Received: 14 March 2019 | Revised: 8 May 2020 | Accepted: 15 May 2020

DOI: 10.1002/app5.305

ORIGINAL ARTICLE

ASIA & THE PACIFIC POLICY STUDIES

Girls' access to adolescent friendly sexual and reproductive health services in Kaski, Nepal

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Abstract

The purpose of this study is to explore the limitations to girls' access to adolescent friendly sexual and reproductive health services in public health institutions in Kaski, Nepal. Seven interviews with health workers and eight group interviews with adolescent girls are analysed using the conceptual framework of access to health care by Levesque, Harris, and Russell and an understanding of gender as embedded in all matters and choices concerning sexual and reproductive health. We find that girls demonstrate poor literacy about sexual and reproductive health, and that most challenges and barriers occur before girls reach health institutions. The strict gender norms, stigmatisation and lack of autonomy are the highest barriers for adolescent girls in seeking care. We find that health institutions are not adolescent friendly and have a passive outreach strategy.

KEYWORDS

access to health care, adolescents, girls, Nepal, sexual and reproductive health

1 | INTRODUCTION

1.1 | Government strategies for addressing adolescent health

As with most countries in South Asia, Nepal struggles with issues of adolescent health, due to unplanned and unwanted pregnancies, unprotected sexual activity, unsafe abortion, lack of

knowledge regarding sexual and reproductive health, and lack of access to contraceptives as well as early marriage (before the age of 20) and childbearing (Ministry of Health and Population [MoHP], 2017; World Health Organization [WHO], 2011). The Ministry of Health and Population in Nepal has shown its commitment to addressing these problems through a series of programs. First, Nepal committed to a plan of action at the International Conference on Population and Development in 1994. Then, in 1998, adolescent sexual and reproductive health was included as one of the crucial components of the National Reproductive Health Strategy. In 2000, the Family Health Division of the Department of Health Services developed a National Adolescent Health and Development Strategy. The implementation guidelines on adolescent sexual and reproductive health services was developed in 2007. Between 2009 and 2010, 26 health facilities in five districts provided adolescent friendly services as a pilot intervention (MoHP, 2011). In 2010, the Nepal Health Sector Programme II (NHSP-IP 2) 2010–2015 set an ambitious target of making 1,000 public health facilities adolescent friendly by 2015 (MoHP, 2010). To meet this target, the National Adolescent Sexual and Reproductive Health (ASRH) Program developed a new implementation guide in 2011 and, by fiscal year 2015/16, a total of 1,134 health facilities in 63 districts were providing adolescent friendly services. But simply meeting the target number of facilities does not guarantee improvements in adolescent sexual and reproductive health (Department of Health Services [DoHS], 2017, 2018, 2019).

The national ASRH program aims to enable health institutions to provide adolescent friendly sexual and reproductive health services. This includes allocating budgets, selecting districts, and organising two-day orientation programs for regional- and district-level health managers and assigning ASRH focal persons at the local level. In addition to services for family planning, pregnancy, abortion, sexually transmitted infections, Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDs), and gender-based violence, adolescent friendly information services should cover more general issues related to puberty and bodily changes, genital and menstrual hygiene, relationships, nutrition, contraceptives and life skills counselling, as well as tobacco and alcohol counselling (MoHP, 2011; WHO, 2012).

According to the program implementation guide, in order to be considered adolescent friendly, the health facilities must treat everyone equally regardless of gender and marital status. There should be an adequate supply of contraceptives and information, education and communication (IEC) materials, and a guaranteed short waiting time for adolescents. The physical infrastructure also needs to have an adolescent friendly profile, with a convenient location and favourable service hours. The service should have a welcoming environment and a separate counselling room to ensure privacy. It is essential that the health personnel treat adolescents with respect and without prejudice and maintain privacy and confidentiality. Involvement with adolescents in schools and youth clubs is also crucial (MoHP, 2011; WHO, 2012).

In addition, the Nepal Health Sector Strategy Implementation Plan 2016–2021 released by the Ministry of Health stresses the importance of creating a conducive environment for adolescents to access reproductive health services in all public health facilities (Ministry of Health, 2017). To measure the success of the national ASRH program, the government uses indicators such as age at marriage, the use of modern methods of family planning, unmet needs for family planning, adolescent pregnancy, adolescent fertility rate and prevalence of HIV infections (MoHP, 2011).

