Challenges and Barriers to Adolescent Friendly Sexual and Reproductive Health Services for Girls in Kaski, Nepal

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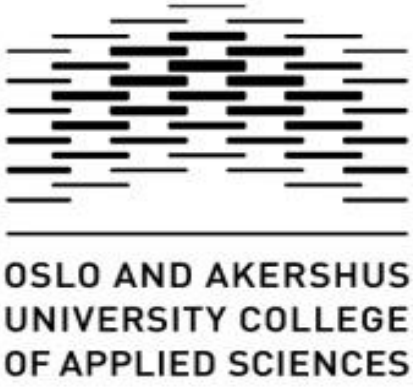

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List of Contents

ACKNOWLEDGEMENT ii
List of Figure v
List of Table v
ABSTRACT vi
L.IST OF ABBREVIATION vii
CHAPTER 1:INTRODUCTION 1
Background 1
Research Questions 3
A conceptual framework of access to health care 3
CHAPTER 2: LITERATURE REVIEW 8
Who is adolescent and why to invest on them? 8
Adolescent sexual and reproductive health as an International Agenda 9
Adolescent Sexual and Reproductive Health Issues in a global scenario 10
Adolescent sexual and reproductive health status in Nepal 12
Situation of Adolescent Sexual and Reproductive Health in Kaski, District 14
What government has done to address the Adolescent Sexual and Reproductive health in Nepal? 14
The National ASRH Program in Nepal 15
How the ASRH program work within the Nepalese Health System? 19
Challenges and Barriers in accessing quality health services 20
Service Provider Side 20
Service Receiver Side 23
CHAPTER 3: METHODS 25
Research Design 25
Selection of study site and participants 25
Data collection Techniques 28
Semi-structure in-depth interview 28
Focus Group Discussions (FGDs) 28
Observation 29
Data Analysis 29
Ethical Issues 31
Reflexivity 32

Validity of study 33
Limitation of Study 34
Dissemination of findings 34
CHAPTER 4: FINDINGS 35
A. Interviews with health workers 35
1. Challenges related to resources within program 35
2. Challenges related to placement of program in a larger organization 39
3. Challenges related to individual health workers 45
B. Observation of researcher on service provider's side 48
C. Focus Group Discussion with adolescent girls 51
1. Barriers related to individual 52
2. Barriers related to family 55
3. Barriers related to health sector 57
4. Barriers related to school 59
5. Barrier related to society 60
D. Observation of Researcher on service receiver's side 62
CHAPTER 5: DISCUSSION 63
What are the challenges and barriers to keeping girls from receiving sexual health services? 63
1. What influences the perception of needs and desire for ASRH care? 64
2. What influences ASRH care seeking? 65
3. What influences the ability to reach ASRH care? 66
4. What influences ASRH care utilization? 68
5. What are the ASRH care consequences? 69
CHAPTER 6: CONCLUSION 71
CHAPTER 7: RECOMMENDATION 72
REFERENCES 73
APPENDICES 78
Appendix 1: Semi-structure interview Guide 78
Appendix 2: Focus Group Discussion Guide 80
Appendix 3: NSD Approval 82
Appendix 4: Nepal Health Research Council (NHRC) 86
Appendix 5: Consent form for Focal Group Discussions 87
Appendix 6: Obserbation Checklist for Supervision 89

List of Figure

Figure 1: A conceptual framework of access to health care. 4
Figure 2: Organizational structure of Department of Health Services 20
Figure 3: Conceptual framework of providers' influence on client utilization of sexual and reproductive health services 22

List of Table

Table 1: Table 1: Number of Interviews and FGDs 28
Table 2: Observation check list of health institutions 49

ABSTRACT

Introduction: The overall adolescent's sexual and reproductive health status is poor in Nepal. This shows the demand for the adolescent sexual and reproductive health services but at the same time the utilization of existing by adolescent is low.

Objective: The study aim at finding the challenges and barriers for adolescent friendly sexual and reproductive health services for girls in order to identify the reasons behind low utilization of services by girls from public health institutions in the community.

Methods: Purposive sampling method was carried out for the selection of all participants including health workers and girls based on the purpose of research objectives. Data was collected through six interviews, nine focus group discussion and two observation study.

Findings: The findings of this study elaborate the various challenges health worker face during the implementation of the ASRH program. Lack of resources within the program, lack of prioritization of program and characteristics related to individual health were the major challenges for the ASRH program. Lack of training of health workers, poor programmatic strategies, poor monitoring and supervision of the program, lack of acceptance of ASRH program in the community as well as judgmental attitude of health workers were found making the process of implementation of ASRH more challenging. On the other hand, girls were found experiencing the various barriers form different aspects of society including their own family, school, health sector and their own characteristics. Hence, poor sexual and reproductive health knowledge, strict gender role in community, lack of adolescent friendly health services, stigmatization of SRH services in community were the potential barrier girls were facing during utilization of services.

Conclusion: The poor accessibility of adolescent friendly SRH services and adolescent unfriendly family, school and society leads to low utilization of SRH services in community

L.IST OF ABBREVIATION

AFS	Adolescent Friendly Services
AFHF	Adolescent Friendly Health Facility
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavioral Change Communication
CPR	Contraceptive Prevalence Rate
DOHS	Department of Health Services
DPHO	District Public Health Office
FGD	Focus Group Discussion
FHD	Family Health Division
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IEC	Information Education Communication
NDHS	National Demographic Health Survey
NHSP	Nepal Health Strategic Plan
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
WHO	World Health Organization

CHAPTER 1:INTRODUCTION

Background

According to the World Health Organization (WHO), adolescence characterizes the period of growth and development after childhood and before adulthood. Usually age group of 10-19 years are taken as the adolescent (WHO 2016). Despite being of same age group adolescents are heterogeneous who have different need and circumstances (WHO 2011b, 1). They go through several phases of physical, mental and social development and accordingly develop their attitude, knowledge and behavior (Regmi, Simkhada, and van Teijlingen 2010).

In the South-East Asian region unplanned and unwanted pregnancy, unprotected sexual activity, unsafe abortion, lack of knowledge regarding sexual and reproductive health, lack of access to contraceptives and early marriage and child bearing, are some of the problems faced by adolescence (WHO 2011b). The scenario of Nepal regarding adolescent sexual and reproductive health is not different from it and such problems become more severe due to prevalent social problems like poverty, illiteracy, school drop-out, gender based discrimination and violence. These problems with adolescent's reproductive health and their lack of knowledge has been recognized as one of the main public health concerns in Nepal (FHD 2000).

In Nepal, the first step of commitment towards the adolescent sexual and reproductive health start with signing a plan of action at the International Conference in Population and Development (ICPD) in 1994. From then to now Ministry of Health and Population of Nepal has showed their obligation through series of program and strategies towards adolescent sexual and reproductive health. By the end of fiscal year 2015/2016 total of 1,134 health institutions in 63 districts were providing adolescent friendly services under National Adolescent Sexual and Reproductive Health (ASRH) program. The target set by National ASRH program of achieving 1,000 health institutions were already achieved by July, 2015 (DoHS 2017)

Irrespective to accomplishment of ASRH program in making adolescent friendly institutions, adolescent's sexual and reproductive health issues still exist in society. While analyzing the current annual report of Department of Health and Services on Adolescent Sexual and Reproductive Health from receiver point of view, it puts forward two issues related to adolescent sexual and reproductive health. Firstly, the high prevalence of early marriage and teenage pregnancy and

secondly, low Contraceptive Prevalence Rate and high unmet need for contraception among adolescents (DoHS 2017). Similar problems related to ASRH were reported in the annual report of Department of Health Services of FY 2014/15 (DoHS 2016) and National Demographic and Health Survey report of 2011. All these issues show that there is a strong demand for these services, yet the utilization of the existing services is low by adolescents.

Similarly, while examining the adolescent friendly Sexual and Reproductive Health Program from the supply side perspective, it stated several issues related to implementation of the program varying from quality assurance, inadequate trained human resources to inadequate monitoring and allocation of resources from various level of health system. In addition, it showed the inadequate links with other programs like Family Planning, Safe Motherhood and HIV prevention. Inadequate Information Education Communication (IEC) materials and lack of disaggregated ASRH data by age and sex along with its integration in Health Management Information System were the major issues (DoHS 2017). Annual report of 2016 further explained the poor ownership of ASRH program at local level (DoHS 2016). In 2013, a mid-term evaluation research study of national ASRH program was conducted in some of the selected health institutions in Doti and Banke districts of Nepal. This study highlighted some major issues in addition to the reports of Department of Health Services (DoHS). They were provision of confidential health services, necessity of community based awareness activities and prioritization of the program within the health facility (Baral Chandra et al. 2013).

So all such studies on ASRH program determine the poor implementation of program and poor use of services by adolescents. It is shown that ASRH program is not successful in achieving its target of providing services to adolescent and eventually resulted to poor achievement of program. Therefore low utilization of the services by the target population is the main problem for the health institution at present. Statistics also show that girls seek these services even less than boys do. So overall , these reports from the Ministry of health concluded that the ASRH program is not functioning well as it is expected to work in the community (DoHS 2017, 2016).

In such, one of the major aims of the ASRH program is to increase the utilization of services by adolescents (DoHS 2017). There might be various underlying reasons from both perspective of suppliers and receivers for the low utilization of ASRH services. There might be the problem of looking at the same thing but from different perspective and the mismatch between the available

services and actual need. Also the preferences of the adolescent might create the gap between the reality and intended achievement of the program. Various factors within and outside the health environment might act as the barriers for utilization of health care. In the similar way various internal and external factors related to ASRH program might make it challenging to carry out the activities with perfection in the community. Hence implementation of program in the community level might not take place in the similar manner as planned in the national level.

This shows that services are established and there is a will to increase services utilization in order to improve the health status of adolescent through addressing their sexual and reproductive health problems. But low utilization of services is the major problem faced by the ASRH program in the present day. Thus to minimize this gap in the program and increase the utilization of services, issues related to both sides should be taken into consideration. Therefore, this study will aim at answering the following questions;

Research Questions

- What are the challenges that health providers face while providing ASRH services to girls in adolescent friendly public health facilities?
- What are the barriers for adolescent girls to reach the ASRH services in adolescent friendly public health facilities?

A conceptual framework of access to health care

Theoretical framework connects researcher with existing knowledge of the field. It is an explanation of theories and concepts which describes the research problem and relationship among the variables of the study. In this study, I will use two theoretical frameworks for understanding challenges and barriers of ASRH program between service providers and receivers. Symbolic interactionism is useful to understand how shared symbolic meaning can create barriers for girls in the community to obtain services on sexual and reproductive health, while a conceptual framework of access to health care will provide a framework for understanding challenges and barriers at various steps of accessing health care from both supply and demand point of view.

Firstly, this **conceptual framework of access to health care** will help me to understand the perspective from both the providers and receivers point of view. It has defined access to health care as the opportunity to fulfill the health care needs of individual which starts from identifying the health needs to seeking for it, reaching it and finally using it. It further explained this entire

process is affected by both supply and demand sides of health care which is crucial for recognizing the barriers and challenges for access of health care. The supply side constitutes of health care providers, institutions, health system and policies whereas demand side covers the characteristics of individual personality, households as well as social and physical environments of community including tradition and culture. (Levesque, Harris, and Russell 2013)

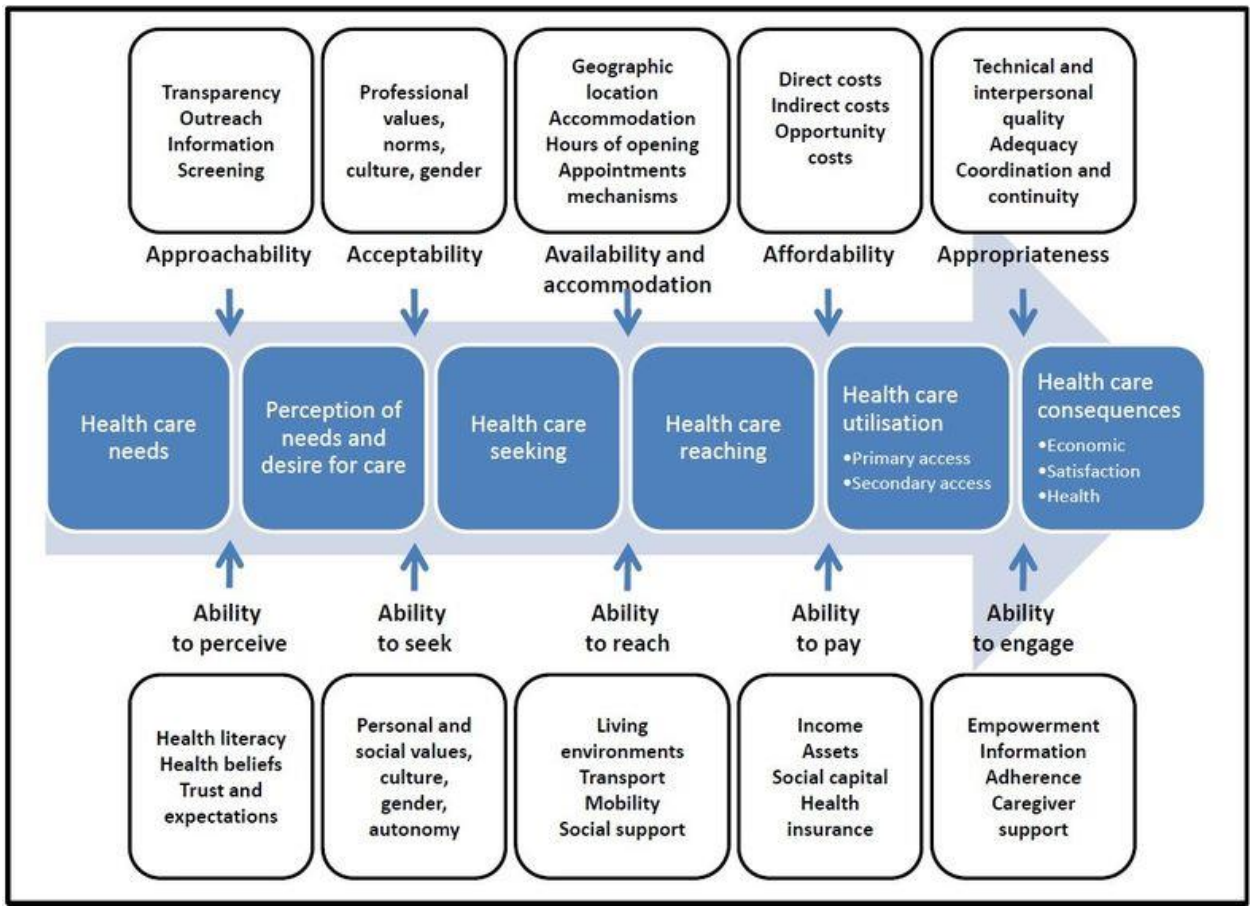

Figure 1: A conceptual framework of access to health care (Levesque, Harris, and Russell 2013).

The figure above, presents five dimensions from the perspective of both supply side and demand side. These dimensions interact with each other in order to generate access to health care. At the first step it illustrates that approachability of supply side and the ability of the individual to perceive the health care needs determine the perception and desire regarding health care needs in the population. Approachability is the phenomenon of making the existing services more familiar to the population and people who are in need of health care seem to be more approachable to services than others. Approachability is determined by various factors like transparency, awareness and information regarding health care system, services and treatment. On the other hand individual

ability to perceive health care needs are determined by their knowledge, literacy and beliefs regarding health issues (Levesque, Harris, and Russell 2013).

Seeking health care is the second step towards access to health care. It explains health seeking behavior of individuals as determined by individual ability of seeking care and the acceptability of available health care. Individual ability regarding health care seeking is not down to individual factors alone, but affected by personal and social values, individual capacity, cultural background and perspective on gender. Acceptance of health care are based on gender sensitivity, professional values, norms and culture related to health care in society (Levesque, Harris, and Russell 2013).

Similarly, various factors from the point of view of individual and health care services affects the phenomena of reaching health care. From the individual perspectives his/her living environment, social support for health care, individuals own knowledge regarding services, occupational flexibility, mobility and transportation have direct or indirect effect on individual ability in reaching health care. Whereas availability and accommodation of health care in terms of geographical location, opening hours, mechanism of providing services, health workers, physical infrastructure and available facilities have high influences on making the care accessible(Levesque, Harris, and Russell 2013).

It further says affordability of individuals to health care services in terms of money and time increase the utilization of services. In contrast, factors like poverty and social isolation hinder the capacity of individual personality to pay for needed health care. Appropriateness of the health care services in terms of technical and interpersonal quality, adequacy of services, providing need based services will help to improve the utilization of services whereas ability of patient to engage and involve on decision making regarding their treatment, informed choice and support will result into the better health care consequences in terms of well-being, satisfaction and better economy (Levesque, Harris, and Russell 2013).

All these five dimensions of accessibility namely approachability, acceptability, availability, affordability and appropriateness of health care services are interrelated and interact with the individual abilities of person on perceiving, seeking, reaching, paying and engaging in health care to fulfill the health care needs. The steps towards the access to health care are chronological as changes in the one step brings noticeable changes on next step. For instance, better perception on health care needs will increase the number of people who seek health services, and greater the

number of people seeking heath care, higher will be the people reaching health care and so on. So in such, every steps of access to health care are closely related with each other. This conceptual framework again puts forward the notion of importance of inclusion of capacity of the individual personality to improve the utilization of services and verify that programmatic accessibility alone is not enough. So population characteristics and various underlying factors affecting the abilities of individuals should be addressed in order to address the gap between the patient's abilities and programmatic strategies to improve the access of health care. (Levesque, Harris, and Russell 2013).

So in order to address the gap, the process of interaction between the two different dimensions and its effect on each steps towards access to health care will be analyzed through the **symbolic interactionism**. It will help to understand the world as seen from the girl's point of view in the society. The entire process of access to health care at various steps from perceiving to engaging in health care is affected by the ability of the girls. So in such I will analyze my findings based on how symbolic interactionism is affecting throughout the process of access of health care from both perspectives. Symbolic interactionism will be more analyzed based on how it is affecting on the ability of individual person, family, society as well as health workers, ASRH program itself and health institutions as a whole.

Symbolic interactionism says that we first interpret the things and in response to that we perform the actions. Interpretation and actions are reciprocal process such that one is followed by other. Our action is based on our perceptions about the situations and later on our actions affect the situations. Symbolic interactions carries the concepts for viewing the social realities. It gives us the way of knowing and growing so that we can express our views on certain meaning, actions and events of where we belong. Individual action in a society is determined by the prevailing cultural values and beliefs, discrimination and stigma. Our interaction with ourselves and others changes our way of thinking and acting. We try to understand the meaning of other people actions and respond to it. Often, we construct our roles in the society as compare to the roles of other people (Charmaz 2014). Crotty in his book "The foundations of social research" talks about the concept of social interactionism of Mead which define society as the whole and individual as a part of it. Individual act and behaviors are shaped by the society (Crotty 1998).

In society, symbolic meaning influences the mind and action of youth. The way of thinking and their activities are highly influenced by judgments and perceptions of people of the society. Acceptance and use of the ASRH services by adolescents is affected by the collective symbolic meaning of people in the society attach to such services. Such meanings can be emotions like trust, fear, social pressure, expectation and discrimination. Many studies showed tradition, cultural norms, family values, peer group and global environment as important factors influencing the sexual practices of adolescents and other issues related to their sexual and reproductive health. At the same time, it will be interesting to see how this framework of symbolic interactionism influences putting the ASRH program into practice in a community level.

