salary but not to serve people."*

*- IDI with disable adolescent girl, Kaski*

Some adolescents also reported that they were discriminated against based on caste and/or on their ability to pay for services:

*"The service providers discriminate us by saying that, 'you belong to small caste/ethnicity'. They possess feeling of discriminating us. They discriminate us because we are poor and we belong to lower caste in the society."*

*- 13 yrs, Dalit girl, 7 Pass student, Unmarried, AFHS not taken, FESKaski*

*"Service providers treat us according to our capability to pay for the health care services."*

*- 21 yrs, Gurung girl, +2 student, Unmarried, AFHS taken, FES Dolakha*

Some providers reported that they were not comfortable or confident providing care to adolescents who were same sex attracted or transgender. While these adolescents were noted as being particularly underserved in the 2011 Implementation Guide, there is no specific guidance or tools to assist district level authorities or providers to make AFHS more accessible and acceptable to LGBTI adolescents.

## 3.7 Management, monitoring and reporting

### 3.7.1 Recording, reporting and use of data

The 2011 ASRH Program Implementation Guide specifies that each AFHS should collate client data disaggregated by age and service type using a standardised form to monitor progress. In addition, the district ASRH Focal Person or DPHO is required to conduct six monthly monitoring and supervision visits to all AFHS with quarterly and annual review of the overall program at district, regional and central level.

Despite this requirement, the overwhelming majority of facilities did not maintain a separate or complete AFHS register. Many recorded adolescent clients on OPD, FP, ANC/PNC, or abortion registers, however this data generally not extracted into the AFHS reporting form, or any other format that would allow tracking of utilisation by adolescents or monitor progress. In some facilities data on age, sex and marital status were not recorded in any registers, making it impossible to determine utilisation of services by adolescents.

> ***Special observation:*** *A facility in Dolakha had started to maintain the AFHS register. The record in the register was copied from the OPD register. However, the register was not maintained fully and was left half way after copying the OPD record in it for 6 months.*

Poor recording was reflected in poor reporting mechanisms. Reporting of AFHS to DPHO was also lacking in most facilities. Some of the districts had developed a separate reporting format but facilities were not reporting regularly to DPHO.

### 3.7.2 Management, monitoring and supervision

One of the major challenges reported by the providers for delivering AFHS was the lack of monitoring and supervision. As noted previously, around half of facilities had not had any monitoring or supervision visits related to AFHS and of those that had many reported that this was inadequate to meet the needs of the AFHS program. Providers from almost all the facilities emphasized the importance of regular monitoring and supervision for the effective implementation of the AFHS.

*"Supervision should be conducted from time to time"*

*- Provider, SHP*

*"Focal person from DPHO had come for monitoring once since the establishment of AFHS in 2012"*

*– In-charge, HP*

*"No one has come for supervision since the initiation of AFHS in 2012"*

*–In-charge, HPand In-charge, PHC*

*"Like other programs (TB, Leprosy, MCH etc.), priority should be given to AFHS and should conduct regular monitoring and supervision"*

*- Provider, HP*

*"After the implementation of the program, there is no monitoring and supervision. You are the first outsiders to come to this facility (pointing to our researchers) after the start of the AFHS program. Only recently we received the register book for AFHS."*

*-Provider, HP*

*"I came here 10 months ago. No one has come for monitoring during this period"*

*-Acting In-charge, SHP*

The majority of the facilities reported that they had not received any funding to support the initiation of AFHS. Those who had received funding (17/72) reported that this was insufficient to upgrade the facility in line with AFHS standards, particularly with respect to providing a comfortable and private space for counselling and services.

# 3.8 Participation of adolescents

## 3.8.1 Opportunities for adolescents to receive confidential counselling and services

Establishing and maintaining confidentiality was identified as key to improving AFHS by adolescents, particularly boys. A lack of trust in providers and perceived lack of confidentiality were among the main barriers impacting on use of services. This was particularly true in rural areas where providers were likely to be known to all in the community.

The 2011 Implementation Guide emphasises the right of all adolescents to confidential counselling and services, and that the involvement of parents is encouraged but not mandatory. This was reinforced by providers, who stated that all adolescents were entitled to confidential care without requiring parental consent, noting that the presence of a parent may prevent adolescents from openly discussing their concerns:

*"Adolescents can see a provider alone and there is no need of parents or any other person"*

*– In-charge, PHC, Dolakha*

*"They cannot tell the problems openly with their parents because they feel shy. They feel uneasy to take the services when they come with their parents. In the presence of their parents, they will also not be able to receive counselling properly"*

*- Provider, SHP, Kailali*

*"Seeing alone the provider is the right of adolescents. To make the counselling and treatment services effective, parents and adolescents should not see provider together"*

*- Provider, HP, Jumla*

The exception was safe abortion services for girls under the age of 16, reflecting the clear policy guidance on consent of minors for this service:

*"It is the legal requirement that a minor girl (below the age of 16 years) requires consent of her guardians for safe abortion service. Besides that, everyone can come alone and get other services"*

*- In-charge, HP, Kailali*

The National Guidelines for Voluntary HIV/AIDS Counselling and Testing also provide some guidance on counselling of minors, stating that adolescents aged 14 years and older may access VCT without parental consent if the counsellor determines that the "*young person has sufficient maturity to understand the testing procedures and results".* However, specific guidance concerning how a provider determines 'sufficient maturity' is lacking, as is similar policy guidance for other SRH and general health services for adolescents below the legal age of majority.

While many providers emphasised the need for adolescents to receive confidential counselling and services for SRH, it was less clear whether all adolescents, regardless of their presenting complaint, were also given the opportunity to see a provider alone. In particular it was not clear whether an adolescent presenting with a general health complaint would be offered an opportunity to see the provider alone where they could raise concerns about SRH or other sensitive issues and be provided with comprehensive assessment and education:

*"Parents may attend for general treatment. But if it is concerned to counselling and treatment of sexual health issues, the adolescents will be seen alone"*

*- In-charge, PHC, Bhaktapur*

### 3.8.2 Opportunities for adolescents to provide feedback on services

Facility In-charges reported various ways that adolescents could provide suggestions or feedbacks on AFHS. More than half reported that they have a 'suggestion box' and if there are any suggestions anyone can drop their written suggestions in that box.

*"Yes, we have kept suggestion box outside the facility. Anyone can drop their written suggestions in this box at any time. We will open the box from time to time"*

*- In-charge, HP, Kaski*

Some of the In-Charges highlighted that adolescents can also provide suggestions or feedback directly to them, through telephone, during community discussion or discussion during committee meetings. It was not able to be determined the extent to which adolescents currently provide feedback through these mechanisms or whether feedback from young clients was actively sought.

*"If there are any suggestions they can tell us directly"*

*– In-charge, SHP, Doti*

*"We have given our telephone numbers, so that they can call us directly for any suggestions. They can also contact the committee members or the providers directly"*

*- In-charge, HP, Doti*

*"We receive suggestions during community discussions"*

*- In-charge, SHP, Bajura*

*"We have two adolescents (one male, one female) in the health management committee. They put the problems related to adolescents in the committee. The committee will discuss and give suggestions"*

*- In-charge, Kailali (HP)*

Some In-charge reported that they do not currently have system for providing suggestions or feedback, while others were planning to introduce such a system.

*"We do not have the system of providing feedback"*

*- In-charge, PHC, Jumla*

Some adolescents identified the lack of suggestion box or means to provide feedback to the facility as a reason for poor use of services.They also reported that providing opportunities for feedback and suggestion would be important to improve the accessibility and friendliness of services.

*"A suggestion box is required in order to drop a complaint against irrational reasons for extended time in delivering services in a confidential way. Moreover, our complaints might help to improve the services accordingly."*

*- 19 yrs, Darai boy, SLC passed, Unmarried, AFHS taken, FES Kaski*

### 3.8.3 Participation of adolescents in the health management committee

The Implementation Guide specifies that at least one male and one female adolescent should be included as an invited member of HFOMC. However, only a quarter (18 out of 72) of the facilities were found to have adolescent involvement in the management committee. In one case, adolescents were invited as additional members but not regular members of the committee:

*"There are no youth members in the committee. We invited two adolescents in the committee meeting as an additional member. But they never attended the meeting"*

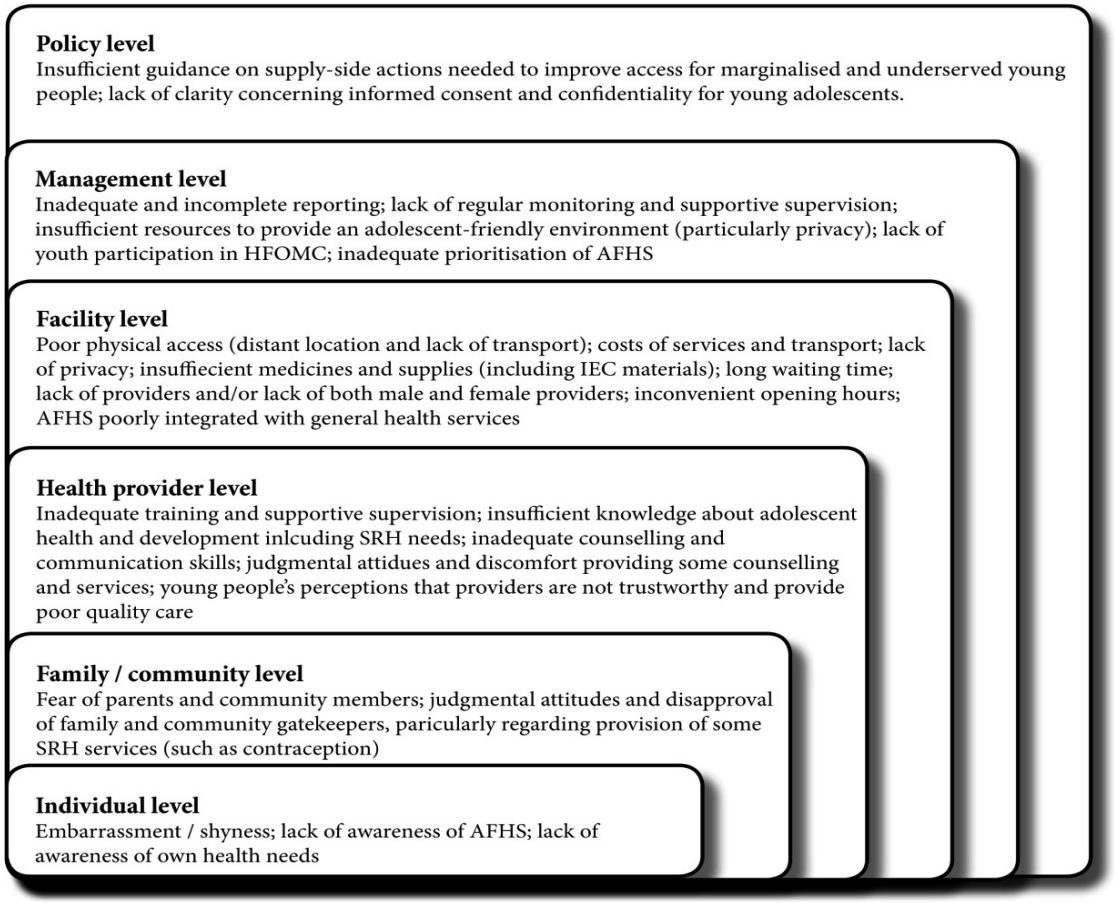
*- In charge, HP, Kailali*

# CHAPTER 4
# CONCLUSIONS AND RECOMMENDATIONS

## 4.1 Discussion and summary of key findings

There have been some important gains made to increase the coverage of AFHS and meet the health needs of adolescents, particularly needs related to SRH. However there are multiple challenges impacting on accessibility and delivery of AFHS. These challenges exist at many levels – from the individual knowledge, attitudes and skills of adolescents themselves to family and community factors, competencies of providers, facility constraints, management and the policy environment. The most significant demand-side barriers relate to low awareness of AFHS among adolescents and their own embarrassment seeking SRH servies, as well as community-level socio-cultural norms and attitudes regarding adolescent SRH. Key supply-side challenges identified by this study include insufficient training and supervision of AFHS providers, inadequate resources to upgrade facility environments to ensure privacy, and lack of monitoring and supervision from district level to support initiation as well as ongoing implementation of the ASRH Program.The key factors identified by this study are summarised in Figure 4.1.

### Figure 4.1 Key challenges impacting on AFHS



1. ***Despite demand for SRH services and a preference for public health facilities, awareness of AFHS among adolescents is very low***

- Adolescents described a broad range of SRH concerns, from puberty-related needs, sexuality and relationships, sexually transmitted infections and HIV, to contraception and pregnancy-related care. Both males and females reported a preference for receiving advice and services for many of these concerns at public health facilities, including PHCC, SHP and HP. **Despite AFHS being provided at public facilities in all communities included in this study, awareness of such services among adolescents and other community gatekeepers was very low**. Indeed even amongadolescents who had accessed facilities offering AFHS, few were aware that these services existed and few adolescents attending OPD were informed that the facility provided AFHS.

- **Lack of knowledge and information about AFHS was one of the most commonly reported barriers to service utilisation by adolescents.**Promotion of AFHS through schools, peer educators, youth organisations, FCHVs and other community channels is one of the key activities included in the National ASRH Program Implementation Guide 2011. Facilities largely bear the responsibility for coordinating and delivering these activities, however the findings of this study suggest that this component has not received adequate attention. While some facilities reported having conducted awareness raising activities at the community level in the initiation of AFHS (53/72) and through schools (49/72), few had conducted any activities since then.

- Community gatekeepers interviewed in this study, including parents, FCHVs, peer educators and teachers, recognised their own role inpromoting AFHS and raising awareness of services, however these stakeholders appear to have been underutilised. Adolescents also identified increasing public awareness as one of the most important priorities for increasing access to AFHS. This included targeting adolescents, parents and communities with information about services through a variety of channels including schools, youth centres, community groups, mass media and community events.