Despite several interventions, plans and strategies, the health issues of adolescents are still a major public health concern more than 20 years after the first adolescent health strategy was released. Available services are not used to the extent that was expected. This is particularly the

case for young women (Center for Research on Environment Health and Population Activities [CREHPA], 2015; DoHS, 2018; MoHP, 2017).

1.2 | Adolescent sexual and reproductive health status

South Asia has a higher number of adolescents (10–19 years old) compared to any other region (UNICEF, 2016). In Nepal, adolescents constitute nearly a quarter (24.2%) of the total population (National Planning Commission Secretariat, 2012). Although, adolescence is a healthy time of life, adolescents worldwide often suffer from preventable poor health, including sexual and reproductive health, mental health and substance abuse issues, as well as poor nutrition and accidents and injuries (WHO, 2017a). There are no statistics available on the use of modern methods for contraception, fertility or family planning among the unmarried adolescent population in Nepal. The following numbers are therefore about married adolescents only.

Although the Nepal Demographic and Health Survey (NDHS) showed a decrease in the prevalence of early marriage from 2011 to 2016 of just two percentage points, from 29% to 27%, there has been no reduction in adolescent pregnancy; in fact, it stayed at 17% in 2006, 2011 and 2016. The 2016 survey also finds that 20% of adolescent births are unwanted, and shows a reduction in the adolescent fertility rate (live births) (MoHP, 2012, 2017). However, the 2019 annual report of the Department of Health Services claims that the adolescent fertility rate increased from 81/1000 in 2011 to 88/1000 in 2016. This report also states that only 19.5% of pregnant adolescents go for their first protocolled antenatal care check-up, and only 16% complete all four protocolled visits (DoHS, 2019). In other words, the national survey and the annual reports of registered data do not correspond in terms of direction of changes, but all three reports show that statistical changes have been small.

The prevalence of using modern methods of family planning was unchanged from 2006 to 2016 (14–15%), and the level of unmet need for family planning fluctuated from 38.5% (2006) to 42% (2011) to 35% (2016). The statistics shows that the unmet need for family planning is higher in general among married adolescents than among all married women of reproductive age (between 15 and 49 years old) (MoHP, 2012, 2017).

1.3 | Aim of this study

The intention of the government to improve the health status of adolescents is clear and commendable; however, the implementation of the national ASRH program has not been as effective as expected (Bam et al., 2015; DoHS, 2018; MoHP, 2012, 2017). Many studies have identified inadequately trained service providers as well as poor monitoring and supervision as challenges to the program. In addition, poor local ownership of the program and poor linking with other programs have been identified as reasons why it has not met its potential (CREHPA, 2015; DoHS, 2018; WHO, 2017a). The real puzzle to solve, though, is why so few adolescents in need are using the available services (Bam et al., 2015; DoHS, 2018; MoHP, 2012, 2017). In particular, it seems that the program fails to reach adolescent girls, who visit these services less than boys (WHO, 2017a) and who seek health care less than adult women (CREHPA, 2015).

The practice of early marriage is common in Nepal and is deeply rooted in culture. On average, girls get married four years earlier than boys (MoHP, 2017). Social and gender norms

restrict adolescent girls' behaviour and mobility; as well, girls lack the opportunities available to boys to make decisions for their own health (Regmi, Simkhada, & van Teijlingen, 2010). Research also shows that girls lack both self-esteem and social support and that social norms influence their low positive health behaviour (Mahat & Scoloveno, 2001) and low life aspirations (Mathur, Malhotra, & Mehta, 2001). This situation makes the question of how to reach adolescent girls with services crucial. It calls for a qualitative study, where we can explore the reasoning of both the target groups seeking services and those who provide them. We ask: what are the challenges of providing adolescent sexual and reproductive health services to girls and what are the barriers for girls to access them?

2 | METHODOLOGY

We chose to do this study in the Kaski district in the western region of Nepal. As in Nepal at large, adolescent sexual and reproductive health is a major public health concern in Kaski. There is low use of related health services by adolescents throughout the district. Early marriage and early pregnancy are major health issues in the region; the use of modern methods of contraceptives is low among adolescents; and the unmet need for family planning is high (District Public Health Office, 2017; DoHS, 2018).

