UTILISATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES FROM ADOLESCENT FRIENDLY HEALTH SERVICES IN NEPAL

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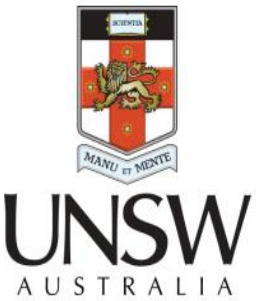
B.Sc. Nursing, MPH

A thesis in the fulfilment of the requirements for the degree of

Doctor of Philosophy



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Based on an interpretive research framework, a qualitative case study methodology was employed to understand the utilisation of AFHS. Health service utilisation was assessed through record review and via observations of health facilities, which results were compared with national standards criteria. A social constructionist lens and principles of grounded theory guided my understanding of adolescents' experience and the factors associated with their accessing SRH services from AFHS; the meaning of AFHS for adolescents; health care providers' attitudes towards adolescents seeking SRH services; and community perceptions and readiness to accept AFHS. A total of 16 interviews and six focus group discussions with adolescents (n=49), nine interviews with health care providers, and 13 interviews with key informants were conducted. Thematic analysis was applied in the data analysis.

The findings showed that both socio-cultural and health facility factors influence utilisation of SRH services. Many of these factors stem from the moral framework encapsulated in socio-cultural norms and values related to the sexual health of adolescents, and health care providers' poor value clarification. For example, health care providers had taken on a policing role in prescribing adolescents' conformity. In describing their ideal AFHS setting, adolescents spoke about maintaining privacy and confidentiality, and dignified SRH services. In stark comparison, the overriding community perception was to ascribe abstinence-only education from these health facilities.

This study provides an empirical understanding of the reasons and factors associated with SRH service utilisation, which goes much deeper than program provision of AFHS in Nepal. The recommendations offered can potentially strengthen policy, program and services to improve AFHS, together with creating an enabling and supportive environment for adolescents to access SRH services.

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DEDICATION

This thesis is dedicated to my mom Kamala Devi Shrestha Pandey and my dad Ram Chandra Pandey for making me who I am. You inspired me to be adventurous, never give up, and encouraged me to search for the unknown. Thank you so much for believing in me and letting me explore the world.

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ABSTRACT

Adolescent-friendly health services (AFHS) are considered key to addressing the sexual and reproductive health (SRH) of adolescents. Since 2009 Nepal has been integrating AFHS into its public health facilities. Despite much attention, and attempts to scale up AFHS, utilisation remains suboptimal. This thesis, therefore, aims to understand the factors contributing to adolescents' utilisation of AFHS in Nepal.

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LIST OF ABBREVIATIONS

AFHS	Adolescent-friendly health services
AHDS	Adolescent health and development strategy
AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent sexual and reproductive health
CSA	Comprehensive sexuality education
FGD	Focus group discussion
GIZ	German-agency for international cooperation
HCP	Health care provider
HF	Health facility
HFOMC	Health facility operation and management committee
HIV	Human Immunodeficiency Virus
ICPD	International Conference for Population and Development
IEC	Information, Education and Communication
KI	Key informants
MDG	Millennium development goals
MOHN	Ministry of Health Nepal
MOHP	Ministry of Health and Population
NGO	Non-government organisation
SDG	Sustainable development goals
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UNAIDS	United Nations Programme on HIV and AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

> *Rita, aged 17, was the mother of a three-month-old when I met her at one of the health facilities. She had come to the facility for the baby's vaccination and family planning service. I met her for an interview after her consultation with the health care provider. As I started my conversation by asking her to reflect on how her consultation went with the health care provider, she burst into tears. I held her baby to give her an opportunity to collect herself. With tears and in a quavering voice, she told me that the health care provider had shouted at her for missing her previous appointment. This happened in front of other patients in the same room. She felt embarrassed and her loss of self-esteem was such that she could not discuss her family planning options with the provider that day. She did not want to go back to see the provider now, and furthermore, she did not want to come to the health facility again.*

The health facility that Rita visited is supposed to be an adolescent-friendly one. She is an adolescent mother who made the effort to come to the health facility but from her account, she was treated in an unfriendly way which resulted in her negative impression of the services. Rita's situation raises a lot of questions. What does an adolescent-friendly health services mean to the targeted user? What does adolescent-friendly mean from the point of view of those providing the health services? What would assist adolescents like Rita to resume using these facilities? These are some of the questions that this study will address.