2. ***Socio-cultural norms and attitudes are an important barrier impacting on adolescents' access to AFHS***

- Encouragingly, parents and community gatekeepers were supportive of SRH services being available to adolescents, in particular highlighting the importance of providing SRH information, education and counselling to prevent adverse health outcomes and address adolescents' health needs. However there was less agreement on the acceptability of providing some SRH services, such as contraception, to unmarried adolescents.

- **Despite the generally supportive attitudes, parents, gatekeepers and adolescents identified negativesocio-cultural attitudes and norms as major barriers to accessing care.** For adolescents their own embarrassment discussing sensitive or taboo issues

related to sex, and fear of stigma, repercussions or judgment from health providers, their family or community were among the most important reasons for not accessing facilities. This was particularly true for unmarried adolescents and most importantly for adolescent girls in rural areas who may not be allowed to leave the house without parental consent, making it difficult for them to access confidential services.

- Community support is an important predictor of adolescents' care seeking behavior and available global evidence suggests that AFHS are more effective if linked with community interventions to increase support for services.[56-58]The findings of this study suggest this is a component of the National ASRH Program requiring greater attention. Adolescents and gatekeepers recognised the need to create a more enabling community environment by addressing negative or discriminatory attitudes and practices and targeting parents in particular with AFHS promotion activities.

### *3. Data on AFHS utilisation are limited but suggest that some groups of adolescents are underserved by AFHS*

- One of the major limitations of this study was the **lack of complete, disaggregated data recorded by facilities providing AFHS**. In the majority of facilities AFHS registers were not maintained or were incomplete, with data concerning adolescent clients being extracted from OPD, FP, ANC/PNC and abortion registers. Lack of uniformity in recording and lack of client data disaggregated by age, sex, marital status, ethnicity makes it difficult to draw conclusion about adolescents' use of AFHS and equity of access.

- The limited data available indicate that roughly equal numbers of boys and girls have received counseling in the previous six months, with older adolescents accessing counseling in grater numbers than young adolescents. However the lack of uniformity and completeness of data makes it difficult to determine the context in which counseling was provided or the nature / content of such counseling. **Most SRH services were providedto older, married adolescent girls for contraception and pregnancy-related care**. While this is likely to reflect the significant SRH needs of this group, qualitative data also suggests that unmarried adolescents, including boys, are currently underserved by AFHS. No data are available for adolescents who identify as LGBTI or those living with disability.

### *4. AFHS providers need additional training and supportive supervision to provide high quality, non-judgmental and confidential care*

- Providers were supportive of adolescents' right to confidential, comprehensive counselling and services. However some discriminatory attitudes persisted, particularly concerning the provision of abortion services, contraception and condoms to unmarried adolescents and discomfort addressing the needs of those who are same-sex attracted.

The real, or perceived, judgmental attitudes of providers and poor quality of care were also commonly reported barriers among adolescents.

- The majority of providers reported feeling confident to provide SRH services to adolescents, largely a result of the training they had received prior to initiation of AFHS**. Training was generally described by providers as valuable, contributing to an increased understanding of adolescent health needs, counselling and communication skills, and awareness of confidentiality.**However additional training needs were identified, including regular refresher training, specific sessions on reproductive health, contraception and STIs and management of AFHS. Addressing sexual and gender-based violence, and working effectively with adolescents who are same-sex attracted and/or transgender were also noted as training needs. It is noted that specific guidance concerning the provision of services to young key affected populations and other marginalized groups is currently insufficient in AFHS policy and National ASRH Program Implementation Guidelines.[†]

- While most providers self-reported improved counselling and communication skills, it is apparent that further training to continue building these skills. In particular, training to address judgmental attitudes is needed to improve quality of care and adolescents' confidence and trust in AFHS.

- **The majority of providers are not satisfied with the frequency and quality of supportive supervision currently provided from district level.** Some providers had not received any supervision since the AFHS inception, while others noted that current supervisory visits only focus on the facility without adequate attention to providers, opportunities for feedback, or support to identify and address challenges. Lack of supportive supervision contributed to a lack of accountability and low motivation in some facilities.

- Concerns about confidentiality and lack of trustworthiness of providers were noted barriers reported by adolescents. Encouragingly, most providers emphasised the importance of providing confidential care to all adolescents, particularly for SRH concerns. However, findings from the desk-review identified a **lack of specific guidance concerning the minimum age at which a young client can access services without parental consent and procedures for determining the capacity of a client under the legal age of majority to provide informed consent for counselling and care.** In addition, there is no guidance regarding circumstances when confidentiality may need to be breached – such as cases of physical or sexual abuse, risk of suicide or homicide, or where an adolescent is at risk of serious harm to themselves or others.

[†]Please refer to the desk review report

### 5. *Facilities require increased support and monitoring to implement the national AFHS standards*

- The majority of the facilities reported that they had not received any funding and those who had reported that the initial funding for program initation was inadequate. **Nearly all the 72 facilities reported that poor infrastructure and lack of financial resources were major impediments to providing a welcoming and acceptable environment in line with AFHS standards**. In particular the lack of a separate room for providing counselling and services means that many facilities are not able to provide adequate visual and auditory privacy – a commonly identified reason for not accessing services by adolescents. Improving privacy was also one of the main priorities for improving the acceptability of facilities by both males and females.

- **The current mechanisms for integrating AFHS with general facility services are unclear**. The majority of young clients appear to present to facilities providing AFHS though OPD or pregnancy-related care and most are not informed at registration of the counselling and services available to them. Many adolescents present to facilities for minor health complaints or illness, representing an opportunity to provide a comprehensive assessment and provide health promotion. Many may also be willing to discuss SRH concerns, but tend not to disclose these issues unless prompted by a provider in a private, confidential environment. However it is currently unclear the extent to which all adolescent clients are provided with a comprehensive assessment using the WHO HEADS approach (Home Education/Employment/Eating, Activity, Drugs, Sexuality/Safety, Suicide/depression)[59]and provided with an opportunity to discuss other health concerns without a parent present. It appears that AFHS is conceptualised as a vertical or standalone SRH program to some extent, rather than an approach to re-orient health facilities to provide accessible, comprehensive and integrated services to all adolescent clients.

- Despite improvements to the facility environment and provider competencies, AFHS still remain inaccessible to many adolescents due to distance and lack of transport. Importantly, inconvenient opening hours (i.e. facilities only open during school times) are a common barrier reported by adolescents and providers.

- **Another significant challenge facing facilities is insufficient numbers or maldistribution of health providers**. While 83% of facilities had two or more trained providers, more than 10% had only one male provider. The lack of access to male and female providers was a considerable concern of adolescents – with both males and females reporting that they would not be comfortable seeking care from a provider of the opposite sex – and was also a concern of providers who felt uncomfortable dealing with unmarried adolescents of the opposite sex.

- **Adequate monitoring and supervision of facilities providing AFHS is generally lacking.** Other than those facilities supported by NGOs, few facilities reported receiving any

monitoring visits related to the AFHS program nor attending a review of the program. This has contributed to a lack of accountability, incomplete reporting, low motivation to meet and adhere to standards, and missed opportunities to identify and address challenges and access additional support. In some instances facilities had not received any monitoring visits since the AFHS was initiated, and stated this as a reason for not fully implementing the program. Similarly, the lack of adequate recording and reporting of data means that most facilities and district authorities are not able to track utilisation of services by adolescents or monitor progress.

### *6. Adolescent participation in AFHS is lacking*

- Meaningful adolescent participation in the design, implementation and evaluation of AFHS is key to ensuring services meet the needs and expectation of adolescents. Adolescent participation is also a requirement of AFHS as specified in the Program Implementation Guide. Despite this, current adolescent participation at most facilities is not adequate. Only around half of all facilities reported having a suggestion box available for clients to provide feedback on services, and there appeared limited efforts to actively seek feedback from young clients. Only a quarter of facilities had adolescent participation in HFMOC.

## 4.2 Recommendations

### *1. Increase efforts to generate demand for AFHS and improve community support*

**1.1. FHD and development partners should improve the delivery of information and promotion of AFHS through currently underutilised channels.**

- Schools, peer education programs, youth clubs and centres, mothers groups, FCHVs and other adolescent-focused programs were identified as preferred sources of information about AFHS, although these are currently underutilised. Mass media (TV, radio, print media) was also identified as a preferred source and has the potential to reach large populations of adolescents, with evidence from other settings indicating it can increase knowledge and service use.[59,62] Opportunities to develop and pilot mass media campaigns related to AFHS should be explored with NHEICC.

- Community gatekeepers including parents, FCHVs, teachers and peer educators recognised that promotion of AFHS to adolescents was an important role for them – therefore AFHS providers should be encouraged and supported to mobilise these actors.

- While the orientation program for AFHS provides some guidance on engaging with community groups and actors, further district-level supervision is needed to support AFHS providers in this role. This could include reinforcing the importance of this role

during provider training, setting clear guidelines that a proportion of non-clinical time should be dedicated to education and promotion of AFHS, and ensuring that this component of the supervision checklist is addressed by the DPHO / AFHS focal person during six-monthly monitoring.

- In addition to strengthening AFHS providers' role in promotion, district level authorities such as the DPHO or AFHS focal person should also take on a greater role in terms of coordinating NGO or other youth-focused programs to ensure that community-based promotion of AFHS is included in other adolescent health and SRH activities.

- At central level, coordination is required between MoHP, FHD, NHEICC and Ministry of Education to ensure that the promotion of AFHS is linked with other initiatives to improve adolescent SRH and create an enabling environment. This includes initiatives such as comprehensive sexuality education, peer education and mass media. Such activities should be prioritised in communities where AFHS are currently operational.

**1.2. Greater coordination between FHD and the Ministry of Education, and district-level counterparts, is needed to improve linkages between schools and AFHS.**

- As per the Implementation Guidelines, linkages with schools are important to increase awareness and demand for services. Schools have the potential for reaching large groups of adolescents with information and education about health needs and AFHS, either through curriculum-based sexuality education or school-based delivery of information through peer educators, distribution of IEC materials, and/or health provider visits to school. The opportunities to include information and promotion of AFHS through existing or planned school-based information should be explored with the Ministry of Education and NHEICC. In addition, AFHS providers should be supported by facility-managers and district supervisors to provide regular health education in school settings through group-based workshops or education sessions and/or provision of school-based one on one education and counseling. Such activities should be conducted at least once every six months as per the Implementation Guidelines.

- There is also evidence that suggests that formalising referral networks between schools and health centres leads to increased service use and improved SRH outcomes in some settings[59,62,63.] It is recommended that FHD and the Ministry of Education provide specific guidance on referral mechanisms, which could be provided through existing school health programs. Specifically, this could include delivering counseling and health services in schools through regular school-based clincis provided by a trained AFHS provider and/or education and counseling provided by a trained peer counsellor. In addition or where school-based clinics are not feasible, formalizing the links between schools and the AFHS would include

assigning schools to the nearest AFHS and providing schools with formal referral forms so that students can be referred to the designated AFHS facility. Such facilities should also offer after-school clinics to cater for the students that they are assigned.

**1.3. FHD and development partners should coordinate with NHEICC, Ministry of Education and NGOs to strengthen the content of AFHS information provided to adolescents and communities, and address stigma.**

- Promotion of AFHS needs to go beyond increasing awareness of the availability of AFHS and address the perceptions and concerns of adolescents. This includes strengthening messages that reinforce confidentiality and privacy, emphasise the availability of trained, skilled and non-judgmental providers, and detail the range (and cost) of services available.

- Given that embarrassment or shyness discussing sensitive issues with a provider was one of the main barriers to accessing care, education and life-skills based activities should also aim to improve health literacy and increase skills and confidence discussing health needs with providers.[64] Approaches could also include increasing provider visits to schools or youth centres to familiarise adolescents with the AFHS provider and/or providing facility 'open days' when adolescents are encouraged to visit the facility and meet the AFHS provider.

- In addition to targeting adolescents with information about AFHS, activities should also focus on community gatekeepers, including parents, to address negative socio-cultural attitudes and generate community support for AFHS. Evidence from other settings indicates that establishing community support is critical to making services accessible to adolescents, but this component of the National ASRH Program has not yet received adequate focus.[57,62] Community mobilisation and participation in AFHS (such as through the HFMOC or VDC) and use of mass media has been demonstrated to improve awareness and communication about SRH and AFHS and may also contribute to improve socio-cultural and community attitudes.[59] In addition to providing support and supervision to AFHS providers to mobilise HFMOC and VDC as well as other community actors, FHD should coordinate more closely with NHEICC to develop and deliver broader communication activities targeting community gatekeepers.

- De-linking AFHS from SRH may also help to reduce the stigma associated with seeking services and improve community support. This could include promoting routine health checks for adolescents or 'healthy adolescent clinics' that normalise adolescent care-seeking behavior.

## *2. Strengthen management, monitoring and supportive supervision of AFHS*

### 2.1. FHD and development partners should increase support and resources provided to facilities during initiation of AFHS.

- Flexible funding should be provided to facilities to upgrade or improve the facility environment in line with national AFHS standards. This funding should be based on facility-identified and prioritised needs, recognising the different challenges and settings of AFHS.

- The role of VDC in supporting the initiation of AFHS should be strengthened. This could include mobilising community resources to assist with facility upgrade in addition to activities to generate community support for the program.

### 2.2. FHD, with the support of development partners, should develop certification criteria for AFHS.

- In addition to the existing selection criteria for identifying facilities to implement AFHS, certification criteria should be developed to ensure minimum standards are met, and used as a basis for monitoring to ensure standards are maintained.