In Kaski, there are two community hospitals, four primary health care centres and 45 health posts. Of the 49 health institutions providing services at the community level, 13 were selected to provide adolescent friendly services in 2013 and another 13 were selected in 2015 (District Public Health Office, 2017). For our study, we selected three health posts and one primary health care centre. Two of them have provided adolescent friendly services since 2013 and two others since 2015. We also wanted geographic variation and chose two health institutions from rural areas and two from an urban setting.

The number of health workers interviewed was determined by the structure of the national ASRH program itself. For each organisational level, we interviewed the main responsible health worker, resulting in two focal persons at the district level, two from the primary health care centres, and one health worker from each health post at the community level. The two district- level managers had bachelor's degrees in health, while the five community-level health workers were all auxiliary nurse midwives or auxiliary health workers.

Health workers helped us to contact schools where the health institutions were involved in school health programs. Since this study focuses on government public health services that are required to extend their services to local schools, we chose to interview only girls attending these particular schools. We asked the principal and the health teacher to recruit girls from Grades 9 to 12. We wanted girls in their late adolescence (15–19 years old), as we believed they would have the maturity to discuss the relevant issues. After piloting individual and group interviews, we decided to ask for girls who were friends. It is likely that a principal or a teacher would choose girls with good educational attainment as participants. However, we hoped that the criteria of the girls being friends would provide us with a varied group. In addition, friendship groups can make the conversation flow, especially when girls feel safe with each other. Group interviews are also preferable when it comes to negotiating common perceptions. We interviewed eight groups with two to five participants in each, a total of 27 girls. They had different marital status and were from several ethnic groups.

We used semi-structured individual interviews with the health workers and guided group interviews with the girls. These interviews formed the basis for our analysis. In addition, we

used the supervision and monitoring checklist for the national ASRH program (MoHP, 2011) as an observation checklist for each of the four health institutions we visited (see Table 1) to evaluate their adolescent friendliness.

TABLE 1 Observation checklist of health institutions

SN	Assessment criteria	HI-1 (2013)	HI-2 (2013)	HI-3 (2015)	HI-4 (2015)
A	**Adolescent friendly service management**				
1	The AFS logo is correctly displayed	No	No	Yes	Yes
2	The opening hours of the AFS are made visible outside the health facilities	No	No	Yes	Yes
3	AFS has been promoted in the past six 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 health facility displays user statistics in their facilities using the given format	No	No	No	No
7	The health facility organisation and management committee minutes show that adolescents have participated in the meeting as an invitee.	No	No	No	No
B	**Delivery of adolescent friendly services**				
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 counselling or treating adolescents is maintained in the health facility, either in a separate designated room or through a curtain	Yes	No	No	No
11	Information, education and communication (IEC) materials are displayed in the waiting room	No	No	Yes	No
C	**Assessment of service providers**				
12	Health workers have received the training on Adolescent Sexual and Reproductive Health through National Health Training Centre	No	No	No	No
13	Health workers have received the two-day orientation on the national Adolescent Sexual and Reproductive Health program	Yes	Yes	Yes	Yes
14	Health workers have a copy of the Adolescent Sexual and Reproductive Health flipchart	No	No	Yes	No
15	Health workers report using the Adolescent Sexual and Reproductive Health flipchart	No	No	No	No
16	Health workers have a copy of the WHO Adolescent Job Aid	No	No	Yes	No
17	Health workers report using the WHO Adolescent Job Aid	No	No	No	No

Source: Based on Supervision Checklist for Adolescent Friendly Services (AFS), Government of Nepal, Ministry of Health and Population, Family Health Division.

2.1 | A conceptual framework of access to health care

We have analysed our data using the conceptual framework of access to health care developed by Levesque, Harris, and Russell (2013) to identify the challenges facing service providers and the barriers girls experience to reach adolescent friendly sexual and reproductive health services. In this conceptual framework (Figure 1), access is defined as the process of identifying and perceiving health care needs, seeking, reaching and using health care, and ultimately fulfilling the need for health care. The authors conceptualise five dimensions of accessibility pertinent to the supply of services: approachability; acceptability; availability and accommodation; affordability; and appropriateness. These five elements interact with five corresponding demand-side dimensions: ability to perceive; ability to seek; ability to reach; ability to pay; and ability to engage. This framework conceptualises access to health care as the outcome of interactions between the provider and receiver in every step of accessing health care (Levesque et al., 2013).