Hence, I will use this theoretical model in the analysis of findings and discussion process of my study. Discussion of this study will be based on adding the findings from the service provider and the receiver side to their respective dimension and see how their interaction will affect the different stages of access to health care. In such, finally, I will be able to identify some of the challenges and barriers that hindering the effective use of the ASRH services provided today.

CHAPTER 2: LITERATURE REVIEW

I have used the online search databases like Google Scholar and PubMed using the endnote software to find articles and documents relating to the topic of this thesis. The keywords for my search are Adolescence, Sexual health, Reproductive health, ASRH program, Adolescence friendly services, challenges, barriers and Nepal. Literature review was done to improve the knowledge on the subject area of my thesis and developing evidences from previous articles which support the validity of my findings. Literature review will start from introducing adolescent and need for investing in their sexual and reproductive health. Then I will explain about what has been done till the date internationally to address the adolescent sexual and reproductive health. Then after that I will talk about present global situation of adolescent sexual and reproductive health including problems, issues and gap, and where the real lagging appears. After that, I will explain about the situation of adolescent sexual and reproductive health in Nepal as well as Kaski district and steps taken by government regarding implementation of program. Lastly, literature review elaborate the potential challenges and barriers related to poor sexual and reproductive health services all around the world.

Who is adolescent and why to invest on them?

Adolescent constitutes of total population of 1.2 billion globally which means one in every six people are adolescent of aged 10-19 years (WHO 2017a). They are the diverse group aged from 10-19 years and have distinct health needs according to their different physical, social and psychological background (WHO 2012a). They have their own particular needs so they can't be cover within criteria of simply old children or young adults as well as they share significant amount (6%) of global burden of disease and injury (WHO 2017b). Adolescence is an important phase of life because the habit and risk developed during this stage can greatly affect the health and well-being lifelong. For example, healthy eating and exercise behavior develop healthy adulthood in contrast unhealthy life styles, risky behaviors including road traffic accidents, unhealthy sexual behavior give rise to various health problems (WHO 2012a). Promoting healthy behaviors during adolescents and protecting them from health risks are important for the prevention of health problems in adulthood as well as for the better future and development of country (WHO 2017a). Investment in Adolescent health should be prioritized because it bring three fold benefits including adolescent at present, in their future adulthood and for the next generation. Adolescent health is

related to every aspect of life, health adolescent is healthy tomorrow. Healthy adolescent is the base for economic, social and healthy society whereas unhealthy adolescent give rise to vicious cycle of ill-health and socioeconomic deprivation (WHO 2009). In such there is no reason left for not investing in health and development of adolescent.

Adolescent sexual and reproductive health as an International Agenda

The rights of children under the age of 18 years was first declared by the Convention on the Rights of the Child in 1990. It declared that the children have right to information and services to survive, and to grow and develop to their full potential (WHO 2017c). After that need and rights of the adolescent of the world was addressed by the International Conference on Population and Development (ICPD) held in Cairo in 1994 and the Fourth World Conference on Women (FWCW) held in Beijing in 1995 for the first time in the history of adolescent health. Policy makers agreed on the declaration regarding adolescent health and development. It insisted that all the sector including government, nongovernment and private sectors should prioritized the program of education, income-generation opportunities, vocational training and health services for adolescent including sexual and reproductive health. At ICPD, emphasis was given to respectful and equitable gender relations in order to achieve educational and health services need of adolescent to enable them to deal with their sexuality in a positive and responsible way. From then it have impact on policy making to implementation of program from international to national level in order to meet the sexual and reproductive health need of adolescents with diverse background (WHO 2011a). It was the first time when sexual and reproductive health of adolescents of 10-19 years and youth of 10-24 years was prioritized to be met and taken as an international agenda (WHO 2017c).

After this, there were a growing acknowledgement and events which supported the importance of addressing the sexual and reproductive health for overall health and development. The Millennium Development Goals report published in 2011 by United Nations talked about the high risk associated with early pregnancy and childbearing in adolescents. It further says in order to improve not only maternal health and child health but also for the reduction of poverty, greater gender equality and women empowerment, early and unwanted pregnancy should be prevented. This report on Millennium Development recognize the importance of adolescent health and said "Reaching adolescents is critical to improving maternal health & achieving other Millennium Development Goals" (UN 2011, WHO 2017c).

Afterwards in April 2012, Adolescents and Youth was the theme of the 45th session of the commission on Population and Development and the discussion was on achievements on sexual and reproductive health so far (Jejeebhoy 2012) and adopted a landmark resolution for strengthening of health systems and ensuring universal coverage of sexual and reproductive health care services by government and other development partners (WHO 2017c). The 65th World Health Assembly have one of the agenda on "Early marriages, adolescent and young pregnancies" and discussion was on linkage between the early marriages and pregnancies, and progress towards the health related Millennium Development goals (WHO 2012b). This Assembly further address the child marriage as violation of girl rights and are illegal in most of the countries, and have the negative health and social consequences (WHO 2017c). In addition, Sustainable Development Goal (SDG 3) set the specific target of achieving universal access to sexual and reproductive health care services by 2030 which include family planning, information and education, and reproductive health integration into the national strategies and programs (WHO 2017a). It's impossible to achieve the 2030 Agenda for Sustainable Development without investing in adolescent health and well-being along with gender equality (WHO 2017b).

Adolescent Sexual and Reproductive Health Issues in a global scenario

In a global scenario overall the access and the utilization of sexual and reproductive health services are improving but in many countries this progress has been slow and very disappointing after the investment of two decades from 1994. Prevalent inequalities in health is the major reason behind it. Women living in low and middle income countries have high risk of mortality and morbidity related to sexual and reproductive health as compare to women of developed countries. In Sub-Saharan Africa where the prevalence of HIV/AIDS is high, one of the major public health issues related to sexual and reproductive health is unprotected sex. The case not might be same in other areas where HIV/AIDS is not the major cause of youth mortality.

The pregnancy and childbirth related mortality and morbidity including unsafe abortion are the major issues related to the health of young women in all developing countries. In the global scenario early age of marriage has been failing but at the same time the number of early exposure to premarital sex is increasing before the age of 18 years and have consequences like unwanted pregnancy and unsafe abortion which have adverse health effects among adolescent girls (WHO 2010b). Out of total childbirth in the world, 11% are given by the girls of age of 15-19 years. Early childbearing is one of the major problem of low and middle income because out of 11% of

worldwide total child birth 95% take place here. Babies born from adolescent mother have risk of being still born or dying as compare to mother of 20-24 years and often are low birth weight. Most of the death are related to the direct maternal complication like hemorrhage, sepsis, obstructive labor and unsafe abortion. Every year almost 3 million adolescent girls undergo unsafe abortions. The risk of dying during pregnancy and delivery in highest in 15-19 years as compare to older women. Complication related to early pregnancy and child birth are one of the leading cause of death among this age group which leads to maternal and child mortality and give rise to vicious cycle of ill health and poverty. (WHO 2017a) Early marriage is also one of the major issues related to adolescent sexual and reproductive health. It is found that more than 60 million women aged 20-24 years were married before the age of 18 years. Although the rate of early marriage is being decreasing trend from previous year but the rate of decreasing is really slow. The severity of this issue varies between the countries and have high prevalence in West Africa Region and Southern Asian part (WHO 2012b).

In the global context at present, available medical, public and technological advancement has improved the health of young people but at the same time new challenges also took place and create risk of young people. During adolescence they reach their puberty phase so it changes the way people treat them, increase the importance of sexuality and introduces various reproductive health risk. (WHO 2009). Although the profound amount of desire on knowing sexual health and reproductive health, level of knowledge regarding sex and family planning is poor among adolescents and skills to transfer that knowledge into practice is even worse which give rise to risky behavior. 2-37% of adolescent are engage in sexual relations prior to marriage. In Sub-Saharan Africa and Southern Asia adolescent girls have high fertility rate (Jejeebhoy 2012). High prevalence of contraceptive use help in reduction of early pregnancy and childbirth but among adolescents use of contraception are low and unmet need of family planning is high. This shows the higher gap between the women's intention and contraceptive behavior and increase the problem of early pregnancy and child bearing (WHO 2012b). It is very difficult to access the unmet need of family planning among never married girls and seek the abortion care more lately as compare to married ones (Lloyd 2005). Most of the countries lack effective sexuality education and only 24% of adolescents were found having comprehensive and correct knowledge on HIV/AIDS. More than 2 million adolescents are living with HIV. Although, overall mortality related to HIV are decreasing but among adolescent are rising especially on WHO African Region.

Only 15% of young women of aged 15-24 years are aware of their HIV status in Sub-Saharan Africa (WHO 2012b).

Adolescent sexual and reproductive health status in Nepal

According to NDHS 2011, the total population of adolescent is 24% in Nepal and median age for first marriage for women is only 17.5 years. In 1996 the percentage of married of aged 15-19 years were 43% and in 2011 it decreased to 29%. While comparing with previous years the relative amount of early marriage is decreasing but the figure of 29% of early marriage is problematic in itself (NDHS 2011). It resulted into early exposure to sexual relationship and potentially increases the chances of early pregnancy and exposure to sexually transmitted infections (Khatiwada1 et al. 2013). Similarly, early child bearing is also one of the major issues related to adolescent health in Nepal. It is estimated that 17% adolescents are either already in their pregnancy or have one child. Early pregnancy increase the drop-out from school and mostly girl have to sacrifice their education. Additionally being pregnant in early ages often resulted into the adverse effects like preterm birth, low birth weight baby, neonatal deaths and so on. It is interesting that adolescent fertility rate is decreasing but still there is the huge gap between rural and urban population. (NDHS 2011).

According to the annual report of department of health services of fiscal year 2015/16, the number of Antenatal Care checkup of adolescent are increasing as compare to previous year but the number of first visit according to the protocol is very low. First of all increasing trend of adolescent visit for ANC itself shows that early marriage, early pregnancy and childbirth still exist in our society. Secondly, not visiting health institution as the protocol shows adolescents delay in accessing health care. In additional to that, total proportion of 4^{th} antenatal visit is less than 1^{st} visit which indicate that health institutions are missing pregnant adolescent from utilizing health care which make their condition even risky. These issues show the poor access to information, lack of preventing activities of early marriage and need for more adolescent friendly health services (DoHS 2017)

The statistics of use of modern methods of family planning (i.e.14%) has not increased by even a single percent in 5 years from 2006 to 2011.The unmet need for family planning is estimated to be highest (42%) on married girls of age 15-19 years as compare to other age group. This ratio is even more among adolescents in rural population than urban setting. Unmet need for FP in adolescent has increased by 3.5% in 2011 than in 2006 (NDHS 2011). The proportion of safe

abortion is 19.7 within the country which means total of 14,699 adolescent girls went through medical and surgical abortion within a duration of one year (DoHS 2017). Most often, abortion is the consequences of unwanted pregnancy so the indicator itself explain about the low contraceptive prevalence rate and high unmet need for family planning. If their family planning need were met the condition never reach to abortion. In Nepal the prevalence of human immunodeficiency virus (HIV) is estimated to be 0.3 percent in the general population age 15-49 and have concentrated epidemics in certain high risk populations. In additional young people are also particularly in risk (Khatiwada1 et al. 2013) as only 26% of girls had comprehensive knowledge on HIV/AIDs (NCASC 2012).

The association between socio-cultural background and adolescent sexuality in Nepalese society is complicated in a sense that it's the mixture of highly pre-dominant traditional norms and modern technology. The most of the older generation carry the conservative traditional norms on sexuality. In contrast, younger population are in complex transition towards modernization at traditional controlled society. At one side, due to the strong cultural norms, youth are not open about sexual and reproductive health problems. Open discussion about sex and sexuality within the family and society are beyond the imagination and taken as taboos. Older generation of society believe that discussion on sexual matters encourage the involvement of adolescents on pre-marital sex and even the friendship with opposite sex is not acceptable. These traditional norms gives rise to communication gap between the generation in the subject matter of sexuality and limit the sources of information of adolescent (Regmi, Simkhada, and van Teijlingen 2010). Nepal as being a patriarchal society, all the decision regarding the small matters to life events are mostly dependent on parents and decision realted to sexuality of married women are pre-dominately lies in the authority of husband (Puri, Tamang, and Shah 2011).

On the other hand, modification in communication, technology and western influences have brought the changes in the life styles of adolescent. There is the shift in concept about sexuality between parents and children resulting into young generation more open about sexuality as compare to their parents. Premarital sex is in increasing trend in Nepal and a study in 2009 showed that more than 35% of boys and 15% of girls were involved in premarital sex. Increasing curiosity on sexual issues, peer pressures and media were found to be associated with premarital sex and risky sexual behavior of youth is in increasing trend in Nepal (Regmi, Simkhada, and Teijlingen

R 2010). Sexual behavior among the young people of Nepal is unsafe and correct transition of knowledge into safe practices is very low (Upreti et al. 2009).

Situation of Adolescent Sexual and Reproductive Health in Kaski, District

There is no difference on the sexual and reproductive health status of adolescent in Kaski district as compare to overall scenario of Nepal. Increasing antenatal care visits of adolescents in health institutions demonstrated the existence of early marriage and early pregnancy as being the major issues in this region. Both the abortion and unmet need of family planning are in increasing trend whereas use of modern methods of contraceptives are low in adolescent age group (DoHS 2017). Kaski district lack the disaggregate data on adolescent sexual and reproductive health on its annual health report of fiscal year 2015/2016. The overall report on family planning and safe motherhood program showed the decreasing number of current users of contraceptives like pills, Depo-Provera and increasing unmet need for family planning. In addition, lack of proper recording and reporting along with poor co-ordination with other sector were pointed as major issues under family health program (DPHO 2017).

What government has done to address the Adolescent Sexual and Reproductive health in Nepal?

To address all the prevalent adolescent sexual and reproductive health problems, the Ministry of Health and Population has showed their commitment through series of programs and strategies. Firstly, Nepal signed a plan of action at the International Conference in Population and Development (ICPD) in 1994, which was the first step towards the development of sexual and reproductive health care services. Then after 4 years, in 1998, Adolescent Sexual and Reproductive Health (ASRH) was included as one of the crucial components of the National Reproductive Health Strategy. In 2000, the Family Health Division developed National Adolescent Health and Development Strategy to address the health and development of adolescents. In 2007, Implementation Guide on Adolescent Sexual and Reproductive health was developed to help district managers. Between 2009 and 2010, adolescent friendly services were provided by 26 health facilities as the pilot intervention in 5 districts (FHD 2011).

After all these programs and strategies, ASRH program was not working as targeted and services were not utilized by the adolescents as expected. Based on the lesson learned from all the past and existing interventions and experiences, Nepal Health Sector Program (NHSP) II set the target

of making 1,000 public health facilities adolescent friendly by 2015 (MoHP 2010). This was 25% of current total number of health facilities in country. Finally, to meet this target National ASRH program implementation guide 2011 was developed with the help of different partner organization (UNFPA, UNICEF, WHO, GIZ, Save the Children, IPAS and ADRA) based on lessons learnt by the program (FHD 2011). The target of achieving 1000 adolescent friendly health institutions was reached by July, 2015. By the end of fiscal year 2015/16, in total 1,134 health facilities in 63 districts were providing adolescent-friendly services (DoHS 2017).

The National ASRH Program in Nepal

The goal of National ASRH program is to promote the health and socio-economic status of adolescences. This program has developed three objectives in order to achieve the goal of the program and they are:

- To increase the availability and access to information about adolescent health and development, and provide opportunities to build skills of adolescents, service providers and educators.
- To increase accessibility and utilization of adolescents health and counseling services for adolescents.
- To create safe and supportive environments for adolescents in order to improve their legal, social and economic status.

The monitoring and evaluation of the national ASRH program are based on the population statistics and will be based on the indicators mentioned below:

- Increase age at marriage
- Increase in use of modern methods of family planning
- Decrease unmet need for family planning
- Reduce adolescent pregnancy
- Reduce adolescent fertility rate
- Decrease prevalence of HIV infections (FHD 2011, 5)

Using these indicators given by the National ASRH program themselves, I analyzed the prevalent various government and other reports to evaluate the success of the ASRH program and found several problems which has been already talked under the topic "Adolescent Sexual and Reproductive Health Status in Nepal".

Adolescent Friendly Services (AFSs) is the strategy taken by the National ASRH program in order to provide the sexual and reproductive health services to adolescents in a friendly manner. Adolescent friendly services are defined as the friendly environment and such favorable condition where adolescents can get access to ASRH services in a comfortable and easy manner. Adolescent is a strategy taken by ASRH program with the aim of increasing the accessibility and utilization of services by adolescent. To be adolescent friendly, health institutions should met the certain standards and characteristics set by the guidelines of National ASRH program. There are nine national standards which need to be followed for implementing adolescent friendly services (FHD 2011, 5-7) and they are:

1. The specified package of health services, that adolescents need, should be provided by the health service delivery points (Service Delivery Packages): It mention about providing specified service delivery packages according to variations in the needs and demands of adolescents at different level of health care facilities in district. District health manager will be responsible to insure these services.
2. Health service delivery points should provide effective health services to adolescents and youth (Organizing Effective Services): Health institutions should be well equipped in terms of required supplies, basic facilities, motivated and qualified health workers in order to provide the effective services.
3. Adolescents and youths should find the environment at health facilities conducive to seek services (Conducive Environment at Health Facilities): Barriers for conducive environment in health institutions should be identified so that adolescent will feel ease to share their problems.
4. Service providers should be capable to address the needs of adolescents and are motivated to work with them (Capacity Building of Service Providers): Health workers judgmental attitude and unfriendly behavior discourage adolescents from seeking health care. So health workers should respect the emotion of adolescents and provide the services in the dignified way. Health workers should be competent and motivated in service provision.
5. An enabling community environment exists in the community for Adolescents and youth to seek the health services they need (Building Enabling Environment): This standard seeks to address these enabling environment building factors to support the efficient delivery of the intended health services.

6. Adolescents are well informed about the availability of good quality health services from the service delivery points (Communication with Adolescents): Lack of knowledge and awareness among adolescent regarding services and its availability minimizes the timely seeking and promotion of services. So gaps in the knowledge and awareness among adolescent should be addressed through the proper communication and promotion measures.
7. Adolescents and youth should be provided skills-based Sexual and Reproductive Health Education (Skills for Health): In order to encourage their healthy relationship through prevention of disease and injury adolescent should be engage in learning experiences. This standard is a part of the FRESH (Focusing Resources for Effective School Health) framework where school and other non-educational organizations can be potential partner to develop the skills for health among these young group.
8. Adolescents and youth enjoy their sexual and reproductive health rights: This standard scales up and builds of programs to protect and promote sexual and reproductive rights through removing stigmatization and discrimination based on marital status, sexuality orientation etc.
9. Health Management systems are in place to improve and sustain the quality of health services: This standards ensures the timely recording and reporting of ASRH data from community, district to central level. Monitoring system should be focused to ensure the effective implementation of interventions as planned and appropriate feedback mechanism should be developed.

Adolescent friendly health facilities should have programmatic characteristics like involvement of adolescents with schools, youth clubs. Adolescents should be treated equally regardless of gender and marital status. Similarly, adequate supply of contraceptives, Information Education Communication (IEC) materials and short waiting time. In terms of physical infrastructure adolescent friendly health facilities should be in convenient location, favorable service hours with welcoming environment and separate counseling room to ensure privacy. To make adolescent friendly health facilities, service providers should have detailed knowledge and skills about the services including counseling, physical examination and referral mechanisms too. They should

have the ability to maintain the privacy and confidentiality of adolescents and treat them respectfully without prejudice (FHD 2011, 7-8)

The reason for making health institutions adolescent friendly is to make more adolescence use available existing Adolescent Sexual and Reproductive Health services in public health facilities. Services provided by these health facilities from district to local level can be categorized mainly in two categories firstly general ASRH counseling and secondly ASRH information and services.