- Such criteria could draw on selection criteria and monitoring indicators currently detailed in the Implementation Guide and could include:
  - All facility staff have received the orientation training
  - At least one male and one female provider is available
  - At least one male and one female provider has received additional technical training related to AFHS
  - The facility provides adequate visual and auditory privacy of consultation and counselling rooms
  - The facility offers dedicated opening hours for adolescent clients at least once per week, in addition to offering adolescent-friendly care at all times
  - The facility provides a minimum package of services related to SRH, mental health and nutrition with documented referral procedures for services not available on-site
  - The facility has adequate and reliable supplies, including of condoms and contraceptives
  - Condoms are provided freely and are easy for adolescents to access privately
  - IEC materials are on display
  - There are documented policies and procedures regarding client confidentiality and informed consent for adolescent clients under the age of 18
  - The reporting system is in place, records are complete and reports submitted monthly
  - A suggestion box is visible and procedures in place to actively seek adolescents' feedback

- At least two adolescents (one male and one female) are active member in the HFMOC
- Sensitisation, awareness-raising, and promotion activities have been conducted with HFMOC, VDC, peer educators and schools at initiation and activities conducted at least once every six months

**2.3. FHD should improve accountability and monitoring of AFHS at both district and central level.**

- As per the Program Implementation Guide, the DPHO and/or District AFHS focal person are required to conduct six-monthly monitoring of facilities providing AFHS and annual program review. To support this role, it is recommended that district-level authorities explore opportunities to integrate AFHS monitoring and review with other health programs,developing integrated monitoring tool of ASRHsuch as reproductive health, family planning, and safe motherhood. District-level authorities should also be required to report to central level on progress and demonstrate regular monitoring visits and supervision as part of their own performance review.

- Monitoring and supervision should use the current supervision checklist provided in the Program Implementation Guide as a basis for discussion with providers concerning progress, challenges and opportunities to improve AFHS at each facility, and active verification sought that AFHS standards are being met. This should include verification that community engagement / awareness activities are being conducted.

- Greater accountability and incentives are required to improve reporting:
  - Verification that records are accurate and maintained and reporting completed monthly should be included as part of the six-monthly monitoring visit and included in criteria for ongoing certification.
  - Opportunities to link AFHS reporting with other routine reporting requirements (such as HMIS 32) should be explored.
  - It needs to be emphasised with providers and facility-in-charge that disaggregated data relevant to the AFHS Program needs to be gathered from all the facility services including OPD, maternal care, safe abortion, family planning, and STI/HIV services.
  - Facilities should receive feedback on submitted reports so that they can track progress and measure performance against other AFHS in the district to improve motivation and compliance with reporting requirements.

- The role of the HFOMC in providing regular monitoring and review of the program should be strengthened and emphasised. This would include a role for adolescent HFOMC representatives to provide review and feedback.

**2.4. Development partners should consider piloting performance-based incentives for AFHS.**

- Studies of approaches to improve utilisation of maternal health services and adolescent friendly SRH services suggest that providing performance-based incentives to facilities or providers can increase uptake and quality of care.[49,65,66]An evaluation of an ASRH program in Nicaragua, for example, demonstrated an increase in providers' knowledge, reduction in barriers and improved attitudes as a result of financial incentives to facilities for each adolescent client served in addition to provider training and vouchers distributed to adolescents.[67]

- The feasibility of piloting a similar approach in Nepal could be explored. Certification criteria could be used to identify facilities eligible for the program (and provide motivation for other facilities to meet minimum standards) with financial or other incentives provided per adolescent client served and/or for maintaining AFHS standards. In addition to improving the delivery of AFHS, such a program may also provide an incentive for providers to increase community engagement and AFHS promotion activities to generate demand.

### *3. Improve AFHS provider training and supportive supervision*

**3.1. FHD should improve coordination with the National Health Training Centre (NHTC) to increase access to and coverage of training.**

- Improved coordination is required to ensure that all facility staff (including support staff) receive AFHS orientation training and that at least one provider per facility receives more in-depth technical training prior to or soon after the initiation of AFHS.

- Greater coordination is also needed to develop and provide regular refresher training to AFHS providers to ensure knowledge and skills are maintained, reinforce positive attitudes, and support provider motivation.

**3.2. FHD and development partners should work with NHTC to develop a more comprehensive, competency-based ASRH training program for AFHS providers**

- This training should be provided to at least two, and preferably one male and one female, provider per facility, focusing on:[49]
    - Increasing ***knowledge*** about adolescent health and development, including issues related to puberty, sexuality, relationships, contraception, STIs/HIV, pregnancy-related care, sexual and gender-based violence, mental health and substance use;
    - Addressing ***attitudes and behavior***towards adolescent clients including the rights and needs of unmarried adolescents, married adolescents, young people who are same-sex attracted and transgender young people;

- Build ***skills*** through participatory learning that focuses on effective communication and counselling;
- Address considerations and procedures related to confidentiality and informed consent of legal minors;
- Provide skills and strategies for working with schools and community actors to improve demand and community support for AFHS;
- Orientation to the use of adolescent job aids and the WHO HEADS approach to comprehensive assessment of adolescent clients; and
- Orientation to reporting requirements and responsibilities.

- Training methods should go beyond lecture-based approaches and incorporate participatory adult learning methodologies that enable providers to develop skills, practice, and receive critical feedback.

**3.3. FHD should explore the possibility of incorporating adolescent health competencies into pre-service education for all primary level health providers.**

- Given the scale-up of the National ASRH Program and high coverage targets for AFHS, opportunities to integrate adolescent health competencies into pre-service training of all health workers should be explored with national medical and nursing training institutions. This could draw on the Western Pacific Regional Office (WPRO) Framework for the integration of adolescent health and development concepts into pre-service health professional education curricula.[68]This could draw on the WHO*Core Competencies in Adolescent Health and Development for Primary Care Providers*.

**3.4. FHD and development partners should strengthen the capacity of districts to provide supportive supervision of AFHS providers.**

- Regular supportive supervision is necessary to maintain quality of care and motivation and allow providers an opportunity to identify and address challenges. The current supervision checklist for district-level supervisors needs to strengthen the component "Assessment of service providers" to go beyond self-reported training attendance and access to/use of flip charts and job aids. Six-monthly monitoring should also include observation of the AFHS providers' clinical and counselling skills, where possible, provide opportunities for on-the-job training, and allocate time for reflection and discussion of specific challenges faced by providers.

- Establishing district-level peer networks of AFHS providers and/or allocating time at the annual program review for providers to share experiences and learn from successful approaches and challenges is also recommended to improve support, motivation and learning.

## *4. Increase support to facilities to improve the accessibility, acceptability and appropriateness of AFHS*

### 4.1. FHD and development partners should increase support to districts and facilities to create a more welcoming and accessible facility environment.

- Lack of space and privacy is one of the major challenges facing AFHS. In the immediate term, the focus should be on ensuring visual and auditory privacy of consultation and counselling rooms rather then separate waiting areas for adolescents. In most cases, a curtain is not sufficient to ensure auditory privacy nor does it provide the same level of privacy during physical examination as a lockable door. It is acknowledged that the physical infrastructure at many facilities, particularly SHP and HP, does not currently allow for adequate privacy. In addition to increasing the resources provided to facilities at initiation of AFHS to improve the physical environment, districts and facilities should also be supported to more actively engage with VDC to mobilise community resources for facility upgrades. In addition, issues of privacy and confidentiality are not exclusive to AFHS but are basic standards of patient-centred care. Therefore, financial resources to improve the physical infrastructure of facilities could also be drawn from other health programs – such as safe motherhood, STI/HIV, safe abortion and family planning programs.

- Where a separate waiting room for adolescents is not feasible due to a lack of space, facilities should be encouraged to offer dedicated adolescent-only opening hours at least once a week (in addition to providing AFHS at all other times). These should be offered outside of normal school hours to improve accessibility and could be combined with other youth-focused activities such as providing peer educators on site. While separate opening hours outside school hours are recommended in the Implementation Guide, few facilities are currently providing such services. Therefore provision of adolescent-only opening hours should be part of certification criteria.

### 4.2. FHD should provide increased guidance on procedures for integrating AFHS with general health services at facility level.

- The importance of integration of AFHS standards with general facility services should be reinforced at district and facility level. Every adolescent client who attends an AFHS facility should be provided with comprehensive, non-judgmental care irrespective of their presenting complaint. This requires training of support staff and clear registration procedures so that each adolescent is informed about AFHS and is seen by a trained AFHS provider, regardless of whether they present through OPD, antenatal care, abortion services, family planning, or STI/HIV services. Similarly, improved training on the use of the WHO Adolescent Job Aid is required so that each young client is comprehensively assessed using the HEADS[61] approach

and offered an opportunity to seek advice, counselling or services related to SRH, mental health, substance use and other adolescent health needs. This could be facilitated by developing standardised clinical forms or protocols based on the HEADS approach to guide providers through each consultation with an adolescent.

**4.3. FHD, with the support of development partners, should develop more specific guidance on confidentiality and informed consent of legal minors.**

- Confidentiality is an essential component of AFHS, and the National ASRH Program Implementation Guide explicitly states that confidentiality is mandatory for AFHS and parental involvement is not compulsory. However, there are some circumstances when it may be in the adolescent's best interests to breach confidentiality – such as in cases of physical or sexual abuse, risk of homicide or suicide, severe mental illness, or when an adolescent is at serious risk of harm to themselves or others. At central level, specific guidance and procedures for facilities and providers concerning confidentiality in these circumstances are needed.

- At central level, specific policy and guidelines are required concerning consent of adolescents under the age of 18 years. There is some existing guidance concerning informed consent of adolescents for HIV testing (14-17 years if the counselor determines the adolescent has sufficient maturity) and safe abortion (16 years and over). However similar policy guidance does not exist for other services, such as STI testing and care or contraception. In addition, guidance is also needed for AFHS providers about how to ascertain whether a young client has the capacity to provide informed consent. The National VCT guidelines for example do not provide specific detail on how a provider or counsellor is to determine whether a 14-17 year old has 'sufficient maturity'.

- Issues of confidentiality and consent need to be incorporated into revised AFHS provider training, with attention to the legal and ethical obligations of providers, the considerations and procedures for obtaining consent from young clients, and procedures for ensuring confidentiality and addressing circumstances where confidentiality may need to be breached.

- At district-level, AFHS facilities should be supported to develop written policies and procedures regarding confidentiality and consent as part of certification criteria.

**4.4. FHD and development partners should explore the feasibility of delivering some SRH counselling and services outside of the facility setting.**

- Adolescents identified peers, FCHVs, teachers, and pharmacies as preferred sources of SRH information and services, in addition to health facilities. Delivering some services to adolescents in the community may overcome some of the barriers associated with accessing facility-based care, particularly for marginalized young

people.[49,62] This could include provision of counselling, distribution of condoms and some contraceptives, and referrals to AFHS through FCHVs, peer educators, youth centres, pharmacies and potentially schools. In particular, improved opportunities for training FCHVs in AFHS, beyond initial orientation, may help to reach some groups of adolescents in the community – such as young married adolescents.

**4.5. FHD and development partners should increase guidance on supply-side actions needed to deliver AFHS for young key affected populations and marginalized adolescents.**

- The current Implementation Guide provides insufficient guidance to districts and providers concerning the delivery of AFHS to particularly underserved adolescents. These include adolescents who are same-sex attracted or transgender, adolescents who use substances, adolescents who sell sex or are affected by trafficking, young people living with HIV, and others who face discrimination. While not a focus of this study, it is recommended that FHD and development partners support further research to identify the specific needs, barriers and preferences of these adolescents to inform specific supply-side actions.

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# ANNEX

# Annex 1

**Assessing Supply Side Constraints Affecting the Quality of Adolescent Friendly Health Services (AFHS) and the Barriers for Service Utilization**

**UNFPA/CREHPA-2014**

## Focus Ethnographic Study (FES) among Adolescents and young people (Male and Female 10-24 yr)

***Registration Sheet***

**Date: …… District: ……. Municipality/VDC : …….**

**Venue:**

**Category of FES Participants : 1. Boys 2. Girls**

**Type of Health Facility Reference:**

| S.N. | Age | Ethnicity | Currently Attending school/college? | | Highest completed educational level | Marital Status | Ever attended an AFHS before? | | Remark |
|---|---|---|---|---|---|---|---|---|---|
| | | | Yes | No | | | Yes | No | |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
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| 11 | | | | | | | | | |
| 12 | | | | | | | | | |

# FES GUIDE

| Topics | Question for free listing | Questions for rating | Reasons for priority rating |
|---|---|---|---|
| **1. Health problems** | Please list all the health concerns, including sexual and reproductive health problems, of a adolescents your age<br><br>**Instructions: For the Boys Group, ask them to lists the health and SRH concerns of adolescent boys only.**<br><br>**Likewise for the Girls Group, ask them to lists the health and SRH concerns of adolescent girls only** | How common do you think these problems are among adolescents and young people of your age in this community?<br><br>For each problem you have listed please score a "3" for very common, "2" for somewhat common and "1" for not common | |
| **2. Health-seeking behavior** | Please list all the people or places where adolescents and young people could go for advice or services for sexual and reproductive health | Which of these people or places would you most prefer to receive advice or services for sexual and reproductive health?<br><br>For each you have listed, please score a "3" for most preferred "2" for somewhat preferred, "1" for less preferred/would not seek care from this source | For all the people or places that you gave a "3" please explain why you would prefer to seek advice or care from these sources.<br><br>For all the places that you gave a "1" please explain why you would not like to seek advice or care from these sources |
| **3. Barriers to accessing AFHS** | You may be aware that ……. provides adolescent friendly health services to adolescents and young people in this community since...<br>.....<br><br>Please list all the barriers or challenges that you think would prevent a adolescents from accessing this facility | How important are each of these barriers?<br><br>For the barriers you have listed please rate them depending on how important or significant you think they are:<br><br>Score "3" for very significant (a major barrier), score "2" for somewhat significant and score "1" for not very significant (not a major barrier) | For all the barriers you have rated "3" as the most important, please explain why. |
| **4. Overcoming barriers** | **4A. Community-level barriers**<br><br>Please list all the things you think could be done in your community to make it easier for adolescents and young people to access services for sexual and reproductive health<br><br>**4B. Facility level barriers**<br><br>Please list all the things that you think could be done at a health facility to make it easier for adolescents and young people to attend | For each of the suggestions you have listed, please rate how much of a priority you think these are. Please give a score of "3" for high priority, "2" for moderate priority and "1" for low priority<br><br>For each of the suggestions you have listed, please rate how much of a priority you think these are. Please give a score of "3" for high priority, "2" for moderate priority and "1" for low priority | For each of the suggestions you rated as "3" high priority, please explain why you think this is a high priority in your community<br><br>For each of the suggestions you rated as "3" high priority, please explain why you think this is a high priority |

**Assessing Supply Side Constraints Affecting the Quality of Adolescent Friendly Health Services (AFHS) and the Barriers for Service Utilization**

**CREHPA/UNFPA – 2014**

# Question guide for FGD with parents (both father and mother of adolescents)

**Informed Consent**

**Introduction:** Namaste! My name is…… I am from CREHPA, a research organization based in Kathmandu. Since the past 19 years, this organization has been conducting a series of research and advocacy activities on health and reproductive rights. Currently, in collaboration of Family Health Division and in coordination with UNFPA and UNICEF we are conducting a study of health facilities that provide Adolescent Friendly Health Services.