We can use this framework to identify where girls experience barriers along the health care utilisation process. Likewise, the model can explain the challenges health care providers face in delivering services. According to this model, these challenges and barriers appear in six intermediate spaces between the supply-side and demand-side accessibility dimensions. The strength of this framework is that it deals with interactions. Context is an essential part of the framework and facilitates an analysis where we can address the characteristics of the girls and their sociocultural environment. Barriers related to a girl's life context can limit her use of services and make access to services theoretically possible but

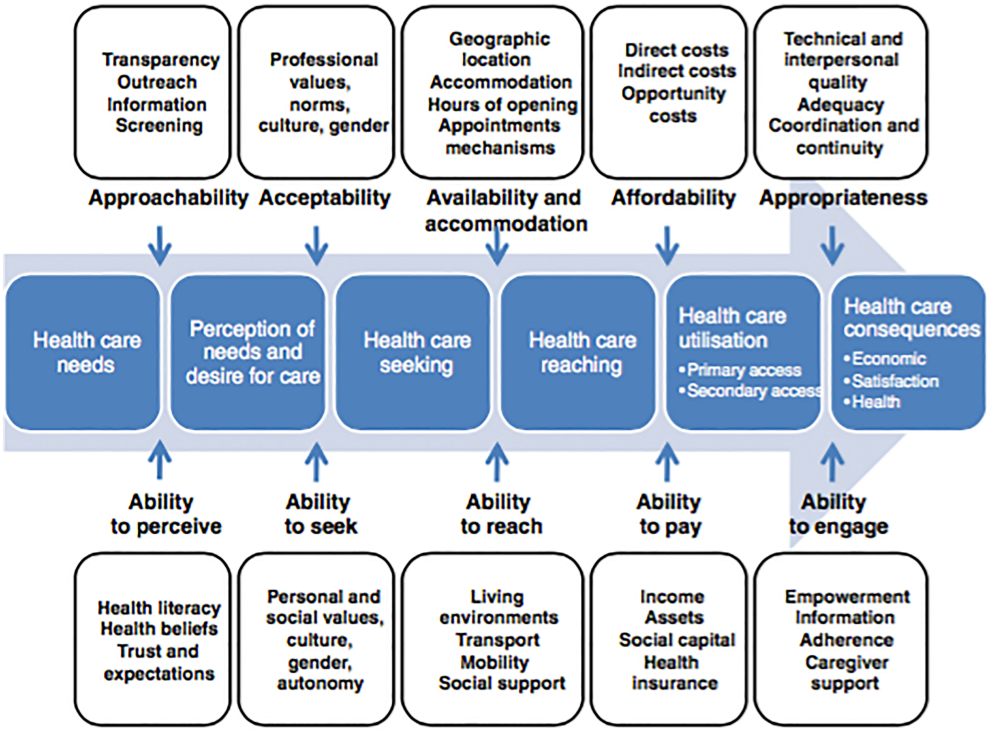

FIGURE 1 A conceptual framework of access to health care
Source: Levesque et al. (2013), p. 5

practically restricted (Levesque et al., 2013). As suggested by Cislaghi and Heise (2018), we apply an intersectional understanding of gendered norms as something that is embedded in all matters and choices regarding sexual and reproductive health (Cislaghi & Heise, 2018; Pulerwitz et al., 2019).

In Section 3, we present and discuss our data according to the six intermediate dimensions of access to health care provided in Figure 1, in a stepwise order, where one dimension must be fulfilled before the next gives an opportunity of access.

3 | RESULTS

Step 1. Sexual and reproductive health (SRH) needs

The first question to ask when implementing a large health reform introducing services for a specific group of the population is whether, in fact, there is a need for such services. During group interviews, girls disclosed their poor knowledge of SRH and used the opportunity to ask just as many questions as they answered. This tells us that they have few informal places to discuss SRH. Most of the girls had experienced painful and untimely menstruation and extra vaginal discharge. Their level of curiosity was high. Girls who were in Grades 9 and 10, aged 15–17, were more curious about their menstruation, puberty and bodily changes, relationships and the meaning of true love. Some of them shared that they had an irregular menstruation three times a month, while others menstruated once in three months. They were curious about the effect of pain killers and reasons for their breasts being painful and asked about why their menstrual blood became black. One of the 16-year-olds asked if masturbation could make her pregnant. Overall, their knowledge was not very substantial.