General ASRH counseling refers for all the counselling services related to the issues of puberty and bodily changes, genital and menstrual hygiene, relationships, nutrition, avoiding early pregnancy, family planning, gender, life skills counseling as well as tobacco and alcohol counseling. During counselling process health workers need to use ASRH flipchart and IEC booklets for proper counselling. At the same time it mentioned about the encouragement of adolescent for reading IEC booklets either before or after the counselling process in community level health institutions (FHD 2011, 18-21).

Likewise, ASRH information and services cover the area of family planning, pregnancy, abortion, reproductive tract infection, STIs, HIV/AIDS, gender based violence, general health services and information (including TT immunization and management of menstrual problems), education and communication. At community level of health institutions family planning cover the services of counselling and provision of condoms, oral contraceptive pills, Depo-Provera and emergency contraceptives. Likewise, antenatal care, safe institutional delivery, post-natal care and neo-natal care and counselling are available to pregnant adolescent. At health institution there is even the services of safe abortion and counselling. Adolescent who are in need of voluntary counselling and testing (VCT) and anti-retroviral therapy (ART) are referral to district and zonal hospital from health institution in community level. In case of gender based violence health institutions are responsible to do physical assessment and examination. Furthermore the case will be follow-up and will referred to community resources if necessary. During delivery of information and services regarding all these issues of adolescent's health workers at all levels are recommended to use WHO Job Aid in order to provide these services in more adolescent friendly manner (FHD 2011). Adolescent job aid is the handy desk reference which is develop for health workers to provide primary health care services more effectively and sensibly to adolescent (WHO 2010a). All level of health institutions from family health division, Regional directorate, district hospitals, primary

health care center to health post to along with female community health volunteers have their distinct responsibility to carryout in National ASRH program (FHD 2011).

How the ASRH program work within the Nepalese Health System?

Ministry of Health and Department of Health services are the central point of health system in Nepal. Department of health services lies under Ministry of Health and is services is responsible for delivering preventive, promotive, diagnostic and curative health services. At the district level it has District Public Health Office or District Health Office who are responsible for responsible for providing essential health care services and monitoring of District Hospitals, Primary Health Care Centers and Health Post. So in such Primary Health Care Centers and Health Post are the first institutional contact point for basic health services. The hierarchy from top to bottom shows the level of health institutions from central to community level (DoHS 2017).

There are total seven divisions under Department of Health Services and Family Health Division (FHD) is one of the division. The ASRH secretariat is located at Family Health Division and is supported by Save the Children Nepal. In such ASRH sub-committee under Family Health Division are responsible for implementation of the program. They provide the orientation to district and regional health manager. Family health division and focal person of ASRH program are responsible budget allocation and scaling up of the program. Then District Public Health Office is responsible for selection of Primary Health Care Centers and Health post to provide adolescent friendly ASRH program.

After selection process of health institutions, health workers will be given training and orientation from district level. In addition, district managers are accountable for regular supervision, monitoring and collection of regular monthly information on ASRH program. The health workers of Primary Health Care Centers and Health Post are the one who are in close contact with community and are responsible to provide the ASRH services and conduct the one day orientation program to the stakeholders of community regarding ASRH program. Furthermore, they are responsible for maintaining monthly recording and reporting of service statistics to district level, They have the important role of coordinating with local communities and upgrading health facilities to make the services adolescent friendly. This is how ASRH program reach to girls from central level of health system in Nepal (DoHS 2017).

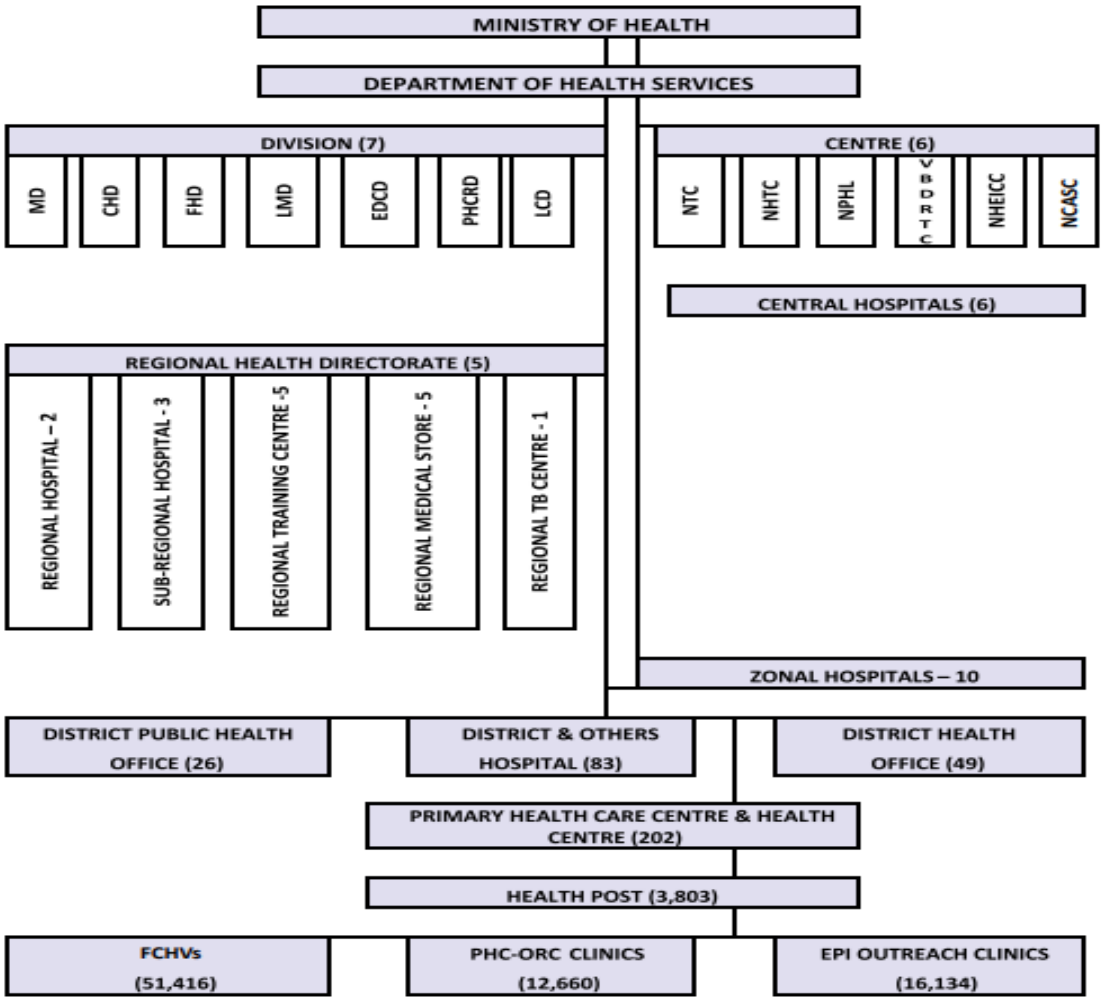

Figure 2: Organizational structure of Department of Health Services (DoHS 2017)

Challenges and Barriers in accessing quality health services

There are many factors which act as the potential reasons for increasing the gap on access to quality health services. They will be discussed as the barriers and challenges related to health sector (service provider side) and outside the health sector (service receiver side).

Service Provider Side

The lack of availability, accessibility, acceptability and equity of health services act as the potential barriers for adolescents in utilizing them. These measures are directly or indirectly related to health institutions and society. There are many associated factors within the health institution which affect all these measures and make it hard for adolescent to reach them. Health services should be geographically, socially, legally and economically available and accessible to adolescent in order

to increase the expansion of coverage of quality of health care services to those who are most in need and face more health and social problems. Similarly services should be acceptable to them in terms of less waiting time, privacy maintenance, respectful behavior and sensitive to fear and anxiety. Treatment with respect and confidentiality maintenance were the two universal quality that adolescent prefer to get from health institutions (WHO 2012a). Almost 83% of the adolescent participants were found to quit accessing sexual health services if their parents would know about it which elaborate lack of confidentiality as the major barrier (Kuzma and Peters 2016). Poor youth friendly services (Regmi et al. 2010), lack of youth friendly service centers, weak heath care system and lack of confidentiality enhance the poor health seeking behavior of young people in Nepal (Upreti et al. 2009). In contrast improving access to youth friendly services, peer education program, effective information system and availability of IEC materials were identified as the factors for the improvement of sexual and reproductive health status of young population (Regmi, Simkhada, and Van Teijlingen 2008) and more information and awareness program is needed to promote safer sexual behavior among adolescent (Regmi, Simkhada, and Teijlingen R 2010).

Health workers have the very important role on increasing the access of quality health care services to adolescents. Health workers are someone who are known as knowledgeable on sexual and reproductive health matters and are trusted by the society as a resource person in these matters. Their practices, behavior and attitude influences the utilization of sexual and reproductive health services as well as affect the knowledge level and cause financial and psychological cost for service receivers. Health worker's influences on utilization of sexual and reproductive health

services are best explained by the conceptual framework listed below.

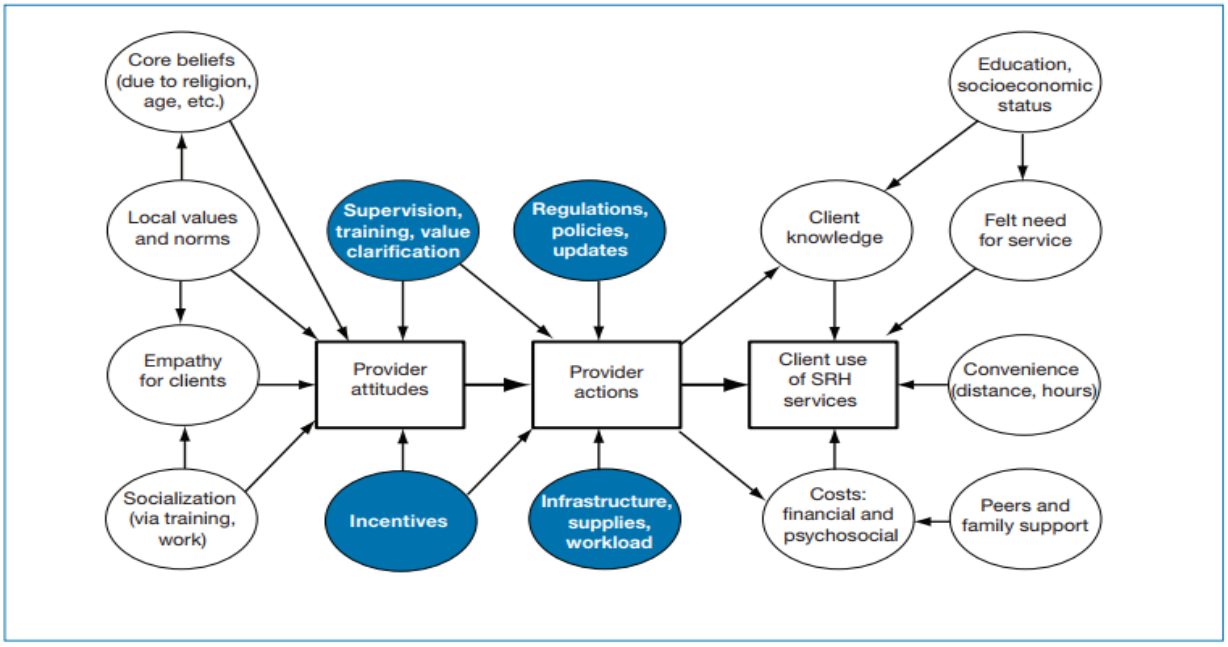

Figure 3: Conceptual framework of providers' influence on client utilization of sexual and reproductive health services (WHO 2010b).

This conceptual framework explains the local values, norms, believes and the socialization attribute to the attitude of health workers. Action of health workers are outcome of their attitude and eventually it effect on access and utilization of services. None of the people should be deprived from friendly, appropriate, client-oriented and affordable sexual and reproductive health services but female are found to experience more judgmental attitude towards them as compare to male from health workers. To improve the utilization of sexual and reproductive health services need to focus more on understanding the service receivers and minimize their psychological and financial cost. Training, regular supervision, availability of resources and motivation of health workers are most feasible area to bring the change in their attitude and practices in order to increase the utilization of services (WHO 2010b). Good communication skill of health worker is crucial in developing trust of service receiver for creating suitable environment to share the problems (Kuzma and Peters 2016). One of the study of Estonia stated enthusiasm and dedication of health worker towards providing health services as one of the major factor for the scaling-up the sexual and reproductive health youth clinic network (Kempers et al. 2015).

In addition, in many countries within the health institution it's difficult to find disaggregate data on what kind of services are used by the age specific adolescent. Most often, health sector lack the data on outcomes and effect of the program on adolescent. This hinder on the formulation of well-informed policies and program in health sector and hence always leave the gap between the program and needed health care services of adolescent (WHO 2009). Evaluation of improvement in sexual and reproductive health status of adolescent is impossible without the proper system of reporting and monitoring system (Kempers et al. 2015). Health sector lack the interventions which will be effective to change the attitude of adolescents towards healthy behavior rather than just bringing change in knowledge level regarding sexual and reproductive health. One of the challenging issue for health sector is the poor collaboration with other sectors and civil society who can potentially make the contribution for health and development of adolescent. In such collaboration of this activities with health sector will surely increase the utilization of services (WHO 2009). Providing sexuality services within and outside of school setting increase the utilization of services like use of contraceptives where community support plays a very important role (Chandra-Mouli et al. 2014).

In 2015, one study was conducted in Colombia to evaluate the youth friendly health services. It concluded lack of trained health workers in sexual and reproductive health and high instability of health workers have negative impact on the provision of services (Huaynoca et al. 2015).

Service Receiver Side

Youth lack adequate education, guidance and services on sexual and reproductive health and involve in risky sexual behavior (Adhikari and Tamang 2009). The cultural, social and economic factors are major factors affecting the sexual and reproductive health of young population. Study shows girls face more socio-economic and sexual problems than boys. This study point out there is the lack ability of making informed choices about their own health in youth (Regmi, Simkhada, and van Teijlingen 2010). Available socio-cultural beliefs and gender norms in society differentiate the standards of behaviors for boys and girls and have different expectation from them. These things have direct influences on who the adolescent share their problems with and hinder their practices of discussing their sexual and reproductive health with their parents and teachers. In these kind of society girls have less power in terms of decision making for themselves and in developing countries sexual and reproductive health programs targeting the youth

population has to face the challenges related to cultural beliefs about sex, way of parenting and traditional gender role (Obare, Agwanda, and Magadi 2013). Gender norms not only limit the girls control over their sexual and reproductive health but also increase the gap between gender inequalities. In such traditional gender norm, education of girls are less valued and always encourage early marriage and child bearing which minimizes the chances of girl's higher education. Increasing gender inequalities not just affect the sexual and reproductive health of girls but do affect the entire quality of life (IPPF 2015).

Social norms have direct effects on the health seeking behavior of adolescents. In such societies where premarital sex is not accepted, adolescent usually don't hesitate to go for the general health problems but it's different for the case of sensitive issues. Mostly they fear of their parents if it cause trouble by visiting health institutions. They usually try to solve the problems by themselves and after it don't get solved, they shared it with the trusted one like friends and siblings. They fear of their privacy and consequences if parents get to know about it. These things minimizes the health seeking of adolescents and at the same time it postpone the health seeking behavior and make the condition more severe. If in case they seek care they don't choose the local area. In most of the south Asian countries decision making authority regarding unmarried adolescents health are in hand of parents and in case of married adolescents it's on hands of their husbands and mother-in-laws (WHO 2012a). Girls have very limited access to information regarding their health and rights, because they have limited exposer to safe and social space outside the home and school where they can meet their friends, develop key skills and knowledge. Adolescent girls have limited number of friends and have poor decision making autonomy within family. Communication between parents and adolescents regarding sexual and reproductive health is very poor. In India, less than 1% of adolescents had discussed with parents regarding their sexual matters (Jejeebhoy 2012). Prevalent negative perception among community people regarding sexual and reproductive health information and services have the adverse effect on the improvement on sexual and reproductive health of adolescent (Huaynoca et al. 2015).

CHAPTER 3: METHODS

This section explains the methodology of entire study under investigation. It describes the design of the research study, reasons for selection of study sites and population taken through different sampling techniques. Furthermore, data collection methods and analysis techniques will be elaborated and ethical measures, reflexivity, validity and limitation of the study will be justified. Finally it ends with a discussion on dissemination of findings in broader context.

Research Design

Research design is the overall plan of the study and its selection is based on the nature of the research problem, individual experience of researchers and potential participants of the study (Creswell 2014). Research questions of the study plays the crucial role for the selection of the methods in the research. The purpose of my research questions is to identify the challenges and barriers for the effective implementation of adolescent friendly SRH for girls in the community. In such this research question is explanatory in nature so it can be answered only by the method of exploring and understanding individual or group's perception of certain social or human problem (Creswell 2014). Qualitative research is the one which have the ability of studying the social phenomena and providing its deeper understanding. It examine people interaction with each other in particular setting and concerned with exploring the behavior of people in everyday life (Silverman 2011). So keeping all this in mind qualitative research design is best to answer the research questions of this study. .

Selection of study site and participants

The rationale of selection of research topic in Nepal has been discussed immensely on the introductory part which is based on the evidenced information. After that for the selection of study sites and participants, I carried out purposive sampling method. This sampling method relies on the judgment of the researchers while selecting the unit of sample. It focuses on the particular characteristics of the sample through which answer of the research questions can be achieved (Bryman 2012). So selection was based on the purpose of research objectives.

I accomplished the process of selecting study sites and participants in four different level. First of all, Kaski district was selected as the study site in Nepal. ASRH issues are one of the major public health concerns all over Nepal and Kaski isn't the distinct one. In additional, I was well aware

about the issues related to ASRH services in this district throughout my working experience of one year under District Public Health Office. So in such it always persuade me in finding the factors behind those issues.

Kaski is one among the 75 districts in Nepal and according to National Population and Housing Census 2011 Kaski district has the population of 492,098. It contains 32 Village Development Community, two municipalities and four electoral sectors. While talking about public health facilities, District Public Health Office (DPHO) is the head institution at district level among the government health facilities. Under District Public Health Office, there are four Primary Health care Centers and two community hospitals in electoral constituency level. In Village Development Community level there are 45 health post, seven urban health centers in Pokhara sub-metropolitan city and five community health unit in Lekhnath municipality. In total there are 26 Health Institutions in Kaski which have adopted the concept of Adolescent Friendly Services. It was introduced in 13 Health Institutions in 2013 and later in 13 HI by the year of 2015 (DPHO 2017).

At the second level, I carried out small meeting with focal person of ASRH program in District Public Health Office for the selection of public health institution in community level. I thoroughly circulated the purpose of the study at the beginning of meeting for the appropriate selection of Health Institutions. Four health institutions get selected and in two health institutions, Adolescent Friendly Services was launched in 2013 and in remaining two the concept was carried after two years in 2015.