In Nepali society, health care providers are people who have earned the community's respect and who are often highly regarded in the social hierarchy. Their social position is likely to create gaps between the service seekers and providers, especially in a society where even today there a caste system also prevails (see chapter 2, section 2.3). This study aims to gain an understanding of the complex, intertwined relationships between individual, family, community, society, health care provider and adolescent-friendly health facility, and how their interactions affect the outcomes for service utilisation among adolescents.

The encounter with Rita during this research was a timely reminder of the need for research in this area. It took me back to the time I was working with CARE NEPAL in the Reproductive Health for Married Adolescent Couple Program. In that program, I encountered married female and male adolescents on a daily basis. These adolescents were generally out of school and confined to their

household and family chores. Many of them had had children by the age of 15-16 years. These adolescents used to visit the project health promotion activities with their babies, and female adolescents were mostly escorted by their husbands or mothers-in-law. During these meetings, these adolescents were too shy to speak for fear of being labelled by talking about contraceptives, which is a sensitive topic of conversation in the presence of others. It took two years for the project, and multiple health promotion interventions in support of local counsellors, to motivate and initiate such young adolescent mothers and youths to use contraceptives. There were also interventions among health care providers of the district to make health services friendly so that young people would seek SRH services. Some of these adolescents later became advocates in campaigns against child marriage. I continued working in adolescent health with the German Agency for International Cooperation (GIZ) to make an impact at a policy level. One of my contributions was towards designing Nepal's national adolescent health program and establishing adolescent-friendly health services in public health facilities. The adolescent-friendly approach and its preliminary results were highly appreciated by government and national and international organisations working in Nepal and resulted in increased funding for this approach. The plan to scale-up adolescent-friendly health services in at least a quarter of all public health facilities in the country was also included in the Nepal National Health Sector Program Implementation Plan II (NHSP-IP 2) 2010-2015. Consequently, beginning in 2010, with the support of UN agencies and government and non-government organisations the program was scaled up nationwide. In one way, I was happy that more than 1,000 health facilities adopted the adolescent-friendly health service approach, but equally concerned about the low utilisation rate of services among adolescents. I was intrigued as to why there wasn't a significant increase in the number of adolescents visiting these adolescent-friendly health services. My concern grew, and I wanted to find out more about the (under)utilisation of these health services targeted to adolescents. This was what drove me to start my PhD journey in 2015.

My attempt in this thesis is to understand the factors that affect adolescents' utilisation of sexual and reproductive health services from adolescent-friendly health services. I have explored the problem from various perspectives, including that of adolescents, stakeholders, key leaders, health care practitioners (HCPs), and peers, using a social constructionist epistemology. As a manager passionate about finding solutions to problem and issues, I have also taken a pragmatic approach and, therefore, I conclude this thesis with practical solutions for the issues identified.

In this chapter, I have structured my writing by giving a brief overview of who adolescents are, the importance of sexual and reproductive health for adolescents, and a short history and concept of adolescent-friendly health services. I then present the significance of this research and its aims, objectives and the research questions that this study addresses. This chapter concludes with an outline of the organisation of the thesis.

1.1 Adolescents

Adolescence is a unique period of physical, psychological, emotional and social maturation from childhood to adulthood (Blakemore, Burnett, & Dahl, 2010; Sawyer et al., 2012; Viner et al., 2012)., The World Health Organization (WHO) defines adolescence as the life stage between the ages of 10-19 years, youth as 15-24 years and young people as 10-24 years of age (World Health Organization [WHO], 1997). Often, young people, youth and young adults are synonyms used for adolescents.

The concept of adolescence varies with social and cultural differences and is often determined by adoptions of adult roles and responsibilities including employment and financial independence as well as the formation of life partnership (Patton et al., 2016). In many developing countries children aged 12-13 years may work full-time, whereas in developed countries adolescence is seen as a developmental stage leading to independence from the family (Gowers, 2005). Girls in developing countries often move from childhood to adulthood immediately after menarche and are assumed to be ready for marriage (Caldwell, Caldwell, Caldwell, & Pieris, 1998). Child marriage (marriage before the age of 18 years) for girls is still practised in a few South Asian countries like India, Nepal, Bangladesh and Pakistan (Barr, 2015; Bhat, Sen, & Pradhan, 2005; Maharjan, Karki, Shakya, & Aryal, 2012; Sharma et al., 2015). In Nepal, the legal age for marriage is 20 years for both men and women (Nepal Law Commission, 2006), in India and Bangladesh is 21 years for men and 18 years for women (Government of India, 2007; Government of the People's Republic of Bangladesh, 2017) and in Pakistan is 18 years for men and 16 years for women (Center for Reproductive Rights, 2018) . Marriage before this mentioned aged in respective countries are considered illegal except in Bangladesh where marriage before the legal age is permited in special condition where parents/guardian and court agrees in the best interest of girl and boy (Government of the People's Republic of Bangladesh, 2017) .