The older girls (Grades 11 and 12, aged 18–19) were more curious about sexual relationships, consequences of having sex, love affairs and available contraceptive methods. Some of them asked about the natural way of preventing pregnancy without using contraceptives, while others were curious about the consequences of having sex at their young age. One of the girls aged 18 asked: 'If a girl at 15 gets married then she has to do sex with her husband. If they don't use safety measures, then what will happen? Will she get pregnant?'

These interviews show that the need for basic information is significant in both age groups.

Step 2. Perception of SRH needs and desire for SRH care

Approachability refers to the extent to which people can acknowledge their health care needs and can identify that some form of service exists, can be reached and have an impact on their health. Services can make themselves more or less known among various social or geographical population groups (Levesque et al., 2013). When we asked health workers about why girls do not come to health institutions, the first response was usually, 'They don't know about the availability of adolescent SRH services in our institution at all!' From the interviews with health workers, we found that the extant programs have a passive promotion strategy. None of the institutions in our study had carried out a single outreach activity, neither to schools nor to local communities in the previous six months. Health workers admitted that very little had been done to make people aware of the services, due to a lack of resources. The health workers all expressed that they would provide the services if people came to their centres. A typical answer was, 'We are here. They must come to us.' A lack of IEC materials was also mentioned

by health workers as a challenge; this shortage also became apparent when using the observation checklist (see Table 1, Items 14–17).

Although the girls were fully aware of the existence of health institutions, they were unaware that adolescent friendly services were available in their area; they also did not know which services were included in ASRH programs. This is in line with other studies from Nepal (Bam et al., 2015; Regmi, van Teijlingen, Simkhada, & Dev, 2010; Sellars-Shrestha, 2013; WHO, 2017a, 2017b) showing that a majority of the participants did not know about the availability of SRH services in their community. One of the participants (aged 18) said in a group interview that 'health facilities never come to my mind when I have queries related to sexual and reproductive health'. Most of the adolescents said they rarely visit public health institutions in their community, and, if they do, they are there for health problems, including menstruation pain. None of the girls in this study had ever gone to a health institution to obtain general adolescent SRH information or counselling. They were nervous about what the health workers would say if they attended a health institution without being sick.

All the girls were disappointed with health institutions for not trying to reach them, especially once they heard about the national ASRH program. They would strongly prefer the health workers to reach them, either through the school or in the community, rather than go to health institutions. Most girls also agreed that group information sessions would be preferable to face-to-face conversation when it comes to general information about, for example, contraceptives.

Girls can talk to their mothers and sisters about their menstruation. For other issues of their sexuality, they were too shy to express their feelings even with their mothers, so their close friends generally became both their primary source of information as well as their discussion partners. Books, television, Facebook and websites were other sources of information. None of these were addressing their questions at the level of their personal knowledge. As a result, girls were left with much unanswered curiosity and ignorance about their SRH. Peers have more or less the same level of knowledge about SRH. The ongoing circulation of insufficient and inaccurate information have left them with a high curiosity and unresolved issues.

Girls were uncertain about how to avoid pregnancy and were ill-informed about available contraceptives. One of the married girls (aged 17) said:

> I sleep separately for 20–22 days after getting menstruation and do not agree to sleep with my husband during that time. All of them [husband, parent's in laws and her own parents] want me to make a baby now, but I'm saying 'no'. My husband does not agree on using contraceptives. I had irregular menstruation before, and after marriage too. Before, I used to get worried because my mother kept on asking so many questions about if I had done something wrong and now, I am the one who gets worried about getting pregnant. So, I want my husband to go abroad for two to three years.

Even after her marriage, she remained unaware of when she was most likely to conceive a child.

Information has to reach the adolescents in order to have an effect on their knowledge, attitude, beliefs and behaviour (Chandra-Mouli, Lane, & Wong, 2015). In order to use the services, adolescents also need to know what issues they have and how to use the available services. Just as Regmi, Simkhada, et al. (2010), we found that adolescents' poor knowledge of

their SRH was the main barrier to them accessing care and limited any further discussion on these issues. Several studies have demonstrated that outreach activities not only inform and encourage adolescents to use the services, but also create a supportive environment for SRH services when parents, schools and the community are involved (Chandra-Mouli et al., 2015; CREHPA, 2015; Regmi, Simkhada, & van Teijlingen, 2008). When poor approachability of available services interacts with poor ability of girls to perceive them, it gives rise to poor perception of needs and desire for SRH care.