**Purpose of the research:** The main purpose of this study is to assess supply side constraints relating to the quality of Adolescent Friendly Health Services (AFHS) and barriers for their utilization, and to make recommendations to improve the existing services and also inform scaling up of the AFHS initiative incountry.

**Potential risk and benefits:** We believe that this study is safe and there is no any risk or harm to you and your community by participating in this study. There are no direct benefits for participating in the study. But, the information you have given may help in developing policies and programs for adolescents residing in districts and in Nepal.

**Confidentiality:** All information collected from you will be kept strictly confidential and will not be shown to anyone. The interviews will be kept safely in a locked cabinet and used only for research purposes. Your name will not go into any document or presentation based on the study. The findings of the study will be shared with the policy makers and concerned stakeholders only. However, there will be no information that could potentially identify you will be going into any report

**Voluntary participation:** Your participation in this study will be completely voluntary.You have the right to take part in the study or not. You may refuse to answer any questions or withdraw from the study at any time. However, we believe that you will provide your valuable information by participating in the study. The interview will take about 45 minutes.

**Who to contact:** This proposal has been reviewed and approved by the Nepal Health Research Council, Kathmandu, a national body whose tasks is to make sure that research participants are protected from harm. If you have any questions you may ask those now or later. If you wish to ask questions later, you may contact to AnandTamang, Director of CREHPA at Phone 5521717, 5546487

We would like to get your permission for tape recording the discussion so that the information you provide could be presented as it is. Your name will not be tape recorded and this tape record will be access to the researcher only. You may stop recording at any time. Do you agree to record the discussion?

Shall we start discussion?

Yes..... 1 (Start discussion)

No..... 2 (End discussion)

**Ice Breaking Question:**

What do the adolescents of your community do during the leisure?

We have discussed about how the adolescents do during the leisure time in the community. Now let's move on to our core discussion session.

## FGD Guideline

| Theme | Core Questions | Probing Questions |
|---|---|---|
| **Health problems/ concerns** | What are the main health problems/ concerns of adolescents in your community?<br><br>Are these problems/ concerns different for boys and girls? | • Health problems/ concerns including sexual and reproductive health<br>• Changes witnessed among and within adolescents (both physical and mental) |
| **Health care seeking behavior** | ***In general:***<br>You have just mentioned that ……are the main health problems/ concerns of adolescents. In your opinion, where do adolescents<br>• seek information or<br>• advice or<br>• seek health care services about these issues?<br><br>Do you think these are good sources of advice/information/ delivering health care services?<br><br>What do you think about the quality of these services?<br><br>***AFHS related***<br>Are there any services in your community that are especially for adolescents?<br><br>What do you think about the quality of these services?<br><br>In your opinion, do adolescents use these services? Why they take service there? | • Which ones?/ Where? And why?<br><br>• Are these places/ person good sources for sexual and reproductive health related problems/ concerns as well? Why? Why not?<br><br>• Counseling, gender friendliness, disability friendliness, ensured privacy and confidentiality, behavior of service provider, service hour, availability of needy resources including medicine, etc.<br>• If yes, why?/ If no, why? |
| **Barriers** | What are the main barriers that prevent adolescents from using health services?<br><br>Do these barriers differ among adolescents boys and girls?<br><br>Are these barriers different for unmarried and married adolescents? | • Including barriers regarding issues related sexual and reproductive health<br>• Barriers such as social, economic, cultural, religious, family, service providers, knowledge, geo-ecological, time, infrastructures of health facility, etc.<br><br>• If yes, what kind of barriers?<br>• If no, which ones? Why do you think so?<br><br>• If yes, what kind of barriers?<br>• If no, which ones? Why do you think so? |
| **Need of services** | In your opinion, what types of services should be available to adolescents? Why do you think so? | Including:<br>• SRH counseling<br>• STI testing and treatment<br>• HIV testing<br>• Condoms<br>• Contraception<br>• Emergency contraception<br>• Pregnancy testing<br>• Abortion<br>• Pregnancy care |

| | | |
|---|---|---|
| | What do you think about adolescentsmarried and unmarried adolescents having access to contraceptives?<br><br>In your opinion, what age should aadolescents be able to receive SRH counseling by themselves, without a parent present?<br><br>In your opinion, what age should aadolescents be able to receive SRH services (like condoms, contraceptives, STI and pregnancy testing) by themselves, without parental consent? | • If yes why?/ If no, Why?<br><br>• Please explain why you think this age is most appropriate?<br><br>• Please explain why you think this age is most appropriate? |
| **Overcoming the barriers** | What do you think could be done to improve adolescents's access to health services?<br><br>What do you think are the most important factors that make a health facility 'youth friendly'? | • Gender friendly, disable friendly, confidentiality and privacy should be ensured; job aids- IEC and BCC materials, counseling, behavior of service provider, service hour, availability of needy resources including medicine, Family planning contraceptives; etc.<br><br>• Quality ensure, awareness campaigns through different types of media such as electronic media (radio, TV, internet), paper media (newspapers and magazines, pamphlets, brochures, holding boards, flip charts, pictures) and social media (through dramas, flash mop, community announcements, peer education, etc.) |
| **Role of parents** | Do you as parents of adolescents feel that you have some role in improving adolescent friendly health services (AFHS)? What kind of roles?<br><br>What do you think you as parents of adolescents can do to increase adolescents's access to and use of AFHS? | • Why do you think you have some role? |

**THANKS FOR YOUR TIME AND INVALUABLE INFORMATION**

**Assessing Supply Side Constraints Affecting the Quality of Adolescent Friendly Health Services (AFHS) and the Barriers for Service Utilization**

**CREHPA/UNFPA – 2014**

# Question guide for FGDs with adolescents

Note: FGDs to be separated into male and female groups (with 15-24 age groups)

**Ice Breaking Question:**

What do the adolescents like you do during the leisure time in the community?

We have discussed about how the adolescents like you do during the leisure time in the community. Now let's move on to our core discussion session.

## FGD guideline:

| Theme | Core Questions | Probing Questions |
|---|---|---|
| **Health problems/ concerns** | What do you think are the main health concerns for adolescents of your age?<br><br>**<u>Suggested activity: Body mapping</u>**<br><br>***<u>Need</u>:*** *large piece of paper and markers*<br><br>***<u>Method</u>:*** *Ask one adolescents to lie down on the paper and have another person draw an outline around their body. Ask another person to write down the name of different parts of the body. Ask other participants to add the missing body parts. Use this body outline to stimulate discussion about the different types of health issues that affect adolescents. Ask the group to write or draw on the body outline to explain all the different health problems that adolescents face)* | • Health problems/ concerns including sexual and reproductive health<br>• Changes witnessed among and within adolescents (both physical and mental) |
| **Health care seeking behavior** | You have just mentioned that ……..are the main concerns of adolescents. In your opinion, where do adolescents go for information or advice or seeking health care services about these concerns?<br><br>Are these same for boys and girls?/ Married and unmarried adolescents?/ advantaged and disadvantaged groups?<br><br>Do you think these are good sources of advice/ information or service delivery facility?<br><br>Where and from whom would you prefer to get advice about the concerns you have mentioned earlier?<br><br>Are there any services in your community that are especially for adolescents? What are they?<br><br>Do you think these places provide good quality care for adolescents? How?<br><br>Do you think adolescents such as yourselves use these services? How? | • Which ones?/ Where? And why?<br><br>• If yes, why? / If no, why?<br><br>• If yes, why do you think so?/ If no, why do you think so?<br><br>• Why?/ Why not?<br><br>• Why?/ Why not? |

| | | |
|---|---|---|
| **Barriers** | What are the main challenges or barriers that make it difficult to access health services?<br><br>**<u>Suggested Activity</u>: <u>Card game</u>**<br><br>***<u>Need</u>**: Blank cards and markers*<br><br>***<u>Method</u>**: Ask the group to think of all the barriers that might stop adolescents going to a health facility. Ask the group to write one barrier on each card. Encourage all participants to contribute. Ask them to explain barriers that are not clear. Record all the barriers that are mentioned and the order in which they were mentioned in the FGD notes.*<br><br>*Once they have written down all the barriers on cards, ask the group to put the cards in order from the most serious barrier to the least serious barrier. Record the order in the FGD notes. Ask the group to explain why they have put them in this order and record their explanations.* | • Including barriers regarding issues related sexual and reproductive health<br>• Barriers such as social, economic, cultural, religious, family, service providers, knowledge, geo-ecological, time, infrastructures of health facility, etc.<br>• Ask the group whether these barriers are different for boys and girls, married and unmarried adolescents, in and out of school, marginalized adolescents<br>• Specifically ask the group about the **barriers to accessing contraception** and whether it is different for married or unmarried adolescents |
| **Overcoming the barriers** | You have enlisted ……as barriers to adolescents. Out of these, you have already ranked top three barriers, which you thought were the most important to be overcome. In your opinion, what could be done to overcome these top three barriers? How?<br><br>**<u>Suggested Activity: Community mapping</u>**<br><br>***<u>Need</u>**: Large piece of paper and different colored markers*<br><br>***<u>Method</u>**: Explain to the group that you would like them to design the 'ideal' health service for adolescents – that is, what would make a health facility adolescent friendly.*<br><br>*Give the group a large piece of paper with a square drawn in the middle. Ask them to design the 'ideal' health service inside the square. They can draw pictures or write words – whatever method they like. Prompt them to think about the facility environment, opening hours, activities/IEC materials, and the characteristics of the staff who would work there.*<br><br>*Once they have finished designing the health service, ask the group what would need to be done outside the square (in the community) to make it easy for adolescents to access the service. Again, they can draw pictures or write words. Prompt them to think about all the community barriers they mentioned in the previous activity.*<br><br>*Ask the group to explain their ideas and record their responses. Make sure to take a photograph of the design.*<br><br>Is there anything else that anyone would like to say about improving health services for adolescents? | • Gender friendly, disable friendly, confidentiality and privacy should be ensured; job aids- IEC and BCC materials, counseling, behavior of service provider, service hour, availability of needy resources including medicine, Family planning contraceptives; etc.<br><br>• Specifically ask the group to describe the characteristics of a friendly AFHS provider (what knowledge should they have, what skills do they need, how should they treat adolescentsclients)<br><br>• Quality ensure, awareness campaigns through different types of media such as electronic media (radio, tv, internet), paper media (newspapers and magazines, pamphlets, brochures, holding boards, flip charts, pictures) and social media (through dramas, flash mop, community announcements, peer education, etc.) |

**THANK YOU FOR YOUR TIME AND INVALUABLE INFORMATION**

**Assessing Supply Side Constraints Affecting the Quality ofAdolescent Friendly Health Services (AFHS) and the Barriers for Service Utilization**

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# Observation Checklist and Facility In-Charge question guide

## I. Introduction and background information

| | |
|---|---|
| District | 1. Dolakha 2. Bajura 3. Jumla 4. Udayapur 5. Bhaktapur 6. Kaski 7. Pyuthan 8. Doti 9. Jhapa 10. Mahottari 11. Kapilvastu 12. Kailali |
| VDC / Municipality | |
| Ward No. | |
| Level of health facility | 1. Hospital 2. PHCC 3. HP 4. SHP 5. NGO clinic (specify)…… |
| Sex of In-Charge | 1. Male 2. Female |
| Designation of In-Charge | 1. CMO 2. MO 3. PHN 4. HA 5. Sr AHW 6. SN 7. ANM 8. Counsellor 9. Other |
| How long have you been working at this facility? | .....Month |
| How long have you been In-Charge at this facility? | .....Month |
| AFHS started date | |
| AFHS currently operating or not | |
| Mention, if separate hour for AFHS service | |
| Mention, if separate day for AFHS service | |
| Staff interviewed | |
| Name of interviewer/observer | |
| Date of observation / interview | |

## II. Client volume and services provided

This section is for gathering information on client volume and the range of services provided. Using the facility record books, collect information for the previous 6 months. Record the total number of all the clients the number of adolescents served disaggregated by age.

This information could be gathered from facility records and then entered into this table later.