During selection of adolescent friendly health institutions, geographic variation was also addressed and selected health institutions were representative of both urban and rural areas. The variation in selection of health institutions according to placement of Adolescent Friendly Services program and geographic location were made to see its contribution on variation on challenges and barriers from different perspective in contrasting setting. After selection of health institutions, nearby school were selected with the help of focal person of those respective health institutions at third level. Then at fourth level, adolescent participants for the study were chosen through the help of principle and health teacher of those school. Prior meeting was carried out in all health institutions and schools for selection process.

This study includes two groups of participants. The first study group are health care providers of public health institution from district to community level. District Public Health Office's Family

planning supervisor and Public Health Nurse were selected for interview because they are the focal person of adolescent friendly sexual and reproductive health services in district level. They are responsible for implementation of the services from district level through distribution of resources to training of HWs from public health facilities. At the community level four focal person of ASRH program were selected as one from each four Health Institutions. It was found that most of the health workers from Health Institutions have got the orientation on ASRH program so, health In-charge of respective institution were selected as focal person. So in such from provider side, I interviewed total six health care providers- two from district level and four from community level.

The second group for the research are adolescent girls of aged 15-19 years. There are many reasons for the selection of girls on their late adolescence. Firstly, prevalence of sexual health problems are high in this age group as compare to early adolescent period. So if this group of girls have more problems so they are more likely in need of the services and have high chances of facing more barriers while accessing it.

Secondly, they seemed to be more confident and knowledgeable on SRH as they are in higher grade of education as compare to early adolescents. So I thought to answer my research questions late adolescents (15-19 years) will be better option than early adolescents (10-14 years). Girls were selected from schools which were near to public health institution because in the initial phase, they are the first target population for providing ASRH program in friendly manner. While selecting adolescents, I gave preferences on inclusion of variation in characteristics of participants by categorizing girls according to their marital status and level of education. So in such from demand side, I conducted total of eight Focus Group Discussion and one interview covering 27 participants.

Table 1: Number of Interviews and FGDs

Location		Interviews of HWs	FGDs of adolescent
District level		2	0
Community level	1st place	1	1st FGD=3 girls 2nd FGD =3 girls 3rd FGD =4 girls
	2nd place	1	1st FGD =5 girls 2nd FGD =2 girls
	3rd place	1	1st interview=1 girl 2nd FGD =2 girls
	4th place	1	1st FGD =4 girls 2nd FGD =3 girls
Total		6	8 FGDs and 1 interview
Total participants		6	27

Data collection Techniques

I used three data collection techniques namely Interviews, FGDs and observation in order to answer the research questions of this study.

Semi-structure in-depth interview

An interview is a conversation between a respondent and an interviewer on a given subject to obtain detail insights and thoughts (Bryman 2012). In total, I took six semi structured in-depth interviews, four in the community level with the health In-charge of health institutions and two interviews with focal person of ASRH program in district public health office. All the interviews were conducted with the help of semi structure interview guideline and was later translated to native Nepali language (appendix 1) to make it easier. According to Bryman, semi-structure interview always help to keep the interview in a specific track and at the same time it allows to explore more on the issues regarding challenges faced by the health care providers. All the interviews were taken in their respective working places and entire interview process was recorded in tape recorder for further analysis. Each interview lasted between 45 minutes to 1.5 hours.

Focus Group Discussions (FGDs)

FGD is a group of individuals selected and assembled by researchers to discuss and comment from their personal experience in the subject of research. This technique helps researchers to emphasize a specific theme to be explored in a group interview and can give diverse explanations to a

phenomenon in question. It may uncover the unexpected ideas from participants while interacting in group (Bryman 2012). Altogether, I did eight FGDs and one interview between the age group of 15-19 years girls. There is always a concern about how to create openness and trust in interviews. This issue become even more debated when it comes to Focus Group Discussions whether these fora are well suited for talking about sensitive issues. Participants for starting two Focus Group Discussions were randomly selected and from that FGDs girls told that they are more open to their SRH issues in front of their close friends within class. So furthermore, I gave more emphasis on choosing close friends within the class as the participants of each FGDs with the help of teachers. I carried out five Focus Group Discussions continuously and on 6th time I procured one interview as an experiment for effective data collection in order to get more fruitful result from girls. Testing was done through interviewing a girl but unfortunately she was so shy and didn't open to questions that had been asked. She limited her answers in between yes or no and sharing somehow very little experiences in this study matter. Afterwards, I continued data collection only through Focus Group Discussions. All the FGDs and interview were performed in schools where the participants study and that was recorded. For each Focus Group Discussions in community level, FGDs guidelines were prepared and translated to native language (appendix 2).

Observation

It was carried out throughout the entire process of data collection from beginning to the end. I observed health workers, adolescent girls, surrounding environment, health institutions and their services too. Supervision and monitoring checklist for ASRH program from District Public Health Office (Appendix 6) was eventually converted into observation checklist of this study and marked in it accordingly. Four observation checklist were filled in total including one from each health institution. In case of adolescent girl's observation was done on their skills of participating in discussion, the way they present themselves, their expression and surrounding environment throughout the whole process. Some of the notes were immediately made on note books during the observation time in field and some were noted down after returning home by recalling the whole scenario and incidents on daily basis.

Data Analysis

For the analysis of data, I used thematic analysis approach. Creswell explained thematic analysis as a process which starts with reading the collected data thoroughly in repeated mode and focusing

on the repeated topics, metaphors and analogies, linguistics connectors, similarities, differences and so on which will give rise to codes. After coding is completed, theme was formed from those codes which form the descriptions and try to answer the research. Then at the last interpretation of data take place (Creswell 2014).

In my analysis, I used the conceptual framework of access to health care (Levesque, Harris, and Russell 2013) as a point of departure. I decided to work separately with collected data from the health workers and the girls respectively through interviews and Focus Group Discussions. analysis procedure at the first stage began from the very first day of data collection in field. After returning from field note books and recorded tapes were followed on regular basis of each day. When data collection process was completely finished then all the tape recording were translated and transcribed into words in English and printed out. Interviewed data were first analyzed which was followed by Focus Group Discussions data and analysis of observation data was performed at last. Analysis of all the data went through the similar process.

Then after printing all the data, I read and re-read all the materials many times to get the overview of whole context. After continuous reading identified important prior findings were highlighted through different color pencils and I keep on making the personal notes at the very side of that highlighted parts. After going through all the highlighted and noted parts repeatedly, coding was done. I wrote all the codes on A4 size papers and similar codes were highlighted by same color. Later on codes were categorized into different group according to their colors. After categorizing all the codes of similar characteristics, I tried to fill the content into conceptual framework for further analysis to develop the relation between them and the research questions. Where content could not be added or where there was congestion of codes, I took this as an indication that this particular step of the framework was important which led me to discuss certain element of framework more than others. The elements that became important in my analysis were judgmental attitude, stigmatization, less freedom for girls, control of time, poor knowledge, strict gender role, poor knowledge and heath seeking behavior from focus group discussions of girls. On the other hand, elements like lack of awareness program, training of health workers, resources within the ASRH program and its implementation, socio-cultural prejudices, and health worker's behavior came up to be important from service provider's perspective.

Toensure rigor, I always prioritized the opinion and advices of my supervisor throughout the whole analysis process. At the same time colleagues and seniors with social science background provided their valuable inputs through various discussion and opinion sharing. In such, after hard process of going back and forth in analyzing process themes were molded out through those categories. All these themes were written and re-written down on A4 size papers and sticky notes to make sense on developing its relation on answering the research questions based on the theoretical framework of the study. Finally all these themes were then applied to describe the situation and conceptualized the findings regarding challenges and barriers for adolescent friendly SRH services in Kaski district of Nepal.

Ethical Issues

First ethical clearance was pursued from Norwegian center for research data (NSD) (Appendix 3). After that ethical approval was collected from Nepal Health Research Council (NHRC) to conduct the research work in Nepal (Appendix 4). In addition authorization letter was taken from DPHO, Kaski in order to perform the research in public health institution in community. In field, during data collection process through FGDs, schools were provided with official letter by the In-charge of public health institutions of that area.

Before conducting the interviews, I took verbal informed consent with the health workers whereas participants of FGDs were provided with a written consent form for their agreement on taking part in research study voluntarily (Appendix 5). Written consent form were signed by both the participants and researcher before conducting FGDs. I clearly communicated the objectives and purpose of the research to the participants before interviews and FGDs. In addition they were informed that they can withdraw from the study at any point of time without any explanation and their decision will be respected.

Then the interview and FGD was carried out in a place where participants felt comfortable as choice for selection of place was completely given to them. Confidentiality was maintained throughout the process as all information was tape recorded without including the names and places of the participants. During interview, at district, focal person insisted personally to include their name also so they mention their name during interviews. In contrast while interviewing health workers at community health institution their name and name of health institutions was not mentioned and recorded. I recognized them through their voice during analysis process. In case of

girls they were asked to only mention about their age, education level and marital status. All the data were securely stored in a personal laptop and its access was limited to researcher only. After the transcription and uses of data all the recordings were deleted.

Reflexivity

Reflexivity is defined as the process which attends or explain how the individual opinion or anything related to researcher have influences on the whole research process from beginning to end. It measures how the assumption or preconceptions of researcher affects the outcome of the study through its influences on data collection and analysis (Malterud 2001).

On qualitative method of study it requires researcher to specify her personal experience, assumption and prejudices which are related to study. The reason for selection of this particular topic had its own story behind it. After completion of bachelor degree on public health researcher volunteered for one years in district public health office of Kaski in 2013. At that volunteering time researcher got the opportunity to work with different sector varying from statistical section to family planning and safe motherhood throughout the office work and field visit. As a public health person researcher was aware of both negligence of ASRH program within district and its importance for girls. Likewise, sexual and reproductive health was the interest area of researcher from the very beginning of her public health study. In addition as being girl by herself and growing through similar environment regarding SRH made researcher more interested in this study topic of ASRH.

Sharing of same socio-cultural background, language, experiences and being researcher girl by herself with frank attitude might helped adolescents to open to the questions and it eventually made the data collection process through FGDs easier and fruitful. Alike being knowledgeable on ASRH encouraged girls to share their more problems and queries when their initially asked issues were correctly addressed by researcher.

From the side of suppliers researcher was familiar to working condition, health system, health facilities and health workers. These facts helped researcher to develop good communication with health workers and correspondingly HWs were found more comfortable to share the challenges with familiar personality. Similarly, researcher academic background as being a student of master level from Norway which is taken as the one of the best destination for study was appreciated by

HWs. This element made HWs to share their challenges and they were found curious to know the solution based on my experiences on health system of Norway.

Overall both the interviews and FGDs were carried out in supportive environment without pre-judgmental attitude where both parties were free to interrupt in case of disturbance or if further explanation were needed. In such it can be said that data collection process were effective and two-way communication. As being familiar with both the perspective of supply and demand side, researcher have her own knowledge and understanding about the barriers and challenges for the implementation of program. However, Findings and outcome of this research are constructed on the evidence based literature review and facts driven from this study rather than personal feeling of researcher.

Validity of study

According to Leung, appropriateness of the tools, process and data in order to achieve desire answer of the research question is known as validity is qualitative research (Leung 2015). In such validity concludes how truthful the result of the research is (Golafshani 2003)? Primarily this study was intended to explore the challenges faced by health care providers and barriers to adolescent girls in reaching ASRH services which is explanatory in nature and requires in-depth information on the subject matter. So based on the nature of study qualitative methods were chosen as research design in order to deliver the needed answers to the research questions which routinely increase the validity of study. Further multiple methods were used throughout the process of data collection and analysis in order to check or admit the accuracy of findings broadly known as triangulation (Wargo 2016).

Accordingly questionnaire for the semi-structured interview and FGDs were prepared by taking the reference of the various previous research papers as well converted to native language in order to eliminate language barriers. Moreover, different data collection techniques varying from semi-structured interview to FGDs to observation were done to extract more realities and truthful facts. All interviews and FGDs were audio tape which lead to have more accurate report of them through transcription. Researcher further conducted two more FGDs of girls in another area within same district but was not within the selection public health institutions. Similar opinion were shared by the informants so it can be said that data collection process were performed near saturation point where addition of new informants didn't put forward addition of any new information (Mason

2010). During the analysis of data suggestions and opinion of supervisor and colleagues were put on consideration so researcher strongly believed that it also helped to improve the quality of data.

Limitation of Study

Only the girls aged 15-19 years were included as participants where the girls below the age of 15 years were excluded. Additionally inclusion of drop-out girls and disable girls of same age group could have added variation in the study and possibly new explanations to the problem in question. Regarding the health provider's participation, only the opinion of in charge of public HFs were included and further inclusion of other health care workers of that HFs would have added more insights in to the study.

Dissemination of findings

This thesis is a part of the fulfilment for the master degree in International Social Welfare and Health Policy at Oslo and Akershus University College of Applied Sciences (HiOA). A full report of this thesis will be sent to Nepal Health Research Council (NHRC), DPHO of Kaski and the four public health institutions involved in this study. Provision of report to HFs in community will make it accessible to adolescents, school and other community. This study tries to explore the challenges ASRH providers face and barriers that hinder adolescence to reach these services. By knowing the realities behind the poor achievement of the ASRH program, it will help authorities to improve the health services and upgrade the policies in order to implement the program effectively in community. In longer term, this study can help in improving the health status of adolescent girls in the community. Furthermore, it will offer opportunities for other researcher to conduct studies to fill the further gap between supply and demand sides.

CHAPTER 4: FINDINGS

First, I will present the voices of the health workers, before I compare it with the opinions and experiences expressed by the adolescent girls in the Focus Group Discussions. Finally, I will discuss these findings up against my own observations from the field work.

A. Interviews with health workers

Interviews with health workers put forward tremendous amount of challenges they face during implementation of ASRH program in community. After analyzing all these interviews, health worker's challenges are categorized into three different aspects. One of the challenge is related to the resources within the program. Likewise, another challenge is categorized as the expansion of ASRH program in community and final category is related to the individual health worker's characteristics. There are many challenges, reasons and the consequences which attribute to these main three categories and will be elaborated more in detail.

1. Challenges related to resources within program

This section comprises of the challenges related to the resources within program. Almost all the health workers involved in the study pointed out lack of resources as the main challenge of the program. Resources not only entails the financial aspects but it cover wide range of resources accounting from skills, materials, modern technology, health workers and physical infrastructure of health institutions. Lack of these resources have direct and indirect effect on the ASRH program and make the implementation process even more challenging.

Majority of health workers talked about the importance of **training** for the development of their skills, knowledge and capability to address the problems of adolescents. They all believed that these qualities have direct effect on the implementation of services. Almost all staff mentioned that two days orientation was not sufficient for them and they are in need of more training to scale up their skills. None of the health workers in community were found to have five days standard training on Adolescent Friendly Services. Health workers from the community said that training should be intense and provide in-depth knowledge. They further added that training should be specific and make them able to solve the problems of adolescent along with proper suggestions. So that it will help to improve the perception of adolescent towards their sexual and reproductive health.

"ASRH is not only the health problem. In future it might linked with social issues so HWs should be equipped with necessary skills to deal with that." ……. "HWs should be trained to make them compatible enough to deal with problems……"

-Male, 42, Health worker

So in such, all the health workers stated lack of proper training as one of the crucial challenges faced by them which make their work more challenging. Insufficient training has direct effect in their competency and communication skills.

Both focal persons from the district and health workers from community revealed **instability of health workers** becoming challenging for provision of services. Health worker from district meant that this create problems in providing services in two ways. Firstly, they will lose trained health workers and secondly, people from respective community take time to develop friendly relations, on which trust has to be built upon. So both these effect the flow of clients to health institutions. One of the staffs said that due to the instability of health workers, the program is suffering from lack of sustainability. She said the one who got training will move to some other places and the ASRH program in previous place remain the same as before without any progress. It is found that blame of the discontinuity of program was limited within the instable health workers. While asking about the reasons behind not maintaining ASRH services report she said: "*There were other health workers at that time when program was launch but now they have moved to other places. That leaves the program where it was before."*

Throughout the whole study, **lack of financial resources** was found as one of the most widespread challenges from the perspective of health workers. Almost all service providers agreed on lack of funds for Adolescent Friendly Sexual and Reproductive health services. They mentioned lack of budgetary allocation as the core reason behind the dissatisfactory result of the program. While asking about the budgeting of the program, most of the health workers said they exactly don't know about the budgeting. They got money comprising NRs 30,000 (300 US dollar) and materials like table, chair, cupboard, hanging bag for flip chart, job aid books for the implementation of the program in the starting year.

"We have no funds at all. Funding is the main problem to continue the program. We don't have money to even offer them tea during orientation of program."

-Male, 55, Health worker

Due to lack of funds, health providers were unable to cover the large group of population. Coverage of large group of population often demands high budget but program don't have enough money to cover the mass. Scarcity of financial resources were found affecting directly to awareness program, co-ordination with school, community, media etc. In such, ASRH program was limited within small group of population in their area. It was found that adolescent friendly health institution were focusing only in one nearby school from their health institution. Health workers were found to be unsatisfied with school health programs and expressed that in the whole year there were only 4-5 school health program. They further added those school health program are not only for sexual and reproductive health education but they also need to cover nutrition, communicable and non-communicable disease too. One of the female interviewee mentioned allowances as motivational factor to health workers in work. She further says: "*….DPHO do not even have budget for staffs for conducting 10 school health program. What will they give to extra classes of ASRH?"*

It is found that availability of Information Education and Communication (IEC) materials in the health facilities is one of the most important characteristics for adolescent friendly services according to health providers. In contrast, findings of this study showed the lack of effective and useful IEC materials in health institutions. Availability of IEC materials were found to be poor in health institution where program started in 2013. There was not any ASRH booklets and flip charts. It was interesting to hear that one health worker took those IEC materials to home for her daughter and health institution is left with no ASRH booklet.

I have two daughters one in bachelor and another in grade 11. The elder one is mature enough to know about these things but younger one is more immature and silly. I let her read IEC materials and books related of sexual and reproductive health. So that she will know herself that what is right and wrong.

-Female, 45, Health worker

They mentioned they got one set of booklet and flipchart at the start of the program which was not enough to cover the population of girls in their areas. They pointed irregular and untimely supply from District Public Health Office as a reason behind shortage of IEC materials in their health institution.

"Nowadays District Public Health Office have stopped sending IEC materials. Some of them are in that corner but they are not enough. We need more IEC materials which is useful for young people."

-Female, 45, Health worker

District focal person mentioned the need for modern technology to disseminate information and education about ASRH regardless of reality in community health institutions. He mentioned about the influences of media on adolescent at present and possible good impact of media in disseminating information. It would cover wide range of adolescent population if public health institutions were able to use such media. He further added, Health institution lack proper IEC materials and mentioned about the importance of modern technology and techniques on spreading information.

Poor physical infrastructure of health institution was expressed as one of the problem by all health workers while providing adolescent friendly services. Out of four, three health institution were dissatisfied with the building of their health institution. According to them they don't have enough rooms and privacy maintenance during counselling process and it becomes more challenging for them to maintain privacy of adolescents in health institution. Within those limited room of 3-4 they have to provide all the services from general services to family planning, immunization, delivery, antenatal care, counselling at the same place. They said that due to lack of comfortable space, girls doubt in their privacy maintenance. Reality of privacy maintenance can be exaggerate by some of the dialogues of Health workers.

"Yes, we have room to counsel. We make the separate room by using curtain but other people in health post sitting outside can easily hear the voice coming from counseling room."

Female, 52, Health worker

'We don't have separate room as counselling room but when girls come we will make that room as counselling room." (At the moment health institution's helper was making lunch for all staffs in that counselling room. So basically that room turned into kitchen also when needed.)

Male, 42, Health worker

So all these challenges related to resources within the program were seen to affect the approachability of ASRH program.