Step 3. Adolescent SRH care seeking

The model suggests that actually seeking health care rests upon an interaction between the acceptability of the services and peoples' ability to seek these services. The acceptability of services is affected by sociocultural determinants and the considered appropriateness by the people seeking care (Levesque et al., 2013; Regmi et al., 2008). Although the health workers expressed a positive attitude towards the national ASRH program, there are two things that seemed ingrained in their sociocultural consciousness and therefore hard to overcome. One is that SRH care only deals with the physical side of adolescent sexuality. The other idea is that it is not quite appropriate for an unmarried adolescent to seek sexual health care. 'It is too funny when 14- or 15-year-old boys come to get condoms', one of the female health workers said.

The health workers were struggling to grasp the broader situation of adolescent girls and their needs, and they lacked training to combine health and social issues. Health workers knew the necessity of maintaining privacy but, at the same time, they were unaware of their own judgemental attitudes. One of the health workers said:

> Once a 16-year-old girl came here with her mum and said it was a rape case and she had not told anyone. She was already 16 weeks pregnant. If this kind of thing spreads in the society, then it will be impossible for her to get married in the future. I counselled her to find that boy and claim money for treatment and further nutrition ... That girl is bad. It's her deed. Maybe they have physical relations with the consent of both of them.

Stigmatisation of unmarried adolescent sexuality and strict sociocultural gender norms make it challenging for providers to make the program acceptable in the community. Similar findings have been derived by many other studies, both in Nepal and in other countries (Regmi et al., 2008; WHO, 2017b).

A recent study about utilisation of SRH services in the Kathmandu Valley (Tamang, Raynes-Greenow, McGeechan, & Black, 2017) shows that a sociocultural environment which restricts an open expression of sexual issues, particularly for young women, often results in huge discrepancies between knowledge and practice. This was also the case in our study. Sociocultural prejudices were one of the most challenging factors for the expansion of an ASRH program in community settings. One of the health workers said:

> First of all, people should take it positively. In Nepali communities, there is still no such thing that you can go to the community and talk freely about family planning devices and promote them among unmarried girls. Until and unless families understand this program, it's really hard to succeed.

The need for community awareness of SRH is high. However, none of the health institutions had interactions with parents about the ASRH program; further, they felt uneasy about promoting it in the communities. In the family, sexuality is still considered a secret matter. The girls say that their parents think they are too young, or they fear that knowledge might promote sexual activities. Regmi, van Teijlingen, et al. (2010) also find that this attitude among parents hinders adolescents in accessing SRH information and services.

Both health workers and girls in our study pointed out a combination of individual factors, such as shyness, gender, age, unfriendly behaviour and issues of respect, which made communication between them difficult. One of the health workers said: 'They feel very shy. Even when they come simply for measuring their weight, they don't come directly inside. They stand at the side, and we have to ask them why they are coming [or] their friends tell us about their problems.' One of the 17-year-old girls explained, 'Some of the health workers are male and some are too old. I feel shy to share my problems because it feels like talking to my own parents.' The girls said that they wanted to be treated with respect and that their problems should not be made fun of. One participant aged 16 recalled an event, saying:

> Once I had lower stomach pain during menstruation and went to the health post with my friends during lunch break. On my query of painful menstruation, he [the health worker] loudly said, 'GET MARRIED, then everything will be fine!' Then everyone in that room laughed.

In addition, girls doubted the health workers' confidentiality and feared the consequences of private information being spread to their family and community. All the girls thought that society perceived their sexuality as something negative. They fear the judgemental attitudes of society. One 19-year-old girl said:

> Once society knows that girls are involved in premarital sex or have children before marriage then they will not accept her. They will be judgemental about the character of the girl and blame her, but the boys are free in spite of their involvement too.

Seeking SRH services is often stigmatised as evidence of sexual behaviour and, if discovered by the community, will result in more gossip and judgements.

Girls may visit health institutions for problems related to their menstruation, but not regarding information on more sensitive issues. To avoid rumours, stigmatisation and shaming, most of the girls keep quiet about their problems. Other studies from Nepal (CREHPA, 2015; Regmi, van Teijlingen, et al., 2010) show that sharing information about SRH and health-seeking behaviour is highly affected by girls' shyness, fear, discomfort and a sense of shame. Strict gender norms in Nepalese society limit the freedom of girls and restrict a girl's autonomy in care-seeking behaviour.