If a service is not provided to adolescents, please explain why in the **Comments** column

| Service Provided | Is this service provided to adolescents? | | Total No. of clients served in the last 6 months | | No. of adolescentsclients served in the last 6 months | | | | | | Married | | Unmarried | | Comment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | 10-14 | | 15-19 | | 20-24 | | | | | | |
| | Yes | No | M | F | M | F | M | F | M | F | M | F | M | F | |
| **1. OPD** | | | | | | | | | | | | | | | |
| **2. COUNSELING (*If details about the main issue adolescents were counseled about is not available, then just record the total number who received counseling)*** | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - Sexual and reproductive health | | | | | | | | | | | | | | | |
| - General counseling | | | | | | | | | | | | | | | |
| - Relationships | | | | | | | | | | | | | | | |
| - Puberty | | | | | | | | | | | | | | | |
| - Personal hygiene | | | | | | | | | | | | | | | |
| - Contraception | | | | | | | | | | | | | | | |
| - Abortion | | | | | | | | | | | | | | | |
| - Condoms | | | | | | | | | | | | | | | |
| - HIV | | | | | | | | | | | | | | | |
| - Violence | | | | | | | | | | | | | | | |
| - Sexuality / sexual orientation | | | | | | | | | | | | | | | |
| - Substance use | | | | | | | | | | | | | | | |
| - Nutrition | | | | | | | | | | | | | | | |
| - Mental health | | | | | | | | | | | | | | | |
| - Other issues (specify) | | | | | | | | | | | | | | | |
| **3. SRH SERVICES** | | | | | | | | | | | | | | | |
| STI testing and treatment | | | | | | | | | | | | | | | |
| VCT | | | | | | | | | | | | | | | |
| PMTCT | | | | | | | | | | | | | | | |
| HIV treatment | | | | | | | | | | | | | | | |
| Contraception | | | | | | | | | | | | | | | |
| Condom | | | | | | | | | | | | | | | |
| Oral contraceptive pill | | | | | | | | | | | | | | | |
| Injectable (Depo) | | | | | | | | | | | | | | | |
| IUCD | | | | | | | | | | | | | | | |
| Implant | | | | | | | | | | | | | | | |
| Emergency contraceptive | | | | | | | | | | | | | | | |
| Pregnancy testing | | | | | | | | | | | | | | | |
| Medical abortion | | | | | | | | | | | | | | | |
| Post abortion care | | | | | | | | | | | | | | | |
| Antenatal care | | | | | | | | | | | | | | | |
| Postnatal care | | | | | | | | | | | | | | | |
| Delivery care | | | | | | | | | | | | | | | |
| Other services (Specify) | | | | | | | | | | | | | | | |

**III. Schedule of available services**

Write in the hours for each day of the week that the following services are available to adolescents

| **Service Provided** | **Sunday** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
|---|---|---|---|---|---|---|---|
| **OPD** | | | | | | | |
| **COUNSELING** | | | | | | | |
| **SRH SERVICES** | | | | | | | |
| - STI testing and treatment | | | | | | | |
| - VCT | | | | | | | |
| - Contraception | | | | | | | |
| - Medical abortion | | | | | | | |
| - Antenatal care | | | | | | | |
| - Delivery care | | | | | | | |
| - Postnatal care | | | | | | | |
| - Other services (Specify) | | | | | | | |

**IV. Personnel and Supervision**

List all personnel involved in the provision of services to adolescents and the training they have received, using the codes beneath the table.

| Job title / designation | Qualifications | Sex | Types of training* | Training agency and date | % of time serving adolescents |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*1= orientation on AFHS 2 = training on AFHS 3 = General SRH 4 = Family Planning 5= Counseling 6= HIV/AIDS including VCT 7=Safe abortion 8 = Management of STIs 9= others (please specific)

Do all staff (including receptionists) receive an orientation about AFHS? Please provide details about which staff receive this orientation and who provides it:

……..

Please provide details about supervision of AFHS providers (title of the supervisor, what organisation / facility they are affiliated with, how often they visit / provide supervision):

……..

If the AFHS provider is not available, who provides services to adolescentsclients?

……..

Is there a separate female provider for girls? .....

Are the sufficient numbers of staff for the AFHS? Why do you say that?

**……..**

Please record all the job aids that are available to assist staff working with adolescentsclients:

| Title of aid | Type of aid (flipchart, poster, pamphlet, models, desk reference/book, etc) | Organisation who developed the job aid | Is the job aid visible? | Is it being used? Why / why not |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**V. Facility environment, accessibility and publicity**

| | Answer | Remarks |
|---|---|---|
| **ACCESSABILITY** | | |
| Is the facility close to schools? | | |
| Is the facility accessible to adolescentsclients living with a disability?* | | |
| Do adolescents who are same-sex attracted or identify as lesbian, gay, bisexual or transgender access this facility? | | |
| Do disadvantaged adolescents access this facility? | | |
| Do staffs provide any outreach activities? If so, what type of activities and where are they provided? | | |
| **FACILITY HOURS** | | |
| What are the opening and closing hours? | | |
| Does the facility have separate hours for adolescents? | | |
| Is there a sign clearly listing services and opening hours? | | |
| is the time appropriate for adolescents? Why? | | |
| **ENVIRONMENT** | | |
| Please describe where AFHS counseling and services are provided | | |
| Is there separate room for AFHS? | | |
| Is there separate waiting place for adolescents? | | |
| Is there separate room for counseling? | | |
| Is there separate room for examination/physical check-up | | |
| Is the facility/surrounding clean? | | |
| Are there toilet facilities? | | |
| Is there drinking water available? | | |
| Is the room ventilatied? | | |

** Consider whether the facility is accessible to adolescents with a physical disability and for adolescents with visual impairment*

| | | |
|---|---|---|
| **PUBLICITY** | | |
| Is the facility linked to a youth information center (YIC)? | | |
| Is there a signboard depicting AFHS? | | |
| Is the AFHS logo visible? | | |
| Is the citizen charter clearly displayed AFHS services? | | |
| How is the AFHS advertised (how is demand generated)? What is the frequency? What is the nature of program? | | |
| Are details about the AFHS, opening hours, and services advertised at schools? | | |

**VI. IEC, PEER EDUCATION AND MATERIALS**

| | Answer | Remark |
|---|---|---|
| **IEC AND PEER EDUCATION** | | |
| What types of materials (printed, computer, audio-visual) are available? | | |
| Are education materials specifically for adolescents available on site? | | |
| What information do they contain (STI, HIV, FP, pregnancy, etc)? | | |
| Are they visible? | | |
| Are there educational posters displayed? | | |
| Is there a poster/brochure that describes adolescents's rights? | | |
| Are there print materials available for adolescents to take home? Describe the materials. | | |
| In what languages are IEC materials available? | | |
| Are there any IEC materials for adolescents living with a disability (such as those with visual impairment)? | | |
| Is peer education or peer counseling provided at the facility? | | |

| | | |
|---|---|---|
| How many peer educators/counselors work at the facility? | | |
| What days of the week do they work at the facility? | | |
| Who provided training to them? What was the duration? Are they affiliated with any organization? | | |
| **CONDOMS AND OTHER MATERIALS** | | |
| Are condoms provided to adolescentsmales and females? | | |
| Where is the condom box placed, and does it contain condoms? | | |
| Are there sufficient supplies to meet adolescents's needs (condoms, contraceptives, emergency contraception, medicines)? | | |
| Is there sufficient equipment to provide SRH care to adolescents (small speculum, scales, sphygmomanometer, etc)? | | |

**VII. POLICIES AND ADMINISTRATIVE PROCEDURES**

| | **Answer** | **Remark** |
|---|---|---|
| **CONFIDENTIALITY** | | |
| Are there clear written guidelines for serving adolescentsclients? If so, provide details | | |
| Is client registration private so that other clients cannot hear the conversation? | | |
| Can adolescents register without needing to give their name? | | |
| Do written procedures exist for protecting client confidentiality? If so, provide details | | |
| How is confidentiality ensured, how it is monitored? | | |
| **CONSENT** | | |
| Is there a minimum age requirement for adolescents to receive services? If so, what age and for what services? | | |
| At what age can aadolescents attend this facility without becoming accompanied by a parent? | | |
| If the adolescents attends with their parent or guardian, are they given an opportunity to be seen alone with the service provider? | | |
| At what age can aadolescents be counseled at this facility without parental consent? | | |
| At what age can aadolescents be tested for STIs, HIV or pregnancy at this facility without parental consent? | | |
| At what age can aadolescents be provided with contraceptives at this facility without parental consent? | | |
| At what age can aadolescents receive emergency contraception at this facility without parental consent? | | |
| At what age can aadolescents receive abortion services (safe abortion or post abortion care) at this facility without parental consent? | | |
| **OTHER POLICIES** | | |
| Are there any restrictions on services that can be provided to unmarried adolescents? If so, provide details | | |
| Are there any contraceptive methods that adolescents cannot receive? If so, which ones? | | |
| **ADMINISTRATION** | | |
| Can adolescents be seen without an appointment? | | |
| On average, how long do adolescentsclients have to wait to see a provider? | | |
| What is the average time aadolescentsclient spends with a provider? | | |
| Do adolescentsclients pay a fee for OPD services? If so, how much | | |
| Do adolescentsclients pay a fee for counseling? If so, how much | | |
| Do adolescentsclients pay a fee for STI testing and treatment? If so, how much | | |

| | | |
|---|---|---|
| Do adolescentsclients pay a fee for condoms? If so, how much | | |
| Do adolescentsclients pay a fee for contraception? If so, how much | | |
| Do adolescentsclients pay a fee for pregnancy testing? If so, how much | | |
| Do adolescentsclients pay a fee for medical abortion? If so, how much | | |
| Do adolescentsclients pay a fee for pregnancy and delivery care? If so, how much | | |

### VIII. HEALTH FACILITY MANAGEMENT AND YOUTH INVOLVEMENT

| | Answer | Remarks |
|---|---|---|
| **MANAGEMENT** | | |
| How many members are there in the facility management committee? | | |
| How many female members in the committee? | | |
| How many youth members in the committee? | | |
| How frequently does the committee meet? | | |
| Does the committee discuss on the adolescent's issues/ AFHS? | | |
| Any decisions made on adolescents issues/AFHS? | | |
| Are there any other ways that adolescents currently make suggestions or provide feedback on the AFHS? Please give details | | |
| Does the AFHS receive any monitoring visits from the DPHO? | | |
| If so, how often do these occur? | | |
| **FUNDING** | | |
| Did the facility receive any government funds to support the AFHS? | | |
| How were the funds used? | | |
| Were they sufficient? | | |
| Does the facility receive any other financial support for AFHS? | | |
| If so, from which sources? | | |

### IX. CHALLENGES AND OPPORTUNITIES TO IMPROVE AFHS

Please ask these questions to the facility manager and record his or her response:

How many staffs/providers are there in this facility? How many staffs/provider are there for AFH services?

.....

What changes have you seen since the AFHS started?

……..
……..

In your opinion, what has worked well / been successful?

……..
……..
……..

In your opinion, what have been the main challenges/barriers?

……..
……..

Which of these barriers can be easily overcome though internal managerial decisions (Health Management Committee decisions) and institutional funds.

……..
……..

Which barriers are difficult to overcome, why?

.....

Have you reported this to higher authority? What were the responses?

.....

In your opinion, what could be done to improve the quality of care provided to adolescents?

……..
……..

In your opinion, what could be done to improve adolescents's access to these services?

……..
……..

Is there anything else you would like to say regarding AFHS?

……..
……..

**This is the end of the checklist. Thank you for your valuable time and information.**

**Assessing Supply Side Constraints Affecting the Quality of Adolescent Friendly Health Services (AFHS) and the Barriers for Service Utilization**

**CREHPA/UNFPA – 2014**

## Exit interview with adolescents who has attended an AFHS: question guide

**I would like to ask you a few details about yourself:**

- What is your age? .....( age completed).
- Who do you live with? .....
- What is your ethnicity? .....
- Are you currently attending school or college? .....
    - If yes, what level are you currently attending? .....

**I would like to ask you about your visit to the facility today:**

- How far did you have to travel today? .....Hour.....Minute
- Did you attend the OPD or the AFHS? .....
- What was the main reason you attended the facility? .....
- Was it your first time to attend this facility or have you been before? .....
- Did anyone accompany you to the facility? .....
    - If yes, who? .....
    - If yes, were you given an opportunity to speak with the provider by yourself? .....
- Did you know about the AFHS before you attended the facility? .....
- Who told you about this facility? .....
- Was it easy for you to attend the facility? .....
    - Why / why not? .....

**I would like to ask you about your experiences of attending this facility:**

- Did you find the facility welcoming?
- When you registered were you told about the AFHS?
- Did you have a comfortable place to wait to see the provider?
- Were you satisfied with the level of privacy? Why / why not?
- How were you treated by the health provider?
    - Did they introduce themselves?
    - Did they explain about confidentiality?
    - Did they treat you with respect?
    - Did they make you feel comfortable?
    - Did they explain things clearly to you?
    - Did they give you enough time and listen to your concerns?
    - Did you have an opportunity to ask questions?
    - Where you encouraged by the provider to ask questions?
    - Did you feel comfortable to discuss everything you wanted to discuss? Why / why not?
    - Were you satisfied with the quality of care you received? Why/ why not?

- Were you charged any fees?
    - If yes, for what service?
    - How much?
- Would you return to this facility in the future?
    - Why / why not?
- Would you recommend it to your friends?
    - Why / why not

**I would like to ask you how you think services for adolescents could be improved**

- What do you think could be done to improve the services for adolescents at this facility?
- What do you think would encourage adolescents to come to this facility?

**THANK YOU VERY MUCH FOR YOUR TIME AND INFORMATION**

**Assessing Supply Side Constraints Affecting the Quality of Adolescent Friendly Health Services (AFHS) and the Barriers for Service Utilization**

**CREHPA/UNFPA – 2014**

## Semi-structured interviews with AFHS provider

| |
|---|
| *District: : 1. Dolakha 2. Bajura 3. Jumla 4. Udayapur 5. Bhaktapur 6. Kaski 7. Pyuthan 8. Doti 9. Jhapa 10. Mahottari 11. Kapilvastu 12. Kailali* |
| *Name of VDC/Municipality: .....Ward No:.....* |
| *Level of health facility: 1. Hospital 2. PHCC 3. HP 4. SHP 5. NGO clinic (name of NGO……)* |
| *Sex of provider: Male…….. Female……..* |
| *What is the highest educational qualification you obtained: ……..* |
| *What is your designation? 1. CMO 2. MO 3. PHN 4. HA 5. Sr. AHW 6. SN 7. ANM 8. Counselor 9. Others* |
| *How long have you been working as a..... (Designation): ……* |
| *How long have you been working at this facility? .....* ☐☐☐ |
| *Name of the researcher.....* |
| *Date.....* |

**Question guide**

**Introduction**

1. Please describe your current role at this facility.
    - *What kinds of services do you provide [prompt for SRH services if not discussed]?*
    - *Which of these do you provide to adolescentsclients aged 10-24 years?*
    - *What proportion of your time would you spend with adolescentsclients?*

**Training experiences and needs**

I would like to ask you about your training and supervision.