2. Challenges related to placement of program in a larger organization

Placement of this ASRH program in a larger organization in the community has not been an easy job. This program is facing challenges from different aspects of community so it lacks achievement as targeted by the program in the beginning. There are challenges in implementation of the program while looking from programmatic context. At the same time, socio-cultural prejudices attack the acceptance of the program in society. In addition, lack of support from the other sectors of community makes it less popular among people.

For the success of the program, strong commitment to implementation aspect of the program is required to tackle all the problems in the way, but in contrast, one of the major challenge faced by this program is its **poor implementation**. There has been lack of proper planning of program in terms of its activities, programmatic strategy along with evaluation and monitoring process. Reasons behind poor implementation of program are described below:

Firstly, lack of plan of activities or guidance for the proper implementation of program was found to be the major challenge for health workers. None of the health workers in the community was confident about their future planning regarding ASRH activities. While asked on the planned activities for the implementation of program, all of them stated there are not such plan of activities to be done. They said they got two days orientation from District Public Health Office and basic help on materials to conduct program. After coming to health institution they accompanied one day of orientation program including members of health management committee, two school teachers, Female Community Health Volunteers of their community and some students. After that they mentioned no further particular activities were carried out for creating awareness in the community. While asked on effectiveness of one day orientation program, none of the staffs were confident about it. They said after giving orientation they have not followed-up those persons who took orientation so they were unaware about its effectiveness. All staffs were unsure about future activities, which give rise to the state of confusion regarding the direction of the program. It was seen that they were dependent on the District Public Health Office. Every health workers from community said that District Public Health Office have said nothing regarding what should be done further. Health workers from health institutions (2013) stated they are in great need of guidance to organize the program. One health worker from community said "*we don't have proper physical setting to start Adolescent Friendly Services. If the program would have been started with*

proper infrastructure and adequate institutional setting then it would be easier to tackle difficulties that might arises during its operation."

At the same time focal person from District Public Health Office conveyed *"yes, it's true that there is nothing considering what sort of activities need to carried out throughout the year. Government of Nepal wants to gradually upgrade all the health institutions as Adolescent Friendly Services. In actual all the services are the same as before which were in health institutions. It's only about how these services can be made more adolescent friendly. It's about creating favorable environment for adolescent when they come to health institution."*

So in such, there is the clash of understanding between the health workers in community and district. In one side, health workers from district are arguing about ASRH program is same as before but need to provide in friendly manner. Whereas, health workers from community have a different opinion, advocating that they have no proper base for Adolescent Friendly Services.

Secondly, poor programmatic strategy of the ASRH program is making it challenging for implementation of program. Regarding it, one of the health worker from district puts forward his view in a very creative way which is enough to tell the whole story of gap between adolescent and public health sector of Nepal.

"We are in process and trying our best. There is gap because adolescent themselves have not told us what their exact problems are. They don't tell us but share within themselves. We have indirectly predicted their problems and started the program but unfortunately it is not as they have expected. They are one step forward from what we are doing. While launching the program after indirectly knowing their issues till that time they have move forward from us. Then our program expired. Talking about fashion it's like we are old fashion and they want new fashion. We are not in that situation where we can directly address their problem. If we sit in round table with them and design program immediately after identify their issues, then we can increase the usage but we take more than 1-2 years to implement their suggestions and launch the program. Till then they would have already moved far ahead of us. Then it faces again the problem of acceptance. There's a generation gap."

-District health worker

This shows the lack of programs that address the issues of adolescents directly which might not address the real need of adolescent. So this mismatch between the real problem and the programmatic strategy is one of the main reason behind low usage of the services by adolescent. Further, public health sector seemed lacking usage of new technology on providing services. Some of the health workers talked about the new technologies like toll free numbers, health Apps and use of digital media can cover large population.

While interviewing, all the staff demonstrated their unique view on service provision strategy. Almost all of them said *"We are here in health institution and people who come to us will get the health services."* It is found that health workers are expecting initiation from the receiver's side and expressed that they are responsible for providing adolescent friendly services to adolescent who come to health institution to use these services. It raised the question on what about the rights of all those girls who don't have access to come to health institutions? In such we can say that providers side have been in passive form and expecting users to be active in requesting these particular services.

At the same time, health workers from their stand point, were found to be aware of the insufficient implementation of community awareness program. In addition, they agreed on importance of awareness on availability of services for its usage. Also none of the activities were carried out beside the orientation program. One of the health worker and focal person mentioned the possible activities they could carry out in community within available resources.

We need to manage time for staff. Some staff will stay in health institution and 1-2 can go to schools. If health workers really want to make the change then it's not impossible to make adolescent friendly services popular between adolescent. If everyone come together to promote it then we can do it.

-Female, 52, Health worker

So it showed that the success of the program is not only down to resources. It is also dependent to the willingness of the staff to perform the services.

Thirdly, this study finds that measurement and evaluation of the ASRH program is almost absent in Kaski district. Although all the health workers were aware of the importance of recording and reporting none of the health institutions were found doing this. None of the health institutions were

found maintaining disaggregate data on usage of services regarding different age group. Health workers mentioned about lack of skill in preparing report and none of health institutions were found to have adolescent sexual and reproductive health monthly reporting form in their health institutions.

On maintaining recording and reporting one of the health worker from community said, *"We have not maintained separately. They are registered in out-patient department register. Focal person of this program has been transferred to other place. We need to collect the school health program report and should maintain adolescent health report but it has not been done. Health Management Information System (HMIS) 9.3 ask for the report of adolescent taking various services. But none of the report of adolescent has been maintained yet."*

Another health staff stated, *"If submitting report was made compulsory then we have to do it at any cost, but for now, they are not made compulsory…. We need to be trained to prepare report"*

-Female, 45, Health worker

After the issue of recording and reporting, health workers demonstrated poor supervision and monitoring. They felt program has been given least priority from District Public Health Office, so they lack guidance from higher authority. They further added if someone from District Public Health Office come to check the program and help in making report then it would surely increase the effectiveness of the program. It came to light that there was no supervision and monitoring of program once it get started in their health institution and can see clearly that the program has been neglected.

Socio-cultural prejudices were one of the challenges that had been mentioned many times throughout the whole interview. Health workers mentioned it as one of the most challenging factors for expansion of ASRH program in community and providing these services to girls are even more challenging. They said that this program has not been accepted fully by the community. There are many factors within our socio-cultural aspects which affect directly or indirectly on the program.

It is found that health culture of community have effect on the usage of the services. Health institutions is taken as the place to go after getting sick and lack the concept of going for collecting information without getting sick. They demonstrated the popularity of private health institutes in

community which have direct effect in the number of people coming to public health institution. They said people neglect preventive health services and give priority to curative services. At the same time it is often seen that people have bad impression regarding the public health institutes.

"People think we don't have good quality services because it's for free."

-Female, 52, Health worker

Health workers mentioned that generally girls visit health institutions for general health services like headache, common cold, and fever. In the current scenario, girl's visit to health institution for their menstrual problems and measuring weight has increased slightly but their visit for other ASRH services is still low. Among them the number of unmarried girls are younger than married ones. It has been found that female health workers were more likely to provide services to girls than male health workers.

"I have been working here for 2 years till now and I have not met even a single girl who come with problem related to menstruation also. Other sisters are also in this institution. May be they know about it."

-Male, 42, Health worker

Health workers strongly believe that sexual and reproductive health has been stigmatized in their society and making the process of adaptation of ASRH program in community more complicated. Most of the people in society are with traditional thinking and continue such traditional practices. They further added, flow of wrong message from generation to generation give rise to negative attitude towards sexual and reproductive health. They said that the program is not accepted in the community due to the lack of knowledge among parents about it. On this topic, one of the health worker elaborate, *"First of all people should take it positively. In Nepali community still there is no such environment to go to community and say freely about family planning devices and promote it among unmarried girls. Until and unless family understand about this program, it's really hard to succeed."*

Health workers believed that ASRH services should be taken as normal like other services. There should be acceptance of ASRH program in community so that it will reduce the mental pressure on adolescent regarding stigmatization of sexual and reproductive health. He further said that, *"Now in this generation we can't say that boys and girls don't know anything about sex. We should promote safety rather than ignoring this topic."*

Hence it showed the need to educate the community on sexual and reproductive health but in reality none of the health institutions were found having interaction with parents about their views on the ASRH program. While asked about involvement of family and community in this ASRH program, one health worker gave a realistic answer and stated, *"I can't accurately tell about it because we have not been to community regarding this program. Till this time we have not even reached out to one of the nearest school from health institution. We are not yet able to evaluate how the ASRH program is taken by family of students."*

Prevalent gender inequality in the society was found to be one of the strong reason behind making the process of adaptation of ASRH program in community more challenging for health workers. All of the health personal mentioned that gender inequality and gender role limited the usage of services by girls. They said communities have a harsh and judgmental behavior towards girls as compare to boys. One health worker gave example of smoking and said that while boys smoke people relate it with his behavior but when girl smoke it will related to her character.

One of the health worker described the situation of girl in society as "*They fear to share their things. In the current situation, society is not open towards the sexuality of not only girls but for all female regardless of their age. It's not easy for married and adult women also then we can imagine the situation and problem of adolescent. We still have traditional concept believing that young people shouldn't know more about sex before marriage. Fear of community is winning over the problem adolescent have. They have fear of discrimination from home and society. Due to patriarchal society, girls have more restriction than boys in all manners either it may be studies or health or society."*

In addition to this, decision making power over family planning were seen mostly on male partner over female partner in the community. One of the health worker shared the story of married women who come for family planning services in their health institution. Most of them request health workers to hide their status of using family devices from their husband. Sometimes women are forced to take out family planning devices from their body if their partners are going abroad for working. These examples explain about the depth of gender inequality prevalent in our society where women don't have full rights to make decision over their body and health. In such context, the socio-cultural factors were found to make the expansion of ASRH program challenging for health workers and were directly affect the acceptability and availability of services in community.

Additionally, **Lack of support from all aspects of the society** were seen as the main reason behind the low accomplishment of the ASRH program. Health workers genuinely feel the importance of school in increasing the awareness regarding sexual and reproductive health and services but were not successful in developing the concepts to students about using ASRH services. They said that ASRH is not the issue related to health only. It's multi sectorial issue. It is the issue of education, it is the issue of local development, and it is the issue of women empowerment. They said this issue is surely a part of health but it can't be covered by only health and this should be the issue of school, issue of family and community too. They further said issues of adolescent sexual and reproductive health should be pointed out at every level of our societies from families to communities, schools, cultural aspects to religion. Health worker from the district said health sector have to take the lead on it because this issue is more related to reproductive health and rights but it's not possible to address individually by health sector. According to health workers, they had started the program in health institution with all the health services but also receivers of those services don't visit health institutions as expected. Then all these issues are not anymore related as only health issue. This is the cross-cutting issue, multi-dimensional issue and every sectors should have interest in it. Health sector have the major responsibility and should be responsible enough.

Focal person from district said, *"If service receivers don't use the services due to their social, religious, economic reasons then we can't limit the problem by saying it is just a health problem. School should promote the availability of these services in health institution. At the same time family should also convey the message of importance of services regarding problems at this age. It is not only an issue of health. It should be seen from the perspective of development, education, empowerment and development too. It can't be addressed by just one sector but truth is that role of health is crucial."*

3. Challenges related to individual health workers

This section comprises some of the challenges related to individual health workers who are providing adolescent friendly ASRH services from their health institution.

Knowledge about ASRH program was poor among health workers in community. When asked about the importance of ASRH program for girls all the health workers shows positive attitude towards it but most of them explain ASRH as equivalent to sexuality. Some of the quotes are

presented below which will explain about the knowledge of health worker in sexual and reproductive health.

Now in this generation we cannot say girls don't know anything about sex. ASRH is not only the health problem. Premarital sex, sex education is not allowed in our society. So all the services of ASRH can't be easily acceptable in community.

-Male, 42, Health worker

In my opinion this ASRH program is not fully accepted by the community. If the community is educated then will be quite easy. Still it is hard to talk about these things. People think sex should be hidden. It is not the matter of which people want to talk in public. They don't want to flash their sex life.

-Male, 55, Health worker

While talking about ASRH program health workers show concern on maintaining privacy and providing services to girls regardless of their marital status. Overall, it has been seen that ASRH program is least prioritized in health institution and health workers also have less experience in solving the problems of girls because the flow of girls in health institution is very low. At the same time, health workers mentioned about the need of more knowledge and training regarding ASRH program.

Health workers were found **struggling in understanding adolescent** and their needs. According to health personals mostly girls are shyer than boys and couldn't express their feelings easily due to their introvert nature.

"They feel very shy. When they come simply for measuring their weight also, they don't come directly inside. They stand at the side and we have to ask them the reason for coming. After that they will laugh first and try to tell. Within their group also there are some who are more talkative and smart. Girls usually are not out spoken about SRH problems. So friends often play the role of communicator between HW and patient. Friends of them tell about their problems."

-Female, 45, Health worker

Health workers found girls non-expressive in nature regarding their health problems due to fear of spreading their personal issues in community. In such a situation, health personal were unaware of

their real problems, which create a gap of understanding between providers and receivers. At the same time due to lack of proper training, health workers were found lacking skills of identifying problems through communicating with them. One health worker said, *when we take class on SRH during school health program they don't respond at all. They just stay back and listen. They say nothing about the use of services.*

-Male, 55, Health worker

During interviews with health workers, they seem to be unaware about their **judgmental attitude**. Some of the coding from interviews are presented below;

"Once 16 years old girl who came here with her mom in our health institution, it was a rape case and she hadn't told anyone. When they came she was already 16 weeks pregnant. …. If this kind of things spread in society then it will be impossible for her to get married in future…. I counsel her to find that boy and claim money for treatment and further nutrition….. That girl is bad. It's her deed. …. May be they have physical relation with the permission of both of them."

-Female, 45, Health worker

It's too funny when boys of grade 7-8 comes to take condoms.

-Female, 45, Health worker

"Most of the adolescent have phone and been always engaged in mobile when we see them in bus also. The way of their talking and involving in Facebook shows that they have partner but they say 'no' when we asked them about their partner……..To manage their fashion and mobile fee I think they have been involved with someone…."

-Male, 55, HWC

So in such we can say that health workers were massively suspicious to adolescents regarding their sexual and reproductive health condition, health seeking behavior and even their living condition. They have been blamed as a bad girl while coming to health institution in search of safe abortion care, some as too young for using services and some on using social media. So overall judgmental attitude of individual health workers were found on adolescent sexual and reproductive health..

Lack self-motivation on providing sexual and reproductive health services were found as one of the challenges related to individual health worker which was affecting the proper implementation of program. While asking about the major reasons behind girls not coming to health institution, 'they don't know about the availability of adolescent sexual and reproductive health services in our institution at all" was the first response to my question by all six out of six health workers. In such they know lack of awareness about available sexual and reproductive health services within the girl population. So awareness among girls need to be prioritized but reality was different. None of the health institutions were found to be conducting adolescent sexual and reproductive health awareness program in the period of last six months in their community. At the same time their statement were like,

"District Public Health Office don't even have budget for staff to conduct regular school health program, what will they give for extra classes of ASRH?

-Female, 45, Health worker

"If submission report of ASRH would have been made compulsory we have to do it in any cost but for now they are not made compulsory."

-Female, 45, Health worker

"We have not done anything yet to make it popular among adolescent."

-Female, 52, Health worker

"It (ASRH program) was like this before and remain the same in future too."

-Male, 55, Health worker

B. Observation of researcher on service provider's side

I used the supervision checklist for Adolescent friendly services in health institution by government of Nepal (Appendix 8) as my observation checklist. It is an actual supervision checklist which is usually used for the supervision of health institution in community by health workers from district or from family health division. I used it as the tool of observation through the entire process of data collection. Health workers and their belonging health institutions were observed throughout the study process in field. Observation was done on management and delivery of adolescent friendly services regarding their sexual and reproductive health in health institution by health workers.

Table 2: Observation check list of health institutions

SN	**Assessment Criteria**	HI-1	HI-2	HI-3	HI-4
A	**AFS Management**				
1	The AFS logo is correctly displayed	No	No	Yes	Yes
2	The opening times of the AFS are made visible outside the HF	No	No	Yes	Yes
3	AFS has been promoted in the past 6 months through linking with other institutions (schools, youth clubs, child clubs etc.) and peer educator	No	No	No	No
5	The monthly reporting of use of services by adolescents is done using the given format	No	No	No	No
6	The HF displays user statistics at the HF using the given format	No	No	No	No
7	HFOMC minutes show that adolescents have participated in the meeting as an invitee.	No	No	No	No
B	**Delivery of AFSs**				
8	Separate opening hours for adolescents at least once a week are in place	No	No	No	No
9	The health facility is clean and there is drinking water	**Yes**	**Yes**	**Yes**	**Yes**
10	Privacy when counseling or treating adolescents is maintained in the health facility either in a separate designated room or through a curtain	Yes	No	No	No
11	IEC materials are displayed in the waiting room	No	No	Yes	No
C	**Assessment of service providers**				
12	HWs have received the training on ASRH through NHTC	No	No	No	No
13	HWs have received the two day orientation on the national ASRH program	Yes	Yes	Yes	Yes
14	The HWs have a copy of the ASRH flipchart	No	No	Yes	No
15	HWs report using the ASRH flipchart	No	No	No	No
16	The HWs have a copy of the Adolescent Job Aid	No	No	Yes	No
17	HWs report using the Adolescent Job Aid	No	No	No	No

This observation checklist is made for the assessment of adolescent friendly services in health institution through the assessment of three criteria including management of adolescent friendly services, delivery of adolescent friendly services and assessment of service providers on providing adolescent friendly services. While I evaluated the health institutions based on these criteria, all four health institutions failed the test and the condition of adolescent friendly services were found to be poor in all of them. In spite the fact that adolescent friendly health institutions building was

the first public priority, the condition were even poorer in those where ASRH program started from 2013. Availability of clean drinking water and two days orientation to health workers on national ASRH program were common in all health institutions. Apart from these two facilities none of the other services were common in all four health institutions. While observing on management side of Adolescent Friendly Services, only two new health institutions have Adolescent Friendly Services logo board which main purpose is to notify adolescent and the community that adolescent friendly services are available there. Implementation of the program were seen very poor in all health institutions in such that none of the health institutions were found promoting Adolescent Friendly Services within past six months of time in collaboration with other sectors like schools, youth clubs or other association in community. Similarly monthly recording and reporting by using Adolescent Friendly Services format provided by the ASRH program were found null in all health institutions at community level. Indeed, lack of availability of statistics related to adolescent's usage of services was one of the weakest point observed in all health institutions.

The involvement of adolescent in health facility organizing and management committee (HFOMC) was found not to be in practice. In addition, only one health institution was found displaying IEC materials in waiting room and availability of IEC materials were found limited within the all health institutions. Out of four health institution, I didn't noticed Job aid and 8 IEC booklets in three health institutions. Basically all health institutions tend to have separate room for counselling but maintenance of privacy was always questionable because they have 3-4 rooms to provide all the essential health services from health post level. Only one health institution was found to be having separate designed room for counselling.

One of the major problem was issue related to training. None of the health workers received the 5 days training on ASRH through national health training center. I didn't find any of the health institutions adolescent friendly in the real sense according to the ASRH program implementation guidelines. During interviews, all the health workers said they prioritized privacy maintenance and timely services in their health institutions but both of them were found doubtful while observing.