While the government of Nepal has adopted the WHO's definition of an adolescent (i.e. aged between 10 and 19 years) (Ministry of Health Nepal [MoHN], 2000)[1], there is limited information in Nepal about adolescence, and how people relate to it. Based on this definition, Nepal's adolescent population is one quarter (24.2%) of the total population (Central Bureau of Statistics [CBS], 2012). However, traditional views of the concept of adolescence vary. In Nepalese society, especially among *Brahmins* (one of the higher castes), the Hindu thread ceremony for boys between the ages of 8-12 years is the sign of maturation and transition to adulthood (Penkower & Pintchman, 2014). For girls, menarche is considered a sign of maturation, and many Nepalese believe that with the first menstruation a girl is ready for marriage. Moreover, her family would be interested in having her married as early possible to avoid any risk of her engaging in premarital sexual relationships (Human Rights Watch, 2016). The median age at marriage in Nepal recorded in 2016 was 17.9 years for women and 21.6 years for men (MoH Nepal, New ERA, & ICF, 2017). These ages represent a slow rise over the last 15 years; in 2001 the median age at marriage was 16.6 for women and 19.7 for men (MoH Nepal, New ERA, & ORC Macro, 2002). This means the period between puberty and marriage has increased and is likely one of several factors accounting for more sexually active unmarried adolescents (Patton & Sawyer, 2015). These changes have consequences for the sexual and reproductive health of adolescents, such as the risk of unintended pregnancies, sexually transmitted infections (STI), and HIV (Patton & Sawyer, 2015).

1.2 Importance of sexual and reproductive health of adolescents

Twenty-five years ago, the International Conference on Population and Development (ICPD), held in Cairo, Egypt, recognised reproductive health and associated rights as a key agenda for population and development programs (United Nations [UN], 1995). Reproductive health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes" (UN, 1995, p. 40). Reproductive health care is defined as "the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving

[1] The government of Nepal in last decade has experienced political instability, thus the ruling party government has changed the Ministry of Health's function sometimes with population component and sometimes only with health. Hence, the name of this ministry has been changed as the Ministry of Health or the Ministry of Health and Population frequently. Therefore, either one name or the other has been used in different documents. In this thesis both the names have been referred as per their published names in different documents.

reproductive health problems" (UN, 1995, p. 40). The ICPD specifically recognised the reproductive health needs of adolescents, including the issues of teenage pregnancy and its consequences for the education, economic and social status of women, and sexually transmitted infections including HIV/AIDS (UN, 1995, pp. 40-51). To address the needs of adolescents, the ICPD urged that government and non-governmental organisations establish a range of programs including the provision of family-planning information, counselling and support during pregnancy and early childcare, and information and counselling about sexuality and peer education (UN, 1995, pp. 40-51). Sexual health was also recognized as a vital part to reproductive health at the ICPD in 1994 (UN, 1995). WHO (2006 a) defines sexual health as "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled". The term sexual and reproductive health (SRH) provides a broader explanation of human sexuality and associated reproductive health outcomes such as unintended pregnancies, unsafe abortions, maternal and child mortality and morbidity, HIV and STI, and gender-based violence.

Twenty years on from the ICPD's recommendations, many women and adolescents in developing countries still had unintended pregnancies, which increase the health risks of women and children. The WHO has estimated that every year approximately 16 million girls aged 15-19 years and one million under 15 years give birth, with the majority coming from low and middle-income countries (WHO, 2014). Of these adolescent females giving birth, 70,000 in developing countries die annually due to complications of pregnancy and childbirth (United Nations Population Fund [UNFPA], 2013), a figure which puts adolescent reproductive health on the agenda as a global socio-cultural, socioeconomic and political issue (Chandra-Mouli et al., 2015b; WHO, 2015).

The importance of adolescent reproductive health has been highlighted on the international health agenda. Additionally, the SRH of adolescents has been widely recognized to be interlinked within complex socio-cultural and structural contexts such as family, education, wealth, social environment, etc., that often influence how adolescents view their SRH and their SRH outcomes (Marston & King, 2006; Shneyderman & Schwartz, 2013; Viner et al., 2012). Several challenges for adolescent reproductive health are faced in Nepal. First, Nepal is a low-income, developing country

with limited resources and enormous needs in its health sector; minimal priority, therefore, is given to adolescent reproductive health (MoHN, PMNCH, WHO, World Bank, & Alliance for Health Policy and Systems Research, 2014). The limited financial resources available to the health sector and the wider community impact the ability of individuals to purchase contraceptives and seek health provisions (Regmi, Simkhada, & Van Teijlingen, 2008). Nepal is a patriarchal society with a high degree of gender inequality causing women and girls to experience lack of power and autonomy in accessing information, education, property and decision-making about their health care (Acharya, Bell, Simkhada, van Teijlingen, & Regmi, 2010). In consequence, harmful social practices like early marriage and childbirth, domestic and sexual violence and trafficking of women persist (Nanda, Verma, & Abrahamson, 2012; Samuels & Ghimire, 2013; UN, 2013).