Step 4. Adolescent SRH care reaching

On the fourth step of access to health services, the model indicates that the ability to reach health care services intersects with availability and accommodation, which refer to the extent to which there is a physical infrastructure with sufficient capacity to deliver services. It takes into account both the features of health institutions and the health workers (Levesque et al., 2013). Using the observation checklist for adolescent friendly services (Table 1), none of the health

institutions included in this study were found to be adolescent friendly in terms of physical infrastructure, maintaining privacy, or in attitude and behaviour of health workers.

Previous studies have similar findings regarding poor adolescent friendly services, quality of care, inadequately trained human resources, poor physical infrastructure and lack of ownership in the community (CREHPA, 2015; WHO, 2017a). The health institutions, to some extent, are ignoring the national ASRH program. Poor data on adolescents and the absence of monitoring and supervision contributes to low accountability, incomplete reporting, and low motivation to meet and adhere to standards. By not prioritising an adolescent SRH service, health institutions miss the opportunity to identify and address challenges (CREHPA, 2015). All these factors influence the availability of services in the community.

Participants in our study complained that they have more time limitations and less freedom than their male siblings at home. They said that they needed to return home on time after school and that they had household chores to do. According to one of the girls, 'My brother can go to his friend's place and stay overnight, but for me it is impossible.' Controlling a girl's mobility and time is equivalent to the control over her health and body, and in effect she is not free to make decisions for herself. The choice of services, along with where and when to use them, are highly influenced by parental consent. In effect, parents represent an important barrier to girls' access to adolescent SRH services at health institutions.

The girls did not like the traditional customs and beliefs of their family regarding menstruation and felt they were isolated from the family at a time when they needed better care. They felt that their SRH was being stigmatised, even within their own family. They said that their mother did not want them to be corrupted by knowing too much about SRH. Some participants even avoided studying their reproductive health book in front of family members, so as to not evoke suspicion about 'doing something wrong with boys'. Some girls said that their parents probably would become angry if they knew about them visiting health institutions to share their issues with health workers.

Some girls said they were too shy to discuss their problems with male teachers; others did not even ask questions related to SRH in their curriculum. In addition, they suspected that health teachers have insufficient knowledge on SRH. Gender also played a major role in the classroom, where boys typically make fun of girls when teachers talk about female reproductive organs and menstruation. One of the girls said that:

> When we have class on reproductive health, our class seems to be very awkward. Teachers usually feel shy to teach; boys keep on laughing and feel eager to ask questions about girls' reproductive organs and menstruation; while all girls feel shy and put their heads down during the whole class.

Needless to say, girls preferred to have gender-separated classes to discuss these issues with confidence.

Several studies in Nepal have found that, regardless of parents' restrictive attitude and poor social support, adolescents' involvement in risky sexual behaviour is increasing (CREHPA, 2015; WHO, 2017a). Other studies (CREHPA, 2015; Regmi, Simkhada, et al., 2010) have found that a conducive environment within the family has a positive effect on safer sexual practices and in delaying sexual debut. Openness on SRH issues does not seem to be present in our study. The combination of the poor availability and accommodation of services on the one hand, and the strict gender norms and stigmatisation both in schools and in families on the other, means that the ability to reach SRH services among the girls is poor.

Step 5. Adolescent SRH care utilisation

Affordability is related to purchasing capacity in terms of resources and time. It is a combination of direct and indirect costs that determine if services are affordable or not (Levesque et al., 2013). In Nepal, SRH services are available for free from public health institutions. So, in this study, direct cost cannot be a major barrier for utilising the services. However, low approachability and the perceptions of non-appropriateness have already increased indirect cost in the earlier steps of access. For the few girls who actually reached the services, poor-quality service increases indirect cost even more.

Step 6. Adolescent SRH care consequences

Appropriateness refers to a match between services and the needs of clients, if provided correct health care in a timely manner using interpersonal skills suitable to the person seeking care (Levesque et al., 2013). Girls in this study who had visited health institutions for their menstrual problems were not made aware that the services were supposed to be adolescent friendly. They were generally disappointed either with the quality of services or with the health workers' behaviour and attitudes. Sharing their experiences among their peers did not improve the reputation of these health facilities. This eventually gave rise to a vicious cycle of disappointment, limiting the number of girls reaching health institutions and accessing SRH services.