Regarding timely services, here I want to add a story from my field work "*while I was in one of the health institution, in between the interview, one women probably aged 40-42 years, come and*

asked health worker to call lab person and said that she has been waiting for 30 minutes for her blood test. The health worker who was giving interview to me told her to wait in waiting area and conveyed that lab person will come in five minutes. Again maybe after 45 minutes the same lady came and said she will return home because she is tired of waiting." This incident raise the question about the timely services of that health institution and its impact on the perception of that person towards that health institution.

Throughout the whole observation period most of the health workers were seen as judgmental towards adolescent and their problems. Every time while sharing the incidences related to sexual and reproductive health of girls with me, they were trying to get positive response from me on their activities they did during that situation. Implementation of program were seen really poor and none of the awareness program were carried out in community after one day orientation to limited person of community. All the health workers were complaining about the lack of resources but at the same time some of them mentioned about the activities they can carry out within available resources.

At the same time, I realized the lack of research activities regarding ASRH issues in their area. Health workers were found doubtful and unknown about the health seeking behavior of girls in their catchment area. Some of the health workers were wondering about "*where girls go to take the services or either they take services or not.*" I was conducting interviews with health workers at their respective health institution but didn't get the chance to meet the adolescent girls visiting health institution regarding sexual and reproductive health. Overall from the observation of health institutions and health workers, ASRH program was found least prioritized by district and community level health institution and adolescent friendliness were even doubtful during entire process.

C. Focus Group Discussion with adolescent girls

This section put forward the barriers faced by girls in utilizing the adolescent friendly sexual and reproductive health services in public health institutions in their community. Findings of this study shows numbers of barriers accounting from individual level to society. Girls carry some of the issues within themselves which act as the barrier for the utilization of adolescent friendly services. In addition there are issues arising from family, health sector, school and society which act as main barriers for adolescent girls in not utilizing services.

1. Barriers related to individual

Some of the characteristics of girls hinder themselves from accessing health care. This study came up with some of the findings that act as the barriers for girl themselves. Firstly, girls were found having poor knowledge on sexual and reproductive health. Secondly, health seeking behavior regarding sexual and reproductive health were tremendously poor and lastly girls lack empowerment on decision making on their health. All these barriers are inter related and orientation of one barrier increases the chances of existence of other barriers. For example having poor knowledge somehow give rise to poor health seeking behavior and lack of empowerment of girls on their decision making ability and vice versa.

Throughout the whole study time in field during the Focus Group Discussions, girls were found having high curiosity on sexual and reproductive health which were the result of unanswered question of all of those curiosities. While asked on sexual and reproductive health, most of them said it cover the area of sexual relationship and menstruation. Most of the girls have experiences of painful menstruation period whereas extra vaginal discharge and untimely menstruation were also major issues within them. None of them were found being aware about the reason behind these health problems. There was difference in the level of curiosity among girls of different age groups. In one hand, girls who were in grade ten of age 15-17 years were curious about the problems related to menstruation and meaning of true love. Some of them complain that they don't have regular menstruation and have it thrice a month or some have once in a three month. They were curious about the effect of pain killer used by them during menstruation, reason for painful breast and were asking why their menstrual blood become black in color. I was surprised by the question asked by one of the girl aged 16 on relation between masturbation and pregnancy. She asked me: *Sister, does masturbating cause pregnancy?* While on the other hand, girls who were in grade 10+2 of aged 18-19 years were more curious about the sexual relationship, consequences of physical relation, love affairs, contraceptives and avoiding pregnancy. Regarding prevention of pregnancy most of the adolescents showed more interest on natural way of avoiding pregnancy rather than using contraceptives which figure out the risky sexual behavior of girls. At the same time they were found curious about consequences of physical relation in young age. One of the girl of aged 18 asked; *"....People say that we shouldn't make physical relation in young age but if a girl at 15 get married then she have to do sex with her husband. If they don't use safety measures then what will happen?"*

In such majority of girls **knowledge on their SRH was poor**. Girls said that they can't share all of their problems with their mothers. They share issues related to menstruation with their mothers and choose their friends to share rest of the other problems. They said problems within girls remain circulated within them without getting solved because all of them have same level of knowledge regarding their sexual and reproductive health. During Focus Group Discussions all girls stated that sexual and reproductive health awareness are important to them but they have limited access to information. They said their friends are main source of information. Other than friends, they get some of the information from books, television, Facebook, websites and from mother especially on menstruation. They further clarified that none of them were able to address their questions and problems completely. Within all four catchment area, only girls from one catchment area were found to be aware about Adolescent Friendly Services in health institutions of their area whereas the girls from rest of other places even didn't heard about adolescent friendly services. Girls were found unaware about what kind of ASRH services are provided by health institution. One of the girl was surprised knowing that they can get condoms from health post free of cost as she was unaware before. In this way, due to poor knowledge on their sexual and reproductive health and available services in health institution, it is surely affecting their ability to decide what is best for them.

Poor health seeking behavior among the girls was found as being one of the main reason affecting the utilization of health services. Girls said they are introvert and too shy to ask their question and express their feeling regarding sexual and reproductive health. Public health institutions of their community seemed to be unpopular among the girls when they have issues related to their sexual and reproductive health. One of the participant aged 18 years in Focus Group Discussions further added that; *"Health facilities never comes to my mind while I have quires related to sexual and reproductive health."*

Majority of the girls said they fear to go to health institution without being sick and showed the anxiety saying "*what will doctor say if I go there just for collecting information on sexual and reproductive health without being sick."* It is found that very few girls went to health post while they had painful menstruation and general health problems but none of them were found going there for seeking other sexual and reproductive health services. They even said they are scared of leaking the private information to family and society from health workers and consequently it may

have bad consequences. So they often chose to share their problems with their friends rather than health workers. In most of the girls "wait and see" attitude were more prevalent than going to health institutions for seeking health care. One girl of aged 17 years shared her experience *"I have a problem of extra vaginal discharge from the very beginning after my menstruation started. First I was too shy to share with my mother and my friends too. Then I shared it to my mother and she said that she also have same problem and that it will stop after some time. It didn't stop so I shared with some of my friends and get to know that some of them also have similar problems. So now I realize its common in all girls so I take it normally nowadays."* This statement of girl pointed out the two issues. One is the attitude of "wait and see" is passing from one generation to another and high prevalence of sexual and reproductive health issues within the group of adolescent.

Girls seemed to be **lacking empowerment** within themselves regarding making decision for their health. They said they need someone either it be mother or friends to go with them to health post for general checkup also. While asked about the consequences of unsafe sex, girls were unsure about what kind of actions need to be taken. Within 27 participants three of them were married and one of the married girl of aged 17 years said;

"I sleep separately for 20-22 days after getting menstruation and don't agree to sleep with my husband during that time. All of them (husband, parents in laws and her own parents) want me to make baby now but I'm saying no. My husband don't agree on using contraceptives. I have irregular menstruation before marriage also. At that time while I get irregular menstruation I felt worried because my mother used to ask so many questions if I did something wrong and now I used to get worried thinking that if I am being pregnant in real. So I want my husband to go abroad for 2-3 years."

While I asked her about the reasons for not using contraceptives and its consequences, most of her answers were "I don't know". On my questions regarding what will she do if her husband and family strongly argue on having baby then her answer was *"I don't know. If all of them are happy with having baby then I think I have to make baby for their happiness. All the time they tell me to have baby first then study later."* In such most of the girls were found unsure about the consequences and lack empowerment to take right decision for them. At the same time, it pointed out the issue of unmet need of family planning as she don't want to have baby now and not using any kinds of contraceptives. This scenario explained how the socio-cultural factors affectthe level

of empowerment of girls and found that it is deeply influenced by the dominancy of husband on sexual matters and social pressure of family on having children.

Overall these characteristics of individual girl were found having great impact on their ability to perceive, seek, reach and utilizing the adolescent friendly sexual and reproductive health services in the public health services of their catchment area.

2. Barriers related to family

Throughout the whole study family environment were found highly influential on not utilizing the sexual and reproductive health services by girls. Adolescents talked about traditional customs and beliefs, stigma related to sexual and reproductive health and strict gender roles for them in their society. It was found that attitude towards all these factors immensely varies between parents and girls by analyzing their experiences. They stated that all these reasons are responsible to discourage them to reach ASRH services in health facilities.

All girls expressed their dissatisfaction on the **traditional customs and believes** of their family regarding the menstruation. In some family mother were found to have very strong belief on tradition and girls need to follow them otherwise they will be treated badly by their parents. One of the girl shared her experience on menstruation;

"During menstruation it pains a lot and lasts for very long period of time. In uneducated family during menstruation girls suffers tremendously. During first menstrual event of her life she will be send to someone's house to stay because people believe that she shouldn't see the male members of her family. That tradition has decreased nowadays but still we are not allowed to go to kitchen and using our bed during our period. We are not allowed to touch plants. People think it will die if we touch it. Once I touched some flower plants in my home but it didn't die after touching also. We are not allowed to eat banana, papaya, cow's milk and other dairy products. We have to eat our food sitting out of kitchen. All members eat sitting inside and we have to sit outside."

This shows that the traditional customs and beliefs have the negative attitude towards the sexual and reproductive health of girls and associated with poor outcome. Girls stated that they have been isolated from the family at the time when she is in most need of care, better food and proper hygiene. It is found that girls are more often encouraged to hide their menstruation status and these factors were seen highly influencing the health seeking behavior of girls. In addition, majority of

girls were dependent on their mothers for the solution of the complications that come along with menstruation rather than seeing health workers.

Adolescents stated that their **sexual and reproductive health is being stigmatized** within their family and demonstrated their parents have negative attitude towards sexual and reproductive health. Girls accept the fact that they have never consulted about other sexual and reproductive issues rather than menstruation with their mother. They said their mother don't want them to know more about sexual and reproductive health and thought that they will get spoiled after knowing more about it. Some of participants avoid to study their reproductive health book in front of family members and try to read it when she will be home alone. They said if their parents saw them reading those stuffs they might misunderstand them and doubt if they are doing something wrong with boys. Girls added due to the negative attitude of parents they fear to share their problems with others but not with their parents. Some of the girls put their opinion on not going health institution stating their family will get angry if they know about visiting health institution and sharing problems. So in such, adolescent concluded that if they don't pay more attention on knowing about contraceptives, sexual relation, sexually transmitted diseases, pregnancy, abortion etc. then they will be taken as innocent girls otherwise the way of looking at them won't remain same. So in this way, the stigmatized perception of parents on adolescent sexual and reproductive health were found affecting the activities of girls in terms of accessing health care and collecting information on sexual and reproductive matters.

Through the Focus Group Discussions, it was found that family have more **strict gender roles** for girls. Family have control over time and decision regarding life events of girls. Almost all the participants complain that they have more time limitation and less freedom than their brothers at home. On one hand girls need to return home at time from school and need to stay at home all the rest of the time after school. On other hand, they have more household chores like cooking, cleaning home, washing clothes so don't have spare time for other things. Girls seemed to have equality when it comes to going to school as their male siblings from family but not on other aspects of life. Regarding the life events of girls from choosing life partner, marriage to having baby is on the hands of family. Family are the one who have decision making power over girls. They said most of family have their own definition of conservative gender role stating how girls need to act or what they allowed to do. Girls further added there is issues of trust and understanding

between them and their parents and they need to be answerable to each and every questions of their parents. One of the participants stated that *"parents decide on where they can go or not. Furthermore parents even decide with whom they can talk or not. Parents try to make strict rules for us to prevent problems but it resulted into more severe negative consequences. So often, if girls have boyfriend also they lie to their parents and meet their boyfriend otherwise mother will shout at them."*

So strict gender role within the family were found to control the time of girls at the same time define the acceptable activities of girls. Access to the health care from health institutions was directly affected by the control over the time of girls by family and girl's positive attitude towards learning of their sexual and reproductive health were not found within the acceptable category of activities. Hence, knowledge level of girls on their sexual and reproductive health along with health services using pattern were seen highly determined by gender roles in society.

3. Barriers related to health sector

Most of the adolescents said they rarely visit public health institution in their community. They further said if they go it's only for general health problems, measuring weight and menstruation pain. So in such visit to health institution for other ASRH services were very poor. Their explanation on reason behind not visiting public health institution in their area can be express in terms of perception of health institutions and its services, health worker and programmatic view.

Utilization of sexual and reproductive health services by majority of adolescents were found affected by the **perception of public health institution** in the community. They said most of the people chose private sector and ignore public health institution due to **poor quality of services**. Some participants further added they have same medicine for all health problems and have long waiting time. They complained about lack of suitable environment to share their problems in health post. Some of the girls said they felt uncomfortable to share their problems with health workers in front of other people because they can listen to them. In contrast, some of the adolescents simply said they don't visit health institution because they are not aware about what kind of services are available in those health institutions.

Throughout the whole study **health workers behavior** was identified as one of the main barrier for services utilization from public health institution. High level of dissatisfaction were on health

workers unfriendly behavior. Adolescent said they need more informative and competent health workers who are able to solve their problems and provide good counselling. Gender and age sensitivity in health institutions was found important for girls. One of the girl of 17 years told *"some of the health workers are man and some are too old to share problems. I feel shy to talk with them regarding my problem. It feel like talking to parents and can't share my problems."* Most of the girls complain about health workers as being judgmental for unmarried girls and asking too many unnecessary questions as reason behind not visiting health institutions. In addition, girls expressed, they fear to share their problems with health workers and doubt their confidentiality would not be maintained.

Power imbalance between health worker and girls also seemed to be one of the reason of dissatisfaction for girls. One of the participant share her experience "….*Some of them get angry immediately. I went to Primary Health Care Centre last month to check blood for hepatitis because I had severe headache. I asked them to check for hepatitis infection. In return he replied harshly to me saying that how I knew that its hepatitis. I told him I'm not sure. I have some symptoms that's why I'm coming here to test. Then he angrily told me to go to corner where I can get my blood tested. I found them quite harsh and impolite."*

Girls said they need to be treated with respect and health workers shouldn't make fun of their problems in order to trust them. Regarding making fun one girl of aged 16 years recall an event *"…once I had a very bad lower stomach pain due to menstruation and went to HPs with some of my friends from school during break time. I asked doctor why it always become painful then he loudly said get married then everything will be fine. Everyone in that room hear it and laugh. I felt so bad and I seeing that health post after that."*

While talking on programmatic view of Adolescent Friendly- sexual and reproductive health services, majority of participants were found **unknown about the program and available services in public health institution**. They said there is lack of awareness program in their school and community and expressed dissatisfaction on health workers for not making effort to reach them. In such lack of awareness program on ASRH were one of the major barrier for less utilization of the services in public health institution. As mentioned above none of the girls were found who didn't have interest on knowing about their sexual and reproductive health. All of them had positive attitude towards the importance of awareness on ASRH in order to avoid negative

consequences and being prepared for sexually healthy life in future. One interesting opinion were found among the girls. They strongly preferred health workers to come to them first either it would be in school or community for awareness rather than them going to health institutions. Majority of the girls agreed on their preference regarding group awareness rather than face to face conversation. They said girls need to be aware first then after that it will be easier for them to visit health post.

4. Barriers related to school

Some of the factors like stigmatization of sexual and reproductive health, no availability of gender friendly health teacher, gender inequality within class, lack of IEC materials on sexual and reproductive health within school are found to be discouraging for girls for their quality sexual and reproductive health and have somehow direct or indirect impact on utilization of ASRH services.

Some of the girls were found feeling shy to share their problems with male teachers and even don't ask their queries related to sexual and reproductive health of their curriculum. In contrast some of girls said that even health teacher lack sexual and reproductive health knowledge and don't provide proper solutions of problem. **Gender inequality** were prevalent in every classroom where boys seemed to act superior to girls and make fun of them. One of the girl said *"…when we have class on reproductive health, our class seems to be very awkward. Teachers usually feel shy to teach, boys keeps on laughing and feel energetic to ask questions on reproductive organ of girls and menstruation. Whereas all girls feel shy and put their heads down during the whole class."*

One of the girl shared her experience on menstruation and said that they need to bear **double burden of pain during menstruation** and further said "*….The thinking of people on menstruation is so different. They look at us very differently. Everyone knows it's natural but still they don't leave any chance to tease us and pass comments and make fun. As a result, we continue to bear pain during our period and need to hide from others, which enhance our pain into higher level."*

Stigmatization of SRH and pre-judgmental attitude of both teacher and male counterparts in class were stated as the reasons to hinder girls for raising questions regarding sexual and reproductive health in class. In one Focus Group Discussion, one girl of aged 16 said "*….I usually don't ask questions in class. I listen to other people raising questions and listen to the answer of*

teacher. If I asked questions about physical relation or family planning devices like pills or condoms everyone will think that I'm using them and think of me as a bad girl in class."

Awareness and availability of IEC materials regarding ASRH appeared to be very poor in school. Most of the schools were not found gender sensitive. Firstly as they lack availability of sanitary pad in emergencies and secondly they lack proper management of disposal of sanitary pad after use. One of the girl during FGDs "… *While coming school in morning we use new pad and change it in evening after getting back to home from school. Sometimes, during 2nd or 3rd day we over bleed and it make the condition so uncomfortable."*

5. Barrier related to society

Adolescent girls explained about some of the significant barriers in society which limit them using services. Barriers related to society were found as root cause for all the other barriers at different level varying from individual, family and school to health facilities level.

All of the girls were found having negative impression on society and stated that they fear of society. They fear about the **judgmental attitude** of society which have high impact on their health seeking behavior in a negative way. One of the girl said …. "*In spite of involvement of both boys and girls, we are the one whom are taken as doing the mistakes. Boys are free. So we don't feel like sharing problems. Once society know that girls are involved in premarital sex or have child before marriage then they won't accept her. They will be judgmental to the character of girls."*

Another girl in group discussion further added... *"Main barrier is the society. If girls go to health institution also and want to talk secretly to health workers. Then they will surly judge you keeping in mind that I might have done something wrong without even knowing the reality."*

Participant girls stated that most of the girls in the society don't open up with their sensitive problems related to pregnancy, infection in private parts, abortion and so one. They said otherwise people think of them as being characterless and try to isolated them from others believing that they will spoil other friends also. Girl's visit to health institution for collecting information on pregnancy, contraceptives measures, sexually transmitted diseases were found rare and they stated there's always high risk of spreading the things in society if someone listen them having conversation with health workers. Fear of society and family in the subject matters of sexual issues seemed to be problematic for girls and impede them using the health care services. Some of the

girls shared persistent pressure and fear of family ruin the quality of life and one of the girl elaborated her fear as *"... I always keep on worrying what will happen if my love affair spread from my school and reach my home?..."*

Adolescents described that to avoid the **blame game** on them usually most of the girls keep quiet and stay back due to lack of supportive environment. It might be in case of physical abuse and harassment in school or public transportation or somewhere else. One of the girl said… "*They fear more about what people will say about me. So rather than taking action they prefer to hide it. For physical abuse also people blame girls. They think that all this happens due to girl herself. They think that she was characterless that's why it happens to her. To avoid all these things it's better to hide and girls do the same. They just hide it and take a step back approach."*

Strict gender role in our society limit the freedom of girls and consequently it affect the seeking and utilizing of sexual and reproductive health information and services. Girls expressed that society want them to be more sensitive and keep shyness as jewelry. They further added their patriarchal and male dominant society doesn't want them to be outspoken and confident enough to make right decisions regarding their sexual and reproductive health. One of the girl stated…. "*If boys have girlfriend then people take it normally but when it comes to girls it's always relate with character of girl. Small mistake of girl is taken as blunder made by her and people relate with prestige of society. If daughter do something wrong then society directly target family and their values. So girls are unable to share problems with doctors and hesitate to ask about their curiosity. Girls always need to fear of spreading bad rumors about her. There is more restriction for girls from houses also. No freedom at all. If they come home late by few seconds also then parents start to shout and ask unnecessary questions to their daughters."*

From this findings, it can be concluded that persistent gender role in our traditional society are not open towards the sexual and reproductive health of adolescent girls. In addition, positive attitude and interest of girls towards developing good knowledge on sexual and reproductive health was not accepted as the standard behavior of girls as expected in the society. So, girl's poor abilities in accessing sexual and reproductive health care were found highly altered by gender role of society by limiting access to information and services.