2. What training have you received about sexual and reproductive health?
    - *When was this training received?*
    - *How long was it for?*
    - *Who provided it?*

3. What training have you received about adolescent and adolescents's health?
    - *When was this training?*
    - *How long was it for?*
    - *Who provided it?*

4. How useful has this training been for your current role? tedious
    - *What new skills or knowledge did you gain?*
    - *To what extent have you been able to put this in to practice?*

5. Is there any additional training that you think would help you provide services for adolescentsclients?
    - *Please explain*

*6.* Do you use any job aids or other tools when you are seeing an adolescent client?
    - *If yes, which aids or tools*
7. What other tools or materials would help you in your role?
    - *Job aids, equipment, supervision*

8. Are you satisfied with the level of supervision you receive concerning your role as AFHS provider?
    - *Why / why not?*
    - *Who provides this supervision?*
    - *How often do they provide supervision?*

**Health needs of adolescents and services provided at the facility**

I would like to ask you know about the adolescents who attend your facility.

9. What do you think are the most common health needs/problems of adolescent:
    - Girls?
    - Boys?

    abase
10. Where do they go for advice or care for these problems?
    - *Why do you think they seek advice or care from these places?*
    - *To what extent do adolescents seek advice or care at this facility?*

11. What are the most common health concerns of girls/boys that you deal with at this facility?

12. Do most adolescents attend the OPD or do they come for counseling?
    - *Can you describe the process if aadolescents attends OPD?*
        i. *Are they told about the AFHS counseling services when they register?*
        ii. *Does a provider who has received AFHS training see all the adolescentsclients?*
        iii. *Are they routinely assessed for other health problems or concerns, other than their presenting complaint (does the provider ask all adolescentsclients about their home life, school, substance use, mental health and sexual health)?*
        iv. *What is the process for referring aadolescentsclient who presents to OPD for counseling?*

13. Can you describe the process if an adolescent girl (aged under 20 years) comes to ANC or for delivery care:
        i. *Are they told about the AFHS counseling services when they register?*
        ii. *Does a provider who has received AFHS training see all the adolescentspregnant girls?*
        iii. *Are they routinely assessed for other health problems or concerns, other than pregnancy (does the provider ask all adolescentsclients about their home life, school, substance use, mental health and sexual health)?*
        iv. *What is the process for referring aadolescentsclient who presents to ANC for counseling?*

14. In your opinion, do you think adolescents can easily access the services provided at this facility?
    - *Why / why not?*
    - *Are there certain groups of adolescents who don't use this service (such as married, unmarried, sexual minorities, adolescents living with a disability, marginalized adolescents, adolescents who are same-sex attracted or identify as lesbian, gay, bisexual or transgender)?*
    - *What do you think are the main barriers that prevent adolescents from accessing these services?*

I would like to ask you now about your experiences providing services to adolescents

15. How confident do you feel providing SRH (including HIV) services to adolescents?
    - *Why?*
    - *What would help make you more confident?*

16. Are there any types of counseling or services that you don't feel comfortable providing to adolescents?
    - *Why do you not feel comfortable?*
    - *What will help you make more comfortable?*
    - *Are there any services that make you feel not comfortable in providing to adolescents?*
    - *Prompt about different types of services (contraception, emergency contraception, abortion, STI, condoms, VCT / HIV services) and different groups of adolescents (unmarried, very young, sexual minorities, adolescents living with disability*
    - *What are the reasons for making you not comfortable?*
    - *Prompt: do you think adolescentsunmarried people should be able to access condoms? Why/why not?*
    - *Prompt: do you think adolescentsunmarried people should be able to access contraceptives? Why/why not?*
    - *Prompt: do you think adolescentsunmarried people should be able to access abortion? Why/why not?*

17. What knowledge and skills do you think a service provider needs to be able to provide SRH services and counseling to adolescents?

18. Do you think adolescents should receive SRH counseling and services without their parents or guardian present? comfortable
    - *Why / why not?*
    - *At what age should aadolescents be able to attend a health facility by themselves? Why do you say that?*

19. Are you aware of any policies or guidelines at this facility concerning minimum age requirements for adolescents to access services?
    - *If yes, please describe these*
    - *Under what circumstances do you think you should seek parental consent [prompt: age, marital status, type of problem/service being sought]*

20. Are you aware of any policies or guidelines at this facility concerning confidentiality for adolescents?
    - *If yes, please describe these*

**Challenges and opportunities to improve AFHS**

I would like to ask you now about the challenges that you face in your role and what you think could be done to improve AFHS.

21. In your experience, what has been successful / worked well in delivering AFHS? Why?

22. In your experience, what has not worked so well?
    - *What are the main challenges you have faced providing services to adolescents?*

23. In your opinion, what could be done to address these challenges?

24. What do you think are the most important factors that make a health facility 'youth friendly'?

25. Is there anything else you would like to say about providing AFHS?

***This is the end of the interview. Thank you for giving us your invaluable time and information.***

**Assessing Supply Side Constraints Affecting the Quality of Adolescent Friendly Health Services (AFHS) and the Barriers for Service Utilization**

**CREHPA/UNFPA – 2014**

## Question guide for community stakeholders

**Informed Consent**

**Introduction:** Namaste! My name is…… I am from CREHPA, a research organization based in Kathmandu. Since the past 19 years, this organization has been conducting a series of research and advocacy activities on health and reproductive rights. Currently, in collaboration of Family Health Division and in coordination with UNFPA and UNICEF we are conducting a study of health facilities that provide Adolescent Friendly Health Services.

**Purpose of the research:** The main purpose of this study is to assess supply side constraints relating to the quality of Adolescent Friendly Health Services (AFHS) and barriers for their utilization, and to make recommendations to improve the existing services and also inform scaling up of the AFHS initiative in country. We are contacting 10 community gatekeepers like you from different districts.

**Potential risk and benefits:** We believe that this study is safe and there is no any risk or harm to you and your community by participating in this study. There are no direct benefits for participating in the study. But, the information you have given may help in developing policies and programs for adolescents residing in districts and in Nepal.

**Confidentiality:** All information collected from you will be kept strictly confidential and will not be shown to anyone. The interviews will be kept safely in a locked cabinet and used only for research purposes. Your name will not go into any document or presentation based on the study. The findings of the study will be shared with the policy makers and concerned stakeholders only. However, there will be no information that could potentially identify you will be going into any report

**Voluntary participation:** Your participation in this study will be completely voluntary.You have the right to take part in the study or not. You may refuse to answer any questions or withdraw from the study at any time. However, we believe that you will provide your valuable information by participating in the study. The interview will take about 30 minutes.

**Who to contact:** This proposal has been reviewed and approved by the Nepal Health Research Council, Kathmandu, a national body whose tasks is to make sure that research participants are protected from harm. If you have any questions you may ask those now or later. If you wish to ask questions later, you may contact to AnandTamang, Director of CREHPA at Phone 5521717, 5546487

Do you agree to participate in the interview?

Yes..... 1 (Start interview)

No..... 2 (End interview)

**SECTION 1: INTRODUCTION**

| |
|---|
| District: 1. Dolakha 2. Bajura 3. Jumla 4. Udayapur 5. Bhaktapur 6. Kaski 7. Pyuthan 8. Doti 9. Jhapa 10. Mahottari 11. Kapilvastu 12. Kailali |
| Name of VDC/Municipality: ..... Ward No: ..... |
| Type of health facility: 1. Hospital 2. PHCC 3. HP 4. SHP 5. NGO clinic (Mention the name of NGO)..... |
| Type of community gatekeeper: 1. Teacher 2. Female community health volunteer 3. Religious Leader 4. Peer Educator 5. Member of health management committee |
| Sex of the respondent: 1. Male 2. Female |
| Educational qualification: ..... |
| Name of the Interviewer: …… |
| Date of the interview: ……. |

**Questions**

1. What are the main health concerns of adolescents in your community?
    - *Prompt about SRH concerns if not mentioned*
    - *Are these different for boys and girls?*

2. Where do adolescents seek information or advice about these issues?
    - *Do you think these are good sources of advice/information?*

3. Where do adolescents seek care for these issues?
    - *Prompt about care/ services for different types of SRH issues if not mentioned*
    - *What do you think about the quality of these services?*

4. Are there any services in your community that are especially for adolescents?
    - *Please describe these*
    - *What do you think about the quality of these services?*
    - *Do adolescents use these services? Why/why not?*

5. What are the main barriers that prevent adolescents from using health services?
    - *Are these different for boys and girls?*
    - *Are these different for married adolescents compared with married people*

6. In your opinion, what types of services should be available to adolescents?
    - *Prompt about: SRH counseling; STI testing and treatment; Condoms; HIV testing; Contraception; Emergency contraception; Pregnancy testing; Abortion; Pregnancy care.*
    - *Why should / shouldn't these services be provided to adolescents?*
    - *Is it different for unmarried versus married adolescents?*

7. In your opinion, what age should aadolescents be able to access confidential health services by themselves, without being accompanied by a parent?

8. What do you think could be done to improve adolescents's access to health services?

9. What role should [insert type of stakeholder here] have in improving adolescent friendly health services?

**Assessing Supply Side Constraints Affecting the Quality of Adolescent Friendly Health Services (AFHS) and the Barriers for Service Utilization**

**CREHPA/UNFPA – 2014**

## Question guide for key informant interviews with adolescents living with a disability

**Ice Breaking Question:**

What do you do during the leisure time?

Now let's move on to our core discussion session.

**IDI guideline:**

| Theme | Core Questions | Probing Questions |
|---|---|---|
| **Introduction** | Please tell me about yourself. | • Caste, age, education completed, family background, occupation, marital status, number of children, spouse's background |
| **Health problems/ concerns** | What do you think are the main health concerns of adolescents like you? | • Health problems/ concerns including sexual and reproductive health<br>• Changes witnessed within the participant (both physical and mental) |
| **Health care seeking behavior** | You have just mentioned that ……..are the main concerns of youth like yours. Where do adolescents like you go for information or advice regarding these issues?<br><br>a. Do you think these are good sources of information or advice?<br>b. Do you think these are good sources of services?<br><br>Where and from whom would you prefer to get advice about the concerns you have mentioned earlier?<br><br>If you have a health problem, where / from whom would you seek care? Why? | • Which ones?/ Where? And why?<br><br>• If yes, why do you think so?/ If no, why do you think so?<br><br>• Why?/ Why not?<br><br>• Health problems/ concerns including sexual and reproductive health |
| **Experience/s** | Have you ever accessed a health facility for advice or care related to sexual and reproductive health? If yes, can you tell me about that experience? | • What was the issue that you sought advice/care for?<br>• Where did you go (what type of facility)?<br>• How did you find out about this health facility?<br>• Did you go by yourself or did someone accompany you? Who?<br>• Was it easy to access the facility, why/why not?<br>• Were you satisfied with the level of privacy provided at the facility?<br>• Did you find the facility welcoming?<br>• Did you have a comfortable place to wait to see the provider? |

| | | |
|---|---|---|
| | | • How were you treated by the health provider?<br>➢ Did they introduce themselves?<br>➢ Explain about confidentiality?<br>➢ Treat you with respect?<br>➢ Make you feel comfortable?<br>➢ Explain things clearly?<br>➢ Give you enough time and listened to your concerns?<br>➢ Give you an opportunity to ask questions?<br>➢ Did you feel comfortable to discuss everything you wanted to discuss? |
| | Where there any information materials provided at the facility?<br><br>Were you satisfied with the quality of care that you were given?<br>Were you charged any fees? If so, were these affordable for you?<br>Would you return to that facility? Why/why not?<br>Would you recommend it to your friends? | • Why/why not? |
| **Knowledge regarding AFHS** | Do you know of any services in your community that are especially for adolescents? Please describe these.<br><br>Do you think adolescents use these services?<br><br>What do you think about the quality of these services? | • AFHS related things<br><br>• If yes, why? / If no, why?<br><br>• Poor/ Satisfactory/ Good<br>• In what sense are the services of quality? |
| **Barriers** | In your opinion, what are the main challenges or barriers that make it difficult for you to access health services? | • Including barriers regarding issues related sexual and reproductive health<br><br>• Barriers such as social, economic, cultural, religious, family, service providers, knowledge, geo-ecological, time, infrastructures of health facility, etc. |
| **Overcoming the barriers** | You have enlisted ……as barriers to you. In your opinion, what could be done to overcome these barriers? How?<br><br>What do you think are the most important factors that make a health facility "youth friendly"?<br><br>Is there anything else that you would like to say about improving health services for adolescents like you? | • Gender friendly, disable friendly, confidentiality and privacy should be ensured; job aids- IEC and BCC materials, counseling, behavior of service provider, service hour, availability of needy resources including medicine, Family planning contraceptives; etc.<br><br>• Quality ensure, awareness campaigns through different types of media such as electronic media (radio, tv, internet), paper media (newspapers and magazines, pamphlets, brochures, holding boards, flip charts, pictures) and social media (through dramas, flash mop, community announcements, peer education, etc.) |