4 | DISCUSSION

4.1 | Poor access to adolescent sexual and reproductive health services

By applying Levesque et al.'s (2013) model to our study, we found that most of the challenges and barriers to accessing adolescent friendly sexual and reproductive health services are found in the first steps of access to health care. Already at steps 1 and 2, we see that the girls' poor knowledge, both about their own needs and the availability of services, forms a serious barrier to access.

We find that there is still a lot to be done in improving the facilities and the services. Health personnel lack proper training, materials are few and outdated, and health workers have complained about the lack of resources to do proper outreach activities. Most importantly, the health institutions demonstrated a passive strategy for providing services, expecting the girls to come to their door. However, girls' expectations are that the health workers reach them. The lack of long-term outreach plans and the low priority given to the national ASRH program were the biggest challenges on the supply side. In addition to this, health workers are challenged by traditional perceptions of what they regard as gender- and age-appropriate services.

While improving facilities and services is needed, the most important barriers lie outside the health institutions. The main reasons for girls not attending these services are sociocultural. Embedding a social norm perspective on gender (Cislaghi & Heise, 2018) into the care-seeking model (Levesque et al., 2013), we see that gender interacts with all levels of access to care. From not having enough knowledge to perceive your own needs to lacking the courage to reach out and talk about sensitive issues, these are all barriers to access. There also are issues of a gendered control of time, as well as strict norms for modesty and appropriate knowledge and behaviour for

girls, holding girls back from seeking advice on sexual health, within the family, in schools and in health institutions. In all these arenas, girls are controlled by ridicule, laughter, stigmatisation and demands of obedience. Our study shows that all girls are in need of knowledge, not only those who are in need of health care. This calls for a stronger public outreach strategy.

4.2 | Strategies to improve access to adolescent sexual and reproductive health

Strategies for improving adolescent health must acknowledge that the health care needs of adolescents are different from those for the population at large. Adolescents, in general, are physically well but in dire need of counselling, awareness and literacy about their life skills, their bodies and their sexuality. To improve their health literacy, one strategy could be to strengthen the outreach programs for schools, making sure that health teachers are well trained, use appropriate facilities for their work and teach in gender-divided groups. Another step of increasing knowledge about sexual and reproductive health among adolescent girls would be to reach the girls through a platform that is less dependent on being at a specific place at a given time. Both traditional and digital media can be used as platforms for such anonymous communication.

Adolescents need a supportive family environment in order to become informed and make good health choices for themselves. Less parental control over girls' time and mobility, and less stigmatisation of a girl's sexuality within the family, are crucial for bettering adolescent sexual and reproductive health. A strategy should therefore contain programs to increase parental health literacy. It may be premature to create common health literacy programs for the whole family; however, opening up for parents and adolescents to talk freely about sexual and reproductive health within the family should be a long-term goal.

Finally, for implementation of the national ASRH program, the key actors are in the health care institutions, regionally and locally. For these strategies to be put into action, a two-day orientation for selected personnel only does not suffice. All health personnel must receive the necessary training, not only to perform medical procedures and tests, but to meet and reach the adolescents where they are in their lives. The training must also address health personnel's judgemental attitudes towards adolescent sexuality. They need a more thorough education about what is gender and age appropriate and about sexual and reproductive health not being limited to a medical understanding of the body and to one's marital status.

5 | CONCLUSION

There is still a lot to be done in improving the health facilities and the sexual and reproductive services in Kaski, Nepal, to make them adolescent friendly. However, the most important barriers lie outside health institutions. All girls are in need of knowledge about their sexual and reproductive health, which calls for a stronger public outreach strategy.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ACKNOWLEDGEMENTS

We would like to thank the Nepal Health Research Council for comments and ethical approval of our project and the District Public Health Office, Kaski, for providing access to the health centres, health workers and adolescent girls in district schools. The research in this article is from a master thesis project done through the International Social Welfare and Health Policy program at the Oslo Metropolitan University. We have received ethical clearance from the Norwegian Centre for Research Data (NSD) and from Nepal Health Research Council (NHRC).

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How to cite this article: Shrestha S, Wærdahl R. Girls' access to adolescent friendly sexual and reproductive health services in Kaski, Nepal. *Asia Pac Policy Stud*. 2020;7: 278–292. https://doi.org/10.1002/app5.305