D. Observation of Researcher on service receiver's side

In the beginning girls were seemed to be nervous and unsure about what to share and what not to share. During starting of Focus Group discussion girls were not fully opened to my answers and limited their answer with yes or no or very short answer. Then I gave them some of the examples based on my experiences on my adolescent period. So after I shared my experiences, the participant girls started to open towards the research questions. While Focus Group discussions were carried out within close friends then participants were found more comfortable sharing their problems, experiences and opinion.

I was new to their school so I requested them to choose the comfortable place to them for Focus Group discussions. Most of the adolescents were curious about what I was going to ask them. Once I explained them about my research study and way of collecting data.majority of them asked if they could change the sitting place and choose the new one. So new area was chosen keeping the privacy on mind. During Focus Group discussions in some of the place teacher or other children of school accidently or intentionally was coming towards our group discussion. I found it interesting to see that as soon as participants saw the other person they just stop discussing on subject topic and try to talk something else.

There was one Focus Group discussions which we did on nearby playground of school after their school time was over at 4 pm. I clearly remember that after introducing each other and explaining them about objectives of my research study and we were just supposed to start the focus group discussion, one of the participants got the phone call from her mother. Her mother was not at home that day and were gone for shopping that day. So her mother asked where she was and did she reach home or not? She mention about having Focus Group discussions and will go home after 20-30 minutes. Her mother was not convinced by her and I also need to talk to her mother at last. It made her call three times to get convinced that her daughter is with me and with her friend and it was just for research process and she will be home after 30 minutes. I recall it as a funny incident but at the same time it was related to the daily life of adolescent girls which directly or indirectly limit their opportunity on receiving health services and information.

CHAPTER 5: DISCUSSION

What are the challenges and barriers to keeping girls from receiving sexual health services?
There is a demand for sexual and reproductive health services in Nepal, while there is a low utilization of the existing services by adolescents. At the same time the adolescent friendly SRH program has stated that there are challenges related to implementation of the program.

The main purpose of this study is to identify the factors explaining why girls do not use adolescent sexual and reproductive health services provided by public health institutions in the community. I wanted to look at the issue both from the point of view of the provider and from the adolescent girl's point of view. The findings of this study elaborate the various challenges health worker face during the implementation of the ASRH program. Lack of resources within the program, lack of prioritization of program and characteristics related to individual health workers were the major challenges for the ASRH program. In addition, the barriers girls experience while using ASRH services is also well explained by the informants of this study. Girls experience barriers from different aspects of society including their own family, school and from the health sector itself.

For the analysis, I have used a conceptual framework of access to health care developed by Levesque, Harris and Russel (2013). Access is here defined as the opportunity to have health care needs fulfilled through a process from identifying, seeking, reaching, using and finally meeting the needed health care services. It further explains how both supply and demand sides of health care affect this process. This is crucial for recognizing the challenges and barriers for access to health care. The discussion will be based on this conceptual framework of access to health care (see figure 1).

The authors state that in order to improve the health status of the people, one should focus on increasing utilization of health services. By integrating dimensions and determinants of both demand and supply side and explain their effect during entire process of access to care, this conceptual framework help to identify and minimize the gap between a health care program and the population (Levesque, Harris, and Russell 2013). Using this framework in my study will help to identify potential challenges and barriers for access to adolescent sexual and reproductive health care that hinder the utilization of services.

In this final chapter I will discuss the interaction between findings of the challenges and barriers identified in this study and the five dimensions of accessibility (Approachability, Acceptability, Availability, Affordability and Appropriateness) and five dimensions of abilities (Ability to perceive, Ability to seek, Ability to reach, Ability to pay and Ability to engage).

Challenges and barriers relate to each of the five dimensions in the model of access to health care give rise to poor adolescent sexual and reproductive health consequences. Below, the intersections between the theoretical model and the empirical findings are demonstrated under five main themes; 1) Perception of needs and desire for ASRH care; 2) ASRH care seeking; 3) ASRH care reaching; 4) ASRH care utilization and 5) ASRH care consequences. In addition, symbolic interaction will be incorporated throughout the process of access to health care. This provides a useful approach to see how shared symbolic meaning in society influences the entire interaction between two sides of health care by affecting them individually or collectively.

1. What influences the perception of needs and desire for ASRH care?

Health institutions were found lacking awareness program on ASRH and available services. Lack of financial resources was found to be one of the major reasons for not conducting the awareness program. But at the same time health worker's self-motivation and lack of training were found associated with conveyance of very few awareness program in the community. In addition, absence of plan of activities were creating dilemma among health workers regarding the future direction of the program. Due to these reasons, health institutions fail to make the ASRH program familiar to the girl population and increase their knowledge on their sexual and reproductive health.

On the other side, Girl's poor knowledge on adolescent sexual and reproductive health were found directly affecting their ability to identify their sexual and reproductive health problems. It was affected by how girls interpret their health problems. Most of the girls were found sharing their problems within the limited circle of their friends, who were more or less on the same level of knowledge regarding sexual and reproductive health. Their attitude towards their health problems were defined by their group such that if other friends in a group have similar health problems, then that problem was taken as normal. The level of curiosity was high among girls but none has reached them with information or knowledge so their curiosities remain answered Majority of girls were found unknown about the availability of ASRH services in health institution as well as the knowledge regarding services covered by ASRH program was also very poor. In such they have

limited exposure to resources of information and sharing of poor knowledge and practices from generation to generation affect the ability of girls to identify their sexual and reproductive problems and needs. Similar findings was found by a study stating lack of adequate education and guidance on sexual and reproductive health leads to risky sexual behavior (Adhikari and Tamang 2009). So eventually, interaction between poor approachability of services and inability of girls in identifying their problems leads to poor perception of need and desire for ASRH care.

2. What influences ASRH care seeking?

From the perspective of health sector, its programmatic strategy was found as the major challenge. Combined with girls not accepting the provided health care, there seems to be a mismatch between the programmatic strategies of delivering services and acceptance of those services by girls. In one hand, health providers are focused on providing health services to those who visit the health institution. On the other hand, girls prefer health workers to reach them through awareness programs in their school and community. So there is a gap between the service provision and its acceptance. Girl's acceptability of sexual and reproductive health services were influenced by their perception on public health institutions and health workers. Firstly, most of the girls believed that public health institutions have poor quality as compare to private hospitals and showed their preferences towards private sector for health care visit. Secondly, girls find it difficult to share their problems with older health workers. Furthermore, stigmatization of ASRH program on community itself was the factor associated with acceptance of available services. The persistent traditional practices and cultural belief in our society stigmatize the ASRH services and believed that discussion on sexual matters encourage the involvement of adolescents on pre-marital sex (Regmi, Simkhada, and van Teijlingen 2010). So the stigmatization of ASRH program in community make the providers difficult to implement the program. At the same time, it reduce the acceptance of program by girls in fear of isolation from society.

Girls own ability to seek health care combined with low acceptability of health care define the poor health seeking behavior of girls. First of all, girls were too shy to share their problems related to sexual and reproductive health, at the same time adolescent were found lacking ability in making informed choices about their own health as similar finding to prior study in Nepal (Regmi, Simkhada, and van Teijlingen 2010).The lack of decision making capacity in girls resulted from the fact that as being patriarchal society most of the decision making authority is within the family

and husband for unmarried and married girls respectively (Puri, Tamang, and Shah 2011) Decision making capacity is rooted with the gender roles in family and society. Girls stated they has less freedom and more household chores to do. At the same time, gender norms differentiate the standards of behaviors and expectation for boys and girls and limit the outgoing activities of girls (Obare, Agwanda, and Magadi 2013) which limit the health seeking behavior of girls. These factors were found directly affecting their health seeking behavior. At the same time judgmental attitudes and traditional beliefs were found limiting the ability of girls to seek needed health care. Judgmental attitude associated with sexual and reproductive health expect girls to remain unknown about the subject matter of sexuality whereas traditional norms incorporate the flow of poor information from mother to children and have the attitude of 'wait and see' towards the health problem. In such society, the overall health seeking behavior of girls remained poor within which health seeking regarding sexual and reproductive health were even worse due to the fear of family and society (WHO 2012a) So, the inability to seek health services from girl's side and poor programmatic execution along with poor acceptance of health care services have lead to poor health care seeking behavior of girls.

3. What influences the ability to reach ASRH care?

The availability of ASRH services were found to be poor. One of the main reasons was the poor infrastructure of health institution, which raise questions on the quality of counseling and their ability to maintain privacy for the adolescent. Another crucial question was if adolescent friendly health institutions really are adolescent friendly? Using the official checklist for being adolescent friendly while I visited the health institutions and observed their adolescent friendly characteristics, I found that out of 17 criteria for being adolescent friendly only one criterion was filled by all health institutions. This criteria was cleanliness and presence of drinking water. This is not enough to make it adolescent friendly (see table 2) as compared to the criteria mentioned by the ASRH program implementation guideline of Nepal (FHD 2011).

At the same time, one of the major barriers pointed by all the adolescents were related to health workers. Health workers were found to be highly influential for access to health care as mentioned by WHO "conceptual framework of provider's influence on client utilization of sexual and reproductive health services"(WHO 2010b). Majority of girls showed their dissatisfaction regarding unfriendly behavior of health workers and mention that health workers ask too many

questions and make fun of them. Girls expressed they need to be treated with respect and maintenance of confidentiality will make the services more adolescent friendly to them (WHO 2012a). The present situation within the health institution in my study is that none of the health workers at community level have five days training, which was the basic requirement for providing adolescent friendly health services as mentioned by ASRH program implementation guideline (FHD 2011). Most of the studies state that training of the health worker is important for communication skills and quality services provided. So, lack of training was found affecting the availability of health services for girls (WHO 2010b) and health worker unfriendly behavior discourage the adolescent to visit health institutions (Baral Chandra et al. 2013).

In addition, health institutions lack information education and communication (IEC) material. Each health institution have one or two packages of 8 IEC-booklets, while the target population is more than 1200 individuals (DPHO 2017). How feasible is it that this one book is available for those adolescents who want to read it? These IEC materials were found very useful by adolescents (Baral Chandra et al. 2013).

Furthermore, the ASRH program has low coverage of adolescent population because they were coordinating their services with only one of the nearest school. Similar finding regarding the limited coverage of ASRH program was demonstrated by the one mid-term evaluation study in 2013 in Nepal. Lack of prioritization of program leads to low coverage of population (Baral Chandra et al. 2013). One of the reason for low performances of ASRH program was lack of monitoring and supervision of health institution. None of the health institution were found maintaining disaggregate data on ASRH services utilization which is crucial to know how the health program is performing in community (WHO 2009).

The proportion of adolescents reaching out to health institutions for their sexual and reproductive health care is very low. Girl's ability to reach the health institutions is highly affected by strict gender roles, stigmatization of sexual and reproductive health and dominant gender inequality in society. None of the social institution such as school, family or society were found adolescent friendly in the sense of reaching out with sexual and reproductive health services. Most of the girls stated fear of family for not visiting health institution. Similar finding was shown by the study in 2016 which demonstrated 83% of the adolescents participants of their studies were found to quit accessing sexual health services if their parents would know about it (Kuzma and Peters 2016).In

addition, lack of freedom of girls from household and school dichotomy have affected their ability of reaching health services. Such freedom of girls were found to be affected by gender inequality and gender norms in family. All these challenges related to provider side limit the availability of services for girls in the community, which ultimately minimizes the number of girls reaching the health facilities.

4. What influences ASRH care utilization?

All the sexual and reproductive health services that are provided by public health institutions are free of cost. So low utilization of services in these health institutions were not due to direct cost or affordability to pay. Utilization of services by girls were found more affected by the opportunity cost. Here opportunity cost refers to affordability to utilize health services derived from health workers behavior or due to quality of health services. Such costs are not direct costs that have to be paid to use such services (Levesque, Harris, and Russell 2013). Most of the findings regarding challenges and barriers for access to health care were associated with perceiving, seeking and reaching care. This illustrated that adolescents are somewhere between these steps of accessing care and have not reached at the level of utilizing it. It demonstrated the low utilization of ASRH services in community level as mentioned by different studies in Nepal (Regmi et al. 2010, DoHS 2017) Hence, the adolescents who reached the health services, the affordability of health services were found to be derived by quality of health services, behavior of health workers and programmatic strategy. As already mentioned above, behavior of health workers were not found friendly by the girls who visited health institution.

In addition, perceived lack of quality of services was defined as lack of privacy, poor infrastructure and unsatisfied counseling from health workers. Furthermore, one of the major reasons for low utilization of services was the mismatch between the programmatic strategies of ASRH program with the expectations of girls regarding implementation of program. At one side, health workers said they will provide quality health services to those who will come to health institution. On the other side, girls in the community expect health workers to reach them where they are. They said at present rather than going to health institutions for curative health services they require more awareness and knowledge regarding their sexual and reproductive health. So, there is the gap between the utilization of services due to the lack of a connector between these two parties which is best illustrated by the figure from the analysis given below:

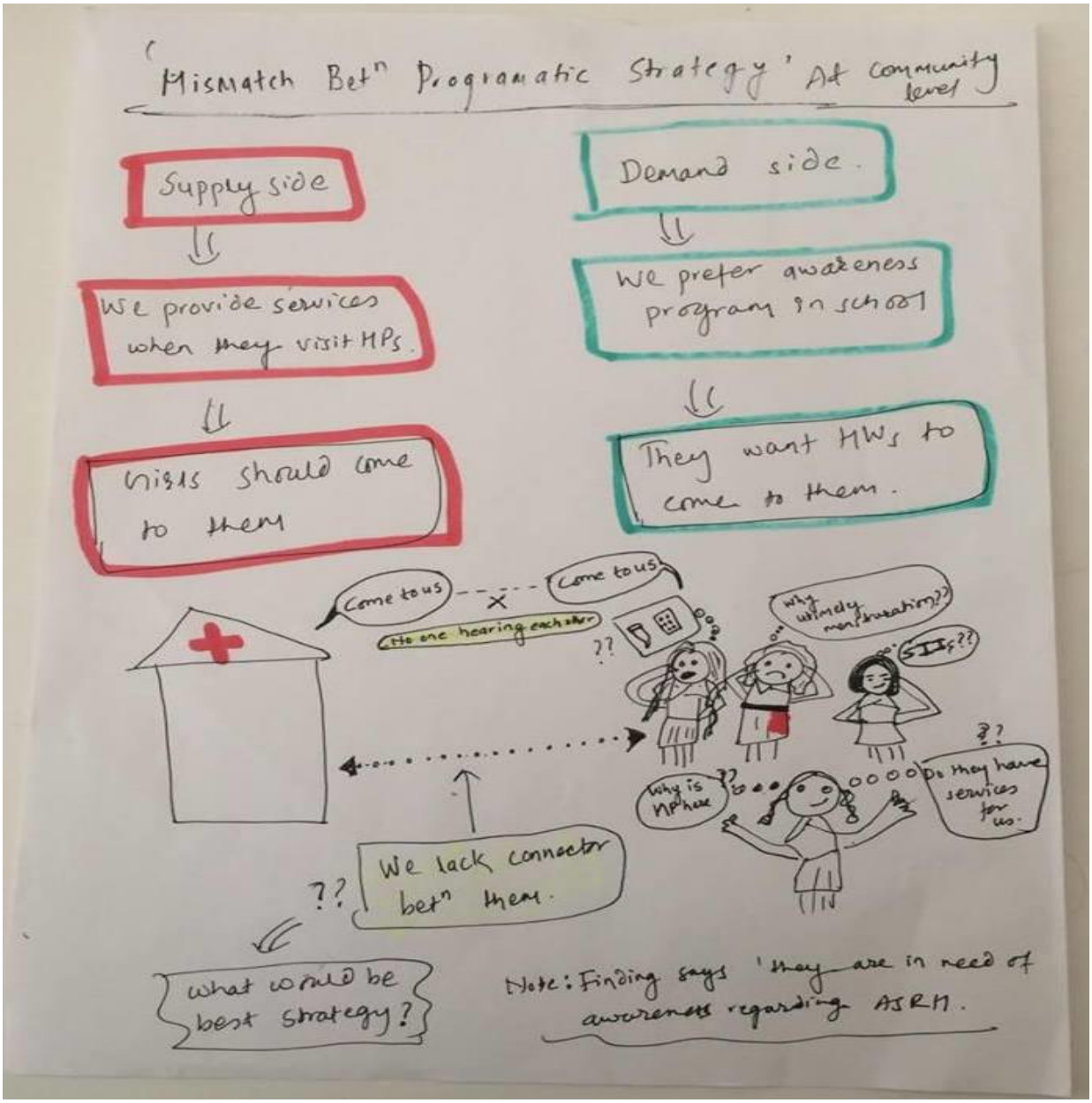

Fig 4: Mismatch in implementation of services between provider and receiver

From service receiver side, social stigmatization and fear from family were found associated with abilities of girls using health services. So, interaction between less affordability of ASRH program and poor ability of girl for paying were found leading to low utilization of services.

5. What are the ASRH care consequences?

The appropriateness refers to the match between the services and the expected need by the recipient (Levesque, Harris, and Russell 2013). The findings of my study showed when the available ASRH

services does not meet the expectation of girls regarding services, it eventually give rise to poor health consequences. Appropriateness of program were defined according to the behavior of health workers towards them. Very few of the girls reached the health institutions, and they were dissatisfied with the health services they received. These girls expressed a dissatisfaction related to the unfriendly behavior of health workers and about matters of confidentiality. Hence, the conceptual framework of provider's by WHO elaborated various factors like local values and norms, core beliefs, socialization, incentives, supervision, training, polices and workload affecting the attitude and behavior of health workers (WHO 2010b). In contrast, this study incorporated effect of health worker's behavior on girl's health care utilization rather than factors affecting behavior of health workers.

Lack of appropriateness of program were found leading to dissatisfaction and poor health outcome. For instance, lack of knowledge, early marriage, early pregnancy, high unmet need of family planning were some of the poor health consequences presented by annual report of Department of Health services (DoHS 2017). The dissatisfaction experience by girls during visit to health facilities affects how girls perceive health care in the community. Girls come back to their community and share their experiences with other girls and it influences their perception on health facilities which eventually give rise to vicious cycle of poor access to health care.

CHAPTER 6: CONCLUSION

This study was carried out to explore the barriers and challenges related to low utilization of adolescence friendly SRH services provided by public health institutions in the community. The analysis of low utilization of services by using the conceptual framework of access to health care not only include accessibility of health services. It include the abilities of girls also in accessing health care. It showed that high accessibility of the health services alone does not guarantee the increase of utilization of services. The abilities of the target population along with determinants enhancing or diminishing those abilities should be taken into consideration. This study showed that girl's access to SRH care is importantly related with both accessibility of SRH services from health sector and the determinants of society where she belong. Both of these have effects on the abilities of girls to access SRH care.