**Thank you very much for your invaluable time and information**

# Annex Tables

**Annex table 3.1: Age-wise health problems identified by adolescent boys- FES**

| S.N | Item | 10-14 age group | | 15-19 age group | |
|---|---|---|---|---|---|
| | | Frequency (%) | Salience | Frequency (%) | Salience |
| 1. | Wet dream/ Night fall | 18.8 | 0.188 | 41.0 | 0.325 |
| 2. | Itchiness in genital area | 25.0 | 0.169 | 19.7 | 0.103 |
| 3. | Rashes and/or wound in genital area | 12.5 | 0.083 | 32.8 | 0.180 |
| 4. | STI(Syphilis) | 6.3 | 0.038 | 18.0 | 0.143 |
| 5. | Pre ejaculation | - | - | 14.8 | 0.079 |
| 6. | HIV/AIDS | 12.5 | 0.025 | 14.8 | 0.061 |
| 7. | Masturbation | 6.3 | 0.021 | 4.9 | 0.033 |
| 8. | UTI (Burning micturation, Urinary Tract Infection) | 6.3 | 0.063 | 8.2 | 0.053 |
| 9. | Penial discharge(Stinky genital, white discharge) | 25.0 | 0.135 | 4.9 | 0.024 |
| 10. | Irregular size of genital | 6.3 | 0.010 | 6.6 | 0.041 |
| 11. | Swelling of genital | - | - | 8.2 | 0.046 |
| 12. | Curvature/ bending of genital | - | - | 6.6 | 0.032 |
| 13. | Hydrocele | - | - | 8.2 | 0.054 |
| 14. | Erection problem | - | - | 6.6 | 0.042 |
| 15. | Lump in nipple (Girkha) | - | - | 1.6 | 0.005 |
| 16. | Incomplete/ under develop of genital | 6.3 | 0.021 | 3.3 | 0.023 |
| 17. | Have only one testis | 6.3 | 0.047 | 4.9 | 0.037 |
| 18. | Foreskin problem (Phimosis, Paraphimosis) | - | - | 3.3 | 0.005 |
| 19. | Insomnia | - | - | 1.6 | 0.006 |
| 20. | Bleeding from penis | - | - | 4.9 | 0.031 |
| 21. | Swelling in nipple | 6.3 | 0.008 | - | - |
| 22. | Burning sensation in genitalia during sex | - | - | 1.6 | 0.003 |
| 23. | Burning sensation in genital | - | - | 1.6 | 0.012 |
| 24. | Burning sensation in penis after masturbation | - | - | - | - |

**Annex table 3.2: Age-wise health problems identified by adolescent girls- FES**

| S.N | Item | 10-14 age group | | 15-19 age group | |
|---|---|---|---|---|---|
| | | Frequency (%) | Salience | Frequency (%) | Salience |
| 1. | Lower abdominal pain during menstruation | 78.90 | 0.679 | 81.10 | 0.728 |
| 2. | White discharge | 60.50 | 0.345 | 58.50 | 0.425 |
| 3. | Irregular bleeding during menstruation (Less, Heavy) | 42.10 | 0.239 | 58.50 | 0.322 |
| 4. | Irregular menstruation | 23.70 | 0.159 | 54.70 | 0.317 |
| 5. | Pain in different parts of body during menstruation (back, limbs and head) | 36.80 | 0.244 | 35.80 | 0.224 |
| 6. | Prolapsed uterus | 21.10 | 0.094 | 26.40 | 0.144 |
| 7. | Dizziness/Nausea/vomiting during menstruation | 21.10 | 0.089 | 15.10 | 0.084 |
| 8. | Miscarriage | 7.90 | 0.035 | 26.40 | 0.142 |
| 9. | Pain in breast (before, during and after menstruation) | 15.80 | 0.078 | 17.0 | 0.089 |
| 10. | HIV/AIDS | 10.50 | 0.105 | 9.40 | 0.055 |
| 11. | Weakness & Loss of appetite during menstruation | 13.20 | 0.054 | 9.40 | 0.065 |
| 12. | Postpartum hemorrhage & maternal death due to early motherhood | 10.50 | 0.062 | 7.50 | 0.018 |
| 13. | Itchiness in genital area | - | - | 15.10 | 0.051 |
| 14. | Rashes and/ or wound in/around genital area | 5.30 | 0.022 | 9.40 | 0.043 |
| 15. | Cervical cancer | 5.30 | 0.044 | 7.50 | 0.037 |
| 16. | UTI (Burning sensation) | 5.30 | 0.009 | 3.80 | 0.008 |
| 17. | Body changes in unusual way | 7.90 | 0.029 | 3.80 | 0.005 |
| 18. | Body swells during pregnancy | 5.30 | 0.024 | 7.50 | 0.030 |
| 19. | Weakness after use of FPCs | 5.30 | 0.010 | 3.80 | 0.008 |
| 20. | Unwanted pregnancy | - | - | 3.80 | 0.019 |
| 21. | Lower abdominal pain during pregnancy | 10.50 | 0.048 | 1.90 | 0.013 |
| 22. | STI (Gonorrhea) | 7.90 | 0.063 | 3.80 | 0.023 |
| 23. | Heavy bleeding after use of FPCs | 5.30 | 0.012 | 3.80 | 0.013 |
| 24. | Swelling of genital during pregnancy | 2.60 | 0.004 | 5.70 | 0.013 |
| 25. | Prolonged bleeding during menstruation | - | - | 5.70 | 0.022 |
| 26. | Dizziness/Nausea/vomiting during pregnancy | 2.60 | 0.009 | 1.90 | 0.009 |
| 27. | Pain in genital after delivery | - | - | 1.90 | 0.007 |
| 28. | Infertility | - | - | 3.80 | 0.019 |
| 29. | Itchiness/Rashes and/ or wound around breast | - | - | 1.90 | 0.007 |
| 30. | Amenorrhea after FPCs | 2.60 | 0.002 | - | - |
| 31. | Uterus related diseases | 5.30 | 0.046 | - | - |
| 32. | Anemia | - | - | 1.90 | 0.011 |
| 33. | Feeling pain in leg during pregnancy | - | - | 1.90 | 0.006 |
| 34. | Breast cancer | - | - | 1.90 | 0.012 |
| 35. | Depression during menstruation | - | - | 1.90 | 0.003 |
| 36. | Delay in onset of menarche | - | - | 1.90 | 0.013 |
| 37. | Unsafe abortion | - | - | 1.90 | 0.016 |
| 38. | Neonatal death because of delivery in early age | - | - | 1.90 | 0.005 |
| 39. | Itchiness in different body parts | 2.60 | 0.011 | - | - |
| 40. | Itchiness in body due to use of pills | - | - | 1.90 | 0.002 |
| 41. | Sack explodes before a baby is born | - | - | 1.90 | 0.004 |
| 42. | Prolonged labor | 2.60 | 0.013 | - | - |
| 43. | Pain in breast during pregnancy | - | - | 1.90 | 0.002 |
| 44. | Problem with breast-feeding | - | - | 1.90 | 0.006 |

**Annex Table 3.3: Age-wise health care seeking behavior among adolescent boys- FES**

| S.N | Item | 10-14 age group | | 15-19 age group | |
|---|---|---|---|---|---|
| | | Frequency (%) | Salience | Frequency (%) | Salience |
| 1. | PHCC/Health Post/Sub health post | 87.5 | 0.73 | 80.3 | 0.666 |
| 2. | Friend/partner | 56.3 | 0.387 | 60.7 | 0.39 |
| 3. | Medical hall/Clinic/Pharmacy | 62.5 | 0.427 | 59.0 | 0.334 |
| 4. | Hospital | 62.5 | 0.353 | 52.5 | 0.279 |
| 5. | Teacher/Health teacher | 18.8 | 0.135 | 42.6 | 0.286 |
| 6. | Health worker | 37.5 | 0.241 | 32.8 | 0.13 |
| 7. | FCHV | 37.5 | 0.188 | 36.1 | 0.217 |
| 8. | Doctor | 25.0 | 0.138 | 27.9 | 0.159 |
| 9. | Elderly people | 31.3 | 0.055 | 21.3 | 0.111 |
| 10. | Family/Parents/Relatives | 12.5 | 0.036 | 26.2 | 0.119 |
| 11. | CSO(Red Cross Society, Peace Win, World Vision, Shova Aids, Gift Bajura, INF) | 25.0 | 0.105 | 31.1 | 0.155 |
| 12. | Clinic run by NGO(FPAN, MSI) | 12.5 | 0.025 | 16.4 | 0.092 |
| 13. | Brother | 6.3 | 0.021 | 21.3 | 0.093 |
| 14. | Media (TV, radio, paper, book, website) | - | - | 4.9 | 0.022 |
| 15. | Mobile camp | 18.8 | 0.113 | 6.6 | 0.029 |
| 16. | Traditional faith healer | 6.3 | 0.007 | 13.1 | 0.064 |
| 17. | Peer educator | 6.3 | 0.063 | 6.6 | 0.048 |
| 18. | Homeopathy | 6.3 | 0.047 | 8.2 | 0.036 |
| 19. | Community leader | - | - | 1.6 | 0.008 |
| 20. | Will not visit anyone/anywhere | - | - | 1.6 | 0.016 |
| 21. | Astrologist | 6.3 | 0.010 | - | - |

**Annex Table 3.4: Age-wise health care seeking behavior among adolescentgirls- FES**

| S.N | Item | 10-14 age group | | 15-19 age group | |
|---|---|---|---|---|---|
| | | Frequency (%) | Salience | Frequency (%) | Salience |
| 1. | PHCC/ Health Post/ Sub Health Post | 89.50 | 0.667 | 69.80 | 0.540 |
| 2. | FCHV | 60.50 | 0.295 | 71.70 | 0.536 |
| 3. | Friend | 60.50 | 0.320 | 67.90 | 0.377 |
| 4. | Hospital | 60.50 | 0.316 | 66.0 | 0.422 |
| 5. | Family/ Parents/ Relatives | 65.80 | 0.458 | 64.20 | 0.408 |
| 6. | Medical hall/ Clinic/ Pharmacy | 34.20 | 0.151 | 45.30 | 0.173 |
| 7. | Health worker | 42.10 | 0.222 | 43.40 | 0.218 |
| 8. | Health specialist/ Doctor | 15.80 | 0.081 | 26.40 | 0.170 |
| 9. | Traditional faith healer | 28.90 | 0.162 | 24.50 | 0.121 |
| 10. | Teacher/ Health teacher | 15.80 | 0.092 | 24.50 | 0.091 |
| 11. | Clinic run by NGO (FPAN, MSI) | 21.10 | 0.153 | 20.80 | 0.122 |
| 12. | Elderly people | 18.40 | 0.084 | 5.70 | 0.013 |
| 13. | AyurvedicAushadhalaya | 5.30 | 0.026 | 15.10 | 0.039 |
| 14. | Doctor | 5.30 | 0.014 | 15.10 | 0.058 |
| 15. | Homeopathy | 10.50 | 0.056 | 11.30 | 0.050 |
| 16. | INGO (UNICEF, Luthren World Federation) | 13.20 | 0.110 | 9.40 | 0.070 |
| 17. | Clubs at local level (Youth, Female, Community improvement service center) | - | - | 9.40 | 0.034 |
| 18. | CSO (Red Cross Society, Restless Development, Threater for Development, Community awareness development (CWF)) | 5.30 | 0.043 | 5.70 | 0.053 |
| 19. | Mobile camp | 2.60 | 0.012 | 5.70 | 0.031 |
| 20. | Media (book, newspaper) | - | - | 1.90 | 0.004 |
| 21. | Pregnant women | 2.60 | 0.004 | 1.90 | 0.003 |
| 22. | Will not visit anyone/ anywhere | - | - | 3.80 | 0.021 |
| 23. | Mother's group | 2.60 | 0.023 | 1.90 | 0.004 |
| 24. | Volunteer | - | - | 1.90 | 0.009 |
| 25. | Married women | - | - | 1.90 | 0.005 |
| 26. | Sexual awareness development group | - | - | 1.90 | 0.006 |
| 27. | Other person who face same problem | - | - | 1.90 | 0.008 |

**Annex Table 3.5: Age-wise Demand Side Barriers of adolescentsboys from FES**

| S.N | Item | 10-14 age group | | 15-19 age group | |
|---|---|---|---|---|---|
| | | Frequency (%) | Salience | Frequency (%) | Salience |
| 1. | Shy nature | 81.3 | 0.646 | 65.6 | 0.448 |
| 2. | Lack of information regarding AFHS | 25.0 | 0.101 | 45.9 | 0.299 |
| 3. | Distant location | 31.3 | 0.217 | 32.8 | 0.249 |
| 4. | Lack of privacy | 12.5 | 0.078 | 36.1 | 0.241 |
| 5. | Unsatisfactory treatment | 31.3 | 0.146 | 29.5 | 0.151 |
| 6. | Absence of service providers | 12.5 | 0.060 | 23.0 | 0.165 |
| 7. | Lack of medicines | 18.8 | 0.077 | 29.5 | 0.157 |
| 8. | Fear of being exposed by villagers | 25.0 | 0.180 | 16.4 | 0.112 |
| 9. | Lack of time to visit health facility | 31.3 | 0.214 | 19.7 | 0.133 |
| 10. | Due to fear of parents | 50.0 | 0.306 | 13.1 | 0.067 |
| 11. | Service provider is not available on time | 6.3 | 0.021 | 13.1 | 0.061 |
| 12. | Service provider is female | 12.5 | 0.094 | 11.5 | 0.079 |
| 13. | Unfriendly behavior of service provider | 6.3 | 0.063 | 6.6 | 0.037 |
| 14. | Poor financial condition | - | - | 11.5 | 0.087 |
| 15. | Lack of separate treatment room | - | - | 11.5 | 0.046 |
| 16. | Facility remains closed | 6.3 | 0.042 | 13.10 | 0.063 |
| 17. | Condom box is not kept outside | - | - | 8.2 | 0.040 |
| 18. | Unnecessary time spent to receive service | 6.3 | 0.063 | 6.6 | 0.037 |
| 19. | Lack of temporary FPCs | - | - | 4.9 | 0.019 |
| 20. | Lack of medical equipment for treatment | - | - | 9.8 | 0.027 |
| 21. | Lack of trust towards health facility/provider | 6.3 | 0.031 | 4.9 | 0.031 |
| 22. | Do not feel need of visiting HF | - | - | 3.3 | 0.033 |
| 23. | Service provider scolds | 6.3 | 0.025 | 4.9 | 0.017 |
| 24. | Lack of transportation facilities | - | - | 1.6 | 0.016 |
| 25. | Negative thinking when receiving FPC | - | - | 3.3 | 0.011 |
| 26. | Discriminatory practice towards poor people | 6.3 | 0.013 | 1.6 | 0.008 |
| 27. | Lack of trained counselor | - | - | 1.6 | 0.016 |
| 28. | Friends can solve sexual health problem | - | - | 1.6 | 0.005 |
| 29. | Lack of suggestion box at facility | - | - | 1.6 | 0.010 |
| 30. | Dirty environment of HF | - | - | 1.6 | 0.007 |
| 31. | Service provider do not work full time | - | - | 1.6 | 0.005 |
| 32. | Prescribe medicine without check-up | - | - | 1.6 | 0.004 |