From the perspective of provider side, major challenge that affected the access of SRH care of girls is due to the poor adolescent friendly SRH services in real sense. Health workers and programmatic strategy of delivering services were found as the most influential determinants to poor adolescent friendly SRH service. On the other hand, from the perspective of service receiver, persistent gender role and stigmatization of SRH were found as the most significant determinants in defining the abilities of girls. So in such, findings of my study concluded that poor accessibility of adolescent friendly SRH services and adolescent unfriendly family, school and society leads to low utilization of SRH services in community.

CHAPTER 7: RECOMMENDATION

For the success of ASRH program through increasing the utilization of services by girls, priority should be given to both perspective of health services which include health service receivers and the providers.

On one hand efforts should be made to train the health workers profoundly for the better attitudes and actions. In addition, emphasis should be given to implementation of such programmatic strategy which will reach out the girls at their premises.

On the other hand, community, school and family involvement in the ASRH program should be prioritized and the programs focusing on changing the attitudes towards girl's role and adolescent sexual and reproductive health are keys.

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APPENDICES

Appendix 1: Semi-structure interview Guide

Interview Guide for Health Workers (English)

1. How frequently do girls visit?
2. Are they comfortable visiting health services
3. What are the barriers to implement the ASRH program? (for e.g.: human resources, infrastructure, context)
4. What could be the barriers for girls?
5. How is the involvement of community and family in this program?
6. In your opinion, are there any hindrance for girls?
7. What kind of challenges you face during provision of services?
8. What are the challenges are there for implementation of program?
9. Based on your experiences do you think this program is effective for addressing the issues of adolescent girls?
10. What other things could we do to reach the girls with this kind of information and services?

Interview Guide for Health Workers (Nepali)

अर्न्तवार्ता गाईड

१. किशोरीहरु स्वास्थ्य चौंकी कतिको आउने गर्दछन् ?

२. के उनीहरु स्वास्थ्य चौंकी आउन सहज महसुस गर्छन ?

३. यो ASRH कार्यक्रम अघि बढाउन अवरोधहरु के के छन् ? (जस्तै : मानव साधन, भौतिक संरचना, वातावरण)

४. यो सेवा सम्म आईपुग्नको लागि किशोरीहरुलाई के अबरोध हुन सक्छ ? तपाईको विचारमा,

५. यो कार्यक्रममा समुदाय र परिवारको संलग्नता कस्तो छ ?

६. तपाईको विचारमा के कुराले किशोरीहरुलाई यो कार्यक्रम सम्म आईपुग्नका लागि समस्या उत्पन्न गराएको छ ?

७. यो ASRH सेवाहरु उपलब्ध गराउँदा कस्तो खालको चुनौतीहरु सामना गर्नु परेको छ ? व्यक्तिगत तवरमा ।

८. ASRH सेवाहरु उपलब्ध गराउँदा कस्तो खालको चुनौतीहरु सामना गर्नु परेको छ ? कार्यक्रम तवरमा ।

९. तपाईको अनुभव अनुसार किशोर, किशोरीको समस्यालाई सम्बोधन गर्न के यो कार्यक्रम सफल भएको छ ?

१०. यस कार्यक्रमको सेवा र सुविधाहरुवाट बंञ्चित भएका किशोरीहरु समक्ष पुग्न र सवैलाई समेट्न अझै हामी के गर्न सक्छौं ?

Appendix 2: Focus Group Discussion Guide

Focus Group Discussion Guide (English)

Introduction: I will talk about fact and scenarios regarding adolescence sexual and reproductive health services in Nepal.

1. If you have any concerns or problems regarding your sexuality or your sexual health status – who would you go to?
2. Have you heard about ASRH services provided in your community?
   -What kind of services we can get there?
   -Have you/do you know someone who used these services?
   -Had the services been useful to you?
   -Did the service address the problem that you have?
   -Were you satisfied with their services?
3. Do you go to public health facilities in your community to take the services? If not then what are the reason behind that?
4. Have any one of you receive any counselling from AFI regarding ASRH?
5. What kind of role your friend, family and community play regarding ASRH issues?
6. Did you know that boys use the services more than girls?
   -Why do you think that is so?
7. In your opinion, what can be done to increase the use of these services by adolescent girls like you?
8. Do you want to talk in any topic that I did not cover? Do you have anything to add?

Focus Group Discussion Guide (Nepali)

फोकस समूह छलफल (FGD)

१. तपाईहरुलाई यौन तथा प्रजनन् स्वास्थ्य सम्बन्धि केहि समस्या वा खुल्दुलि भएमा कहाँ जानुहुन्छ ?

२. के तपाईहरुले तपाईको समुदायमा भएको किशोरकिशोरी मैत्री प्रजजन् स्वास्थ्य सेवा कार्यक्रमको बारेमा सुन्नु भएको छ ?

- कस्तो खालको सेवाहरु हामी त्यहाँ पाउँछौ ?
- तपाईहरुले यो सेवा लिनुभएको छ वा कोहिलाई चिन्नु भएको छ जस्ले यो सेवा लिनुहुन्छ ?
- के यो सेवाहरु तपाईको लागि उपयोगी छन् ?
- के यो सेवाहरुले तपाईहरुको समस्या सम्बोधन वा समाधान गरेको छ ?
- के यी सेवाहरुवाट तपाईहरु सन्तुष्ट हुनुहुन्छ ?

३. के तपाईहरु यी सेवाहरु लिन यहाँ भएको सामुदायिक स्वास्थ्य चौंकी जानुहुन्छ ? यदि जानुहुदैन भने किन ?

४. के तपाईहरु मध्ये कसैले ASRH सम्बन्धि किशोरकिशोरी मैत्री संस्थावाट परामर्श पाउनु भएको छ ?

५. तपाईहरुको ASRH समस्याहरु प्रति तपाईहरुको साथि, परिवार र समुदायको भुमिका कस्तो छ ?

६. तपाईहरुलाई थाहाँ छ ?, ASRH का सेवाहरु किशोरीहरु भन्दा बढि किशोरहरु प्रयोग गर्छन् । तपाईको विचारमा कारण के हुन सक्छ ?

७. तपाईहरुको विचारमा ASRH कार्यक्रमको सेवाहरुको प्रयोग तपाईहरुले झैं किशोरीहरु बिच लोकप्रिय बनाउनका लागि के गर्नु पर्ला ?

८. मैले सम्बोधन नगरेको कुनै विषयमा तपाईहरुलाई बोल्न मन छ ? वा केहि कुरा तपाईहरुलाई थप गर्नु छ ?

Appendix 3: NSD Approval

Randi Wærdahl

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Vår dato: 17.10.2016 Vår ref: 50034 / 3 / AGH Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 16.09.2016. Meldingen gjelder prosjektet:

50034	*Adolescent Friendly Sexual and Reproductive Health Services for Girls in Nepal: Challenges and Barriers*
Behandlingsansvarlig	*Høgskolen i Oslo og Akershus, ved institusjonens øverste leder*
Daglig ansvarlig	*Randi Wærdahl*
Student	*Sunita Shrestha*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 31.05.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Agnete Hessevik

Kontaktperson: Agnete Hessevik tlf: 55 58 27 97

Vedlegg: Prosjektvurdering

Kopi: Sunita Shrestha sunita.shrestha55555@gmail.com

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 50034

The Data Protection Official presupposes that research is conducted in line with laws, regulations and guidelines in Nepal.

PURPOSE

The purpose of the study is to focus on finding the reasons behind low use of ASRH services by the girls from perspective of both provider and receiver.

SAMPLE AND INFORMED CONSENT

It is notified that the sample will consist of adelescent girls aged 15-19 years old and adult health care personnel.

If persons under age will participate, without their parents'/guardians' consent, we presuppose that this is in line with laws/regulations/guidelines in Nepal. Please note that in Norway, youth under 16 years old cannot consent themselves to participate in research project when sensitive information is collected. We advise to not include girls under the age of 16, and only include girls under the age of 18 if this is allowed by Nepalese law.

The Data Protection Official presupposes that the recruitment process is done in a way that fulfils the requirement of voluntarily participation and confidentiality. We assume that Adolescent Sexual and

Reproductive Health cannot give you the contact information of possible participants, and the recuritment must be carried out in a way that does not infringe health personnels duty of confidentiality.

The sample will receive written and oral information about the project, and give their consent to participate. The letter of information and consent form are somewhat incomplete, and we ask that the following is changed/added:

- name and contact information (including e-mail) for the student and the supervisor

- give the date for the end of the project and what will happen to the personal data (you have notified that theend date is 31st May 2017), and that the data will be made anonymous)

We ask that the revised letter of information is sent to personvernombudet@nsd.no before contact with the sample is established.

SENSITIVE DATA

There will be registered sensitive information relating to health.

THIRD PERSONS

You have not notified that you will collect personal data about third persons. However, the interview guide asks about friends' problems and use of the service. We advise against collecting sensitive personal information about identifiable third persons. Such information should be collected from persons first-hand based on and an informed consent. We advise that you ask your sample to talk about other persons in a way that as far as possible avoids identifying individuals.

DATA PROTECTION

The Data Protection Official presupposes that the researcher follows internal routines of Høgskolen i Oslo og Akershus regarding data security. If personal data is to be stored on portable storage devices, the information should be adequately encrypted.

END OF PROJECT

Estimated end date of the project is 31.05.2017. According to the notification form all collected data will be made anonymous by this date.

Making the data anonymous entails processing it in such a way that no individuals can be recognised. This is done by:

- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable data (i.e. an identifying combination of background variables, such asresidence/work place, age and gender)
- deleting digital audio files

Appendix 4: Nepal Health Research Council (NHRC)

Government of Nepal

Nepal Health Research Council (NHRC)

Estd. 1991

Ref. No.: 1201

09 January, 2017

Ms. Sunita Shrestha
Principal Investigator
Oslo and Akershus University College of Applied Sciences
Norway

Subject: Approval of research proposal entitled **Adolescent Friendly Sexual and Reproductive Health Services for Girls in Kaski, Nepal: Challenges and Barriers**

Dear Ms. Shrestha,

It is my pleasure to inform you that the above-mentioned proposal submitted on **02 December 2016** (**Reg.no. 438/2016** please use this Reg. No. during further correspondence) has been approved by NHRC Ethical Review Board on **04 January, 2017**.

As per NHRC rules and regulations, the investigator has to strictly follow the protocol stipulated in the proposal. Any change in objective(s), problem statement, research question or hypothesis, methodology, implementation procedure, data management and budget that may be necessary in course of the implementation of the research proposal can only be made so and implemented after prior approval from this council. Thus, it is compulsory to submit the detail of such changes intended or desired with justification prior to actual change in the protocol before the expiration date of this approval. Expiration date of this study is **May 2017.**

If the researcher requires transfer of the bio samples to other countries, the investigator should apply to the NHRC for the permission. The researchers will not be allowed to ship any raw/crude human biomaterial outside the country; only extracted and amplified samples can be taken to labs outside of Nepal for further study, as per the protocol submitted and approved by the NHRC. The remaining samples of the lab should be destroyed as per standard operating procedure, the process documented, and the NHRC informed.

Further, the researchers are directed to strictly abide by the National Ethical Guidelines published by NHRC during the implementation of their research proposal and submit progress report and full or summary report upon completion.

As per your research proposal, the research amount is **NRs. 2,40,000.00** and accordingly the processing fee amount to **NRS. 10,000.00.** It is acknowledged that the above-mentioned processing fee has been received at NHRC.

If you have any queries, please feel free to contact the Ethical Review M & E section of NHRC.

Thanking you,

Dr. Khem Bahadur Karki
Member-Secretary

Tel: +977 1 4254220, Fax: +977 1 4262469, Ramshah Path, PO Box: 7626, Kathmandu, Nepal
Website: http://www.nhrc.org.np, E-mail: nhrc@nhrc.org.np

Appendix 5: Consent form for Focal Group Discussions
Consent form for interviews and focus group discussion (English)

Request for participation in the project "**Adolescent friendly sexual and reproductive health services for girls in Nepal: Challenges and barriers"**

Purpose
Issues like early age at marriage, low utilization of the modern methods of FP, increasing unmet need of family planning in adolescents, early pregnancy and poor knowledge on HIV/AIDS are the prevalent health issues of adolescents regardless of implementation of ASRH program in the community. Different studies show the low utilization of adolescent health services. My study will focus on finding the reasons behind low use of ASRH services by the girls from perspective of both provider and receiver. This study is the part of master degree in International Social Welfare and Health Policy at Oslo and Akershus University College.

What happens in the study?
I will carry out personal interviews and focus group discussion to explore the challenges and barriers in providing and using adolescent friendly sexual and reproductive health services for girls. I would like to hear from you the current situation of services, the challenges faced by you to provide services and barriers faced by girls to use available services. The interviews and focus group discussion will be audio recorded on your consent and they will be deleted after use.

What will I do with the information you give?
All the information and data will be analyzed and presented in the form of master thesis. All personal information will be kept safe and private. They will not be used in the thesis as identifiable data. This project will be finished on May 2017 and all the data will be made anonymous by this date. There are not direct advantages and disadvantages of participating in the study but in the longer term this study could help in improving the adolescent services available for girls.

Participation in the study
All participation will be voluntary. No one will be forced to participate. All potential participant will be properly informed about the study and process that is to follow. If the participant feel uncomfortable and do not want to continue, s/he can withdraw from the study at any time. Even after the consent, if participant has any question they can contact me as well as my supervisor.

Researcher: Sunita Shrestha (Sunita.shrestha55555@gmail.com) or (00977 9846032493)

Supervisor: Randi Wardahl (Randi.Wardahl@hioa.no)

If you agree to participate then please sign in the declaration of consent.

Consent for participating in study

I am willing to participate

..... Date/place:

I give all the information related to the study

..... Date/place

Consent Form for FGDs (Nepali)

सहमति फारम

अन्तर्वार्ता/फोकस समूह छलफल

अनुसन्धान कार्यक्रममा सहभागि हुन अनुरोध : **"नेपालमा किशोरीहरुको लागि किशोरकिशोरी मैत्री यौन तथा प्रजनन स्वास्थ्य सेवा : चुनौती र अवरोध"**

उद्देश्य

स्वास्थ्य समस्याहरु जस्तै वालविवाह, परिवार नियोजनका आधुनिक तरिकाहरुको कम प्रयोग, किशोरकिशोरीमा परिवार नियोजनको बढ्दो unmet आवश्यकता, कम उमेरमा गर्वभवती हुनु र एच.आई.भी. एड्स जस्ता रोगहरु वारे कम जानकारी हुनु ASRH कार्यक्रम संचालन भई सके पछि पनि समुदायमा व्यथित समस्याहरु हुन। धेरै अनुसन्धानहरुले किशोरकिशोरीको प्रजनन् स्वास्थ्य सेवाको पहुँचमा कमी भएको देखाउछ। मेरो यस अध्ययनले दुवै सेवा प्रदायक र उपभोक्ताको तर्फवाट किशोरीहरुले यस ASRH सेवाहरु कम प्रयोग गर्नुको कारणहरु पत्ता लगाउनु लक्ष्य रहेको छ। यस अध्ययन Oslo and Akershus University College of Applied Sciences, Norway को International Social Welfare & Health Policy को स्नाकोत्तर तहको अभिन्न अंगको रुपमा रहने छ।

यस अध्ययनमा के हुन्छ ?

किशोरीहरुले/लाई ASRH सेवाहरु प्रयोग गर्दा र उपलब्ध गराउँदा उत्पन्न हुने अवरोध र चुनौतीहरुलाई व्याक्तिगत अर्न्तवार्ता र फोकस समूह छलफलको माध्यमबाट अगाडी ल्याउने कोसिस गर्ने छु। म तपाईहरुवाट यस सेवाको वर्तमान अवस्था, सेवा उपयोग गर्न र गर्दा भोग्नु भएको चुनौतीहरु र सामना गर्नु भएको समस्याहरुको वारेमा अवगत हुन चाहन्छु। तपाईहरुको सहमतीमा अर्न्तवार्ता र फोकस समूह छलफल अभिलेखीकृत गरिने छ यसको प्रयोजन प्रस्चात उक्त अभिलेखहरु नष्ट गरिनेछ।

तपाईहरुले दिएको सुचना के गरिनेछ ?

सवै सुचना र तथ्याङ्कहरु विस्लेषण गरिने छ र स्नाकोत्तर थेसिस (thesis) को रुपमा प्रस्तुत गरिनेछ। सबै व्याक्तिगत सुचनाहरु गोप्य र सुरक्षित राखिने छ। यस अध्ययनवाट तपाईहरुलाई कुनै प्रत्यक्ष वा अप्रत्यक्ष लाभ नभएता पनि दिर्घकालिन रुपमा किशोरकिशोरीलाई उपलब्ध सेवाहरुको गुणस्तर बृद्धिमा सहयोग पुऱ्याउने छ।

अध्ययनमा सहभागिता

यस अध्ययनमा सवै सहभागिताहरु स्वच्छिक हुनेछ र कुनै पनि सहभागिहरुलाई सहभागिताको लागि कुनै प्रकारको दबाव दिईने छैन। सवै सहभागिहरुलाई अध्ययनको बिषय र प्रकृयावारे पुर्ण जानकारी गराईने छ। तपाईले चाहेको खण्डमा कुनै पनि समयमा अध्ययनवाट आफ्नो सहभागिता हटाउन सक्नु हुनेछ। यदि सहभागिता पछि पनि तपाईलाई कुनै सोधपुछ वा जानकारीको लागि मलाई वा मेरो सुपरभाईजरलाई सम्पर्क गर्न सक्नुहुनेछ।

अनुसन्धानकर्ता : सुनिता श्रेष्ठ, (sunita.shrestha55555@gmail.com) or, मोवाईल नं. ९८२७१५६७११
सुपरभाईजर : Randi Wardahl (Randi.wardhl@hioa.no)

सहभागि हुनका लागि सहमती फारम

म सहभागि हुन ईच्छुक छु

.....

सहि गर्ने

मिति :

म यकिन गर्दछु कि मैले यस अध्ययनवारे पूर्ण जानकारी दिएको छु।

.....

सहि गर्ने

मिति :

Appendix 6: Obserbation Checklist for Supervision

Annex 8: Supervision Checklist for AFSs

Government of Nepal
Ministry of Health and Population
Family Health Division

Name of the District: Date of assessment:
Name of the Health Facility: Supervision team members:

S.N	Assessment Criteria	Yes	No	Explanation if the answer is No:
A.	AFS Management			
1	The AFS logo is correctly displayed			
2	The opening times of the AFS are made visible outside the HF			
3	AFS has been promoted in the past 6 months through linking with other institutions (schools, youth clubs, child clubs etc.) and peer educators			
4	Health workers feel supported by the HFMOC and the HF-in-charge in providing AFSs			
5	The monthly reporting of use of services by adolescents is done using the given format			
6	The HF displays user statistics at the HF using the given format			
7	HFOMC minutes show that adolescents have participated in the meeting as an invitee.			
B.	Delivery of AFSs			
8	Separate opening hours for adolescents at least once a week are in place			
9	The health facility is clean and there is drinking water and there is clean drinking water			
10	Privacy when counselling or treating adolescents is maintained in the health facility either in a separate designated room or through a curtain			
11	IEC materials are displayed in the waiting room			
C.	Assessment of service providers			
12	HWs have received the training on ASRH through NHTC			
13	HWs have received the two day orientation on the national ASRH programme			
14	The HWs have a copy of the ASRH flipchart			
15	HWs report using the ASRH flipchart			
16	The HWs have a copy of the Adolescent Job Aid			

37

17	HWs report using the Adolescent Job Aid			