**Annex Table 3.6: Age-wise demand side barriers among adolescentsgirls- FES**

| S.N | Item | 10-14 age group | | 15-19 age group | |
|---|---|---|---|---|---|
| | | Frequency (%) | Salience | Frequency (%) | Salience |
| 1. | Distant location | 39.50 | 0.286 | 52.80 | 0.388 |
| 2. | Shy nature | 44.70 | 0.275 | 49.10 | 0.310 |
| 3. | Lack of information regarding AFHS | 36.80 | 0.329 | 41.50 | 0.285 |
| 4. | Lack of time to visit health facility | 47.40 | 0.329 | 34.0 | 0.253 |
| 5. | Unsatisfactory treatment | 42.10 | 0.207 | 34.0 | 0.166 |
| 6. | Because of being a daughter, restriction to go outside home alone | 39.50 | 0.241 | 28.30 | 0.173 |
| 7. | Poor financial condition | 39.50 | 0.222 | 24.50 | 0.138 |
| 8. | Lack of trust towards health facility/ service provider | 31.60 | 0.165 | 17.0 | 0.062 |
| 9. | Unfriendly behavior of service provider | 21.10 | 0.121 | 22.60 | 0.127 |
| 10. | Service provider is male | 13.20 | 0.103 | 22.60 | 0.124 |
| 11. | Lack of medicines | 15.80 | 0.057 | 17.0 | 0.074 |
| 12. | Fear of being exposed by villagers | 7.90 | 0.044 | 18.90 | 0.120 |
| 13. | Lack of transportation facilities | 10.50 | 0.058 | 22.60 | 0.145 |
| 14. | Service provider do not work full time | 15.80 | 0.104 | 11.30 | 0.074 |
| 15. | Absence of service providers | 18.40 | 0.126 | 5.70 | 0.030 |
| 16. | Lack of separate treatment room | 10.50 | 0.026 | 13.20 | 0.058 |
| 17. | Lack of privacy/ Fear of being exposed | 2.60 | 0.018 | 17.0 | 0.093 |
| 18. | Lack of education preventing one from attending health facilities | 13.20 | 0.057 | 11.30 | 0.049 |
| 19. | Health facility charges high fees for treatment | 13.20 | 0.059 | 7.50 | 0.030 |
| 20. | Due to fear of family | 7.90 | 0.054 | 11.30 | 0.089 |
| 21. | Prescribe medicine without check-up | 13.20 | 0.084 | 5.70 | 0.031 |
| 22. | Lack of medical equipment for treatment | - | - | 7.50 | 0.039 |
| 23. | Unnecessary time spent to receive service | 7.90 | 0.042 | 7.50 | 0.029 |
| 24. | Afraid to visit health facility alone | 7.90 | 0.034 | 7.50 | 0.040 |
| 25. | Unavailability of emergency services | 5.30 | 0.010 | 5.70 | 0.027 |
| 26. | Service provider is not available on time | 2.60 | 0.023 | 3.80 | 0.012 |
| 27. | Family does not trust | - | - | 3.80 | 0.030 |
| 28. | Negative views of society towards health facility | 5.30 | 0.014 | 3.80 | 0.017 |
| 29. | Because of being physically challenged, cannot have access to AFHS | - | - | 3.80 | 0.030 |
| 30. | Do not feel need of visiting health facility | 5.30 | 0.025 | - | - |
| 31. | Suggested not to visit health facility by others (relatives, friends, villagers) | 5.30 | 0.026 | - | - |
| 32. | Dirty environment of Health facility | 5.30 | 0.013 | - | - |
| 33. | Discriminatory practice towards poor people | - | - | 1.90 | 0.019 |
| 34. | Due to Patriarchal society | - | - | 1.90 | 0.017 |
| 35. | Lack of proper waiting area | - | - | 3.80 | 0.016 |
| 36. | Health facility remains closed | 5.30 | 0.022 | - | - |
| 37. | Different culture preventing one from attending health facilities | - | - | 1.90 | 0.006 |
| 38. | Health facility remains crowdy that prevents one from attending health facilities | 2.60 | 0.015 | 1.90 | 0.013 |
| 39. | Due to lose/ bad character of service provider | - | - | 1.90 | 0.005 |
| 40. | Discriminatory practice on the basis of gender | 2.60 | 0.009 | - | - |

| | | | | | |
|---|---|---|---|---|---|
| 41. | Health facility does not provide free medicine | - | - | 1.90 | 0.011 |
| 42. | Lack of health security | - | - | 1.90 | 0.008 |
| 43. | Restriction from home to discuss personal matters | - | - | 1.90 | 0.015 |
| 44. | Due to violence in society | - | - | 1.90 | 0.015 |
| 45. | Negative view of society if visited a health facility | 5.30 | 0.014 | 1.90 | 0.003 |

**Annex Table 3.7: Perception of different age group of adolescentboys on overcoming barriers at community level**

| S.N | Item | 10-14 age group | | 15-19 age group | |
|---|---|---|---|---|---|
| | | Frequency (%) | Salience | Frequency (%) | Salience |
| 1. | Conduct various public awareness programs (through TV, radio, posters, street drama, door to door visit) | 68.8 | 0.656 | 77.0 | 0.661 |
| 2. | Creating enabling environment for adolescents with SRH issue to seek AFHS | 12.5 | 0.125 | 50.8 | 0.327 |
| 3. | Improve transportation facilities | 12.5 | 0.047 | 16.4 | 0.142 |
| 4. | RH education in school | - | - | 13.1 | 0.093 |
| 5. | Run community SRH discussion center | - | - | 9.8 | 0.060 |
| 6. | Run clubs for adolescents | 12.5 | 0.078 | 8.2 | 0.036 |
| 7. | Provide information to parents about AFHS | 12.5 | 0.125 | 6.6 | 0.034 |
| 8. | Organize SRH programs | - | - | 1.6 | 0.016 |
| 9. | Educate everyone | 12.5 | 0.063 | 6.6 | 0.055 |
| 10. | Expand health services | 6.3 | 0.063 | 3.3 | 0.033 |
| 11. | By managing cost for visiting health facilities who cannot afford | 6.3 | 0.063 | 3.3 | 0.019 |
| 12. | Demand skilled human resource for HFs | - | - | 1.6 | 0.008 |
| 13. | Organize mobile camps from time to time | - | - | 1.6 | 0.016 |
| 14. | Organize health camps | - | - | 1.6 | 0.008 |

**Annex Table 3.8 Perception of different age group of adolescentgirls on overcoming barriers at community level**

| S.N | Item | 10-14 age group | | 15-19 age group | |
|---|---|---|---|---|---|
| | | Frequency (%) | Salience | Frequency (%) | Salience |
| 1. | Conduct various public awareness programs (through TV, radio, internet, posters, pictures, street dramas, holding boards, FCHVs, mother's group, songs, dance, door to door visit) | 68.40 | 0.574 | 66.0 | 0.557 |
| 2. | Creating enabling environment for adolescentswith SRH issue to seek AFHS | 76.30 | 0.505 | 66.0 | 0.494 |
| 3. | Educate everyone | 28.90 | 0.209 | 26.40 | 0.162 |
| 4. | Provide information to everyone (family, parents, adolescents) about AFHS | 23.70 | 0.160 | 17.0 | 0.099 |
| 5. | Avoid discriminatory practices on the basis of gender, caste/ethnicity | 10.50 | 0.065 | 11.30 | 0.099 |
| 6. | Improve transportation facilities | 10.50 | 0.059 | 7.50 | 0.031 |
| 7. | RH education in school | 7.90 | 0.024 | 5.70 | 0.040 |
| 8. | By managing cost for visiting health facilities who cannot afford | 5.30 | 0.039 | 9.40 | 0.053 |
| 9. | Demand skilled human resource for health facilities | 5.30 | 0.046 | 7.50 | 0.027 |
| 10. | Organize SRH programs | 2.60 | 0.013 | 5.70 | 0.023 |
| 11. | Conduct SRH program at VDC level that will encourage adolescents to seek AFHS | 5.30 | 0.020 | 3.80 | 0.010 |
| 12. | Organize programs after school hours | 5.30 | 0.022 | 3.80 | 0.028 |
| 13. | Demand medicines for health facilities | 2.60 | 0.026 | 1.90 | 0.019 |
| 14. | Demand for gender friendly service providers at health facility | - | - | 1.90 | 0.019 |
| 15. | Demand free distribution of medicines by health facilities | - | - | 1.90 | 0.019 |

**Annex Table 3.9: Perception of different age group of adolescentsboys on overcoming barriers at health facility level**

| S.N | Item | 10-14 age group | | 15-19 age group | |
|---|---|---|---|---|---|
| | | Frequency (%) | Salience | Frequency (%) | Salience |
| 1. | Create separate room for counseling/treatment | 50.0 | 0.359 | 59.0 | 0.445 |
| 2. | Establish gender friendly service | 37.5 | 0.256 | 49.2 | 0.290 |
| 3. | Deliver quality services | 43.8 | 0.197 | 37.7 | 0.220 |
| 4. | Information dissemination regarding AFHS | 18.8 | 0.156 | 36.1 | 0.208 |
| 5. | Maintain/ensure confidentiality | 37.5 | 0.321 | 32.8 | 0.222 |
| 6. | Recruit skilled health care service providers | 25.0 | 0.138 | 32.8 | 0.227 |
| 7. | Appropriate behavior by service providers | 18.8 | 0.167 | 24.6 | 0.167 |
| 8. | Deliver prompt services | 18.8 | 0.125 | 6.6 | 0.049 |
| 9. | Availability of FPCs | 6.3 | 0.031 | 9.8 | 0.060 |
| 10. | Facility should be close | 12.5 | 0.047 | 9.8 | 0.049 |
| 11. | Availability of medicines | 6.3 | 0.016 | 11.5 | 0.054 |
| 12. | Ensure adequate medicines | 18.8 | 0.156 | 6.6 | 0.048 |
| 13. | Need of hygienic environment | - | - | 11.5 | 0.063 |
| 14. | Keep condom box outside | - | - | 8.2 | 0.051 |
| 15. | Deliver 24 hour health care services | - | - | 4.9 | 0.020 |
| 16. | Run mobile camps | - | - | 1.6 | 0.016 |
| 17. | Free services should not be charged fees | - | - | 3.3 | 0.016 |
| 18. | Need of ambulance service | - | - | 3.3 | 0.021 |
| 19. | Availability of all types of instruments | - | - | 4.9 | 0.026 |
| 20. | Improve/introduce Counseling services | 6.3 | 0.042 | - | - |
| 21. | Availability of clean drinking water facilities | - | - | 3.3 | 0.012 |
| 22. | Should not charge fees | - | - | 1.6 | 0.008 |
| 23. | Condom box should be kept in secret place | - | - | 1.6 | 0.013 |
| 24. | Make good roads to have easy access to bring medicines | - | - | 1.6 | 0.014 |
| 25. | Deliver free health care services | 6.3 | 0.021 | - | - |

**Annex Table 3.10 Perception of different age group of adolescentgirlss on overcoming barriers at health facility level**

| S.N | Item | 10-14 age group | | 15-19 age group | |
|---|---|---|---|---|---|
| | | Frequency (%) | Salience | Frequency (%) | Salience |
| 1. | Gender friendly service providers | 53.30 | 0.455 | 47.20 | 0.331 |
| 2. | Availability of adequate medicines | 31.60 | 0.222 | 45.30 | 0.342 |
| 3. | Need of separate room | 31.60 | 0.202 | 37.70 | 0.270 |
| 4. | Need of all kinds of facilities | 26.30 | 0.186 | 28.30 | 0.157 |
| 5. | Appropriate behavior of service providers | 31.60 | 0.191 | 30.20 | 0.174 |
| 6. | Information dissemination regarding services availed | 13.20 | 0.079 | 28.30 | 0.164 |
| 7. | Availability of medicines/services at free of cost | 21.10 | 0.090 | 22.60 | 0.121 |
| 8. | Hygienic environment/clean toilets | 18.40 | 0.119 | 18.90 | 0.061 |
| 9. | Appropriate treatment services | 21.10 | 0.155 | 20.80 | 0.125 |
| 10. | Availability of skilled service providers | 7.90 | 0.059 | 20.80 | 0.113 |
| 11. | Proper counseling services | 26.30 | 0.158 | 15.10 | 0.098 |
| 12. | Prescribe medicines after proper diagnosis | 13.20 | 0.061 | 11.30 | 0.064 |
| 13. | Service providers should be available on time | 7.90 | 0.041 | 7.50 | 0.062 |
| 14. | Availability of safe drinking water | 15.80 | 0.056 | 9.40 | 0.038 |
| 15. | Deliver health care services round the clock | 7.90 | 0.049 | 11.30 | 0.099 |
| 16. | Maintain confidentiality | 10.50 | 0.056 | 7.50 | 0.053 |
| 17. | Need of ambulance | - | - | 17.0 | 0.125 |
| 18. | Availability of adequate human resource | 7.90 | 0.040 | 5.70 | 0.020 |
| 19. | Non discriminatory practice and treat everyone equally | 10.50 | 0.042 | 11.30 | 0.051 |
| 20. | Availability of adequate medical equipments | 2.60 | 0.023 | 5.70 | 0.043 |
| 21. | Deliver prompt services | 5.30 | 0.014 | 5.70 | 0.033 |
| 22. | Should deliver quality services | 5.30 | 0.039 | 3.80 | 0.025 |
| 23. | Separate services hours for adolescents | 5.30 | 0.030 | 1.90 | 0.010 |
| 24. | Health facility should be nearby | - | - | 1.90 | 0.009 |
| 25. | Should have good referral mechanism | - | - | 3.80 | 0.012 |
| 26. | Easy access to services | - | - | 1.90 | 0.010 |
| 27. | Availability of temporary methods of FPCs | 5.30 | 0.022 | - | - |
| 28. | Services should be availed at free of cost | - | - | 1.90 | 0.004 |
| 29. | Services available should be monitored regularly | 2.60 | 0.022 | - | - |