Notwithstanding such a challenging context, Nepal, as one of the signatories to the International Conference on Population and Development (1994), has implemented multiple programs focusing on adolescent health and the promotion of contraceptive use among adolescents. These programs aimed to not only prevent unwanted pregnancies but also to reduce the prevalence of HIV and other sexually transmitted infections. One such program was the introduction of adolescent-friendly health services (AFHS), which is the focus of this thesis. The WHO has defined adolescent-friendly health services as “an approach which brings together the qualitites that young people demand, with the high standards that have to be achieved in the best public services” (McIntyre, 2002). While this program was introduced to increase accessibility and utilisation of adolescent health and counselling services for adolescents in a friendly environment (MoH Nepal, 2011b), SRH service utilisation by adolescents, as indicated by service data, has remained minimal. The focus of this thesis is on identifying factors associated with poor utilisation of SRH services from AFHS and further, exploring the influence of underlying socio-cultural constructs on those factors.

In the next section, the history and concept of adolescent-friendly health services is discussed.

1.3 Adolescent-friendly health services: history and concept

In 1994 the ICPD, as mentioned earlier, laid out a globally accepted plan of action (ICPD-POA) that put the priority on sexual and reproductive health and rights especially in relation to adolescents and young people. It called for "*meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality*". The conference also highlighted the need for sexual and reproductive health services to be accessible through primary health care

systems to all appropriate ages, including adolescents, at the earliest possible time and not later than the year 2015 (UN, 1995).

Five years after the 1994 Cairo conference, a review of the Sexual and Reproductive Health Plan of Action (UN, 1999), highlighted the investment in adolescents as prudent not only for their well-being, but also for the future well-being of Nepal. The WHO redesigned existing services, and advocated that they be accessible, acceptable, and appropriate for adolescents, rather than setting up new service delivery points exclusively for adolescents where health facilities and health service providers would be expected to provide services to young people without discrimination by gender, ethnicity, religion, disability or social status (McIntyre, 2002; WHO, 2012). A further systematic review of 16 developing countries was conducted by the WHO to evaluate the contribution of health services to preventing HIV transmission among adolescents and youth, and which recommended the following three possible changes to health services (Dick et al., 2006).

1. First, health workers must receive specialised training to cater to the unique needs of adolescents and youth, especially communication and counselling skills to provide services in a supportive and friendly manner.
2. Second, the physical attributes of the health centre and service structure should promote confidentiality and privacy, be welcoming, of good quality and acceptable to adolescents and youth, and must be offered at subsidised rates or free of cost.
3. Third, the community must be engaged and given the capacity to conduct social mobilisation interventions that inform adolescents and youth about the services available to them (Dick et al., 2006).

In the Asian countries of Nepal, India, Bangladesh, Sri Lanka, Maldives, Bhutan, Thailand and Indonesia, beginning in 2000, national strategies on adolescent health were developed and programs initiated to address the sexual and reproductive health of adolescents (WHO, 2008). Some countries such as Thailand, India, Bangladesh, Sri Lanka and Indonesia focused on making health facilities adolescent-friendly through government health facilities and NGOs operating locally. In Nepal and Maldives the focus was on peer education to increase awareness about sexual and reproductive health among young people and community mobilisation activities through NGOs to inform community gatekeepers about adolescent health needs (WHO, 2008).

Along with the concept of AFHS, certain essential characteristics of health facilities that make programs effective were also defined (Engender Health, 2002; Senderowitz, 1999; UNFPA & Save the Children USA, 2009; WHO, 2012; WHO, 1999), as follows:

Provider characteristics

- health facilities should have appropriately trained health service providers who can address the specific biological, psychological and health needs of adolescents;
- health service providers should be non-judgemental and provide services in a friendly manner;
- the privacy and confidentiality of adolescent clients should be maintained; and
- adequate time should be allowed for client and provider interaction.

Health facility characteristics

- health services should be readily accessible to adolescents and be located in convenient locations;
- facilities should have flexible opening times for adolescents;
- structures should ensure adequate space and sufficient privacy;
- services should be provided at a reasonable cost or free of charge; and
- health facility environments should be appealing, appropriate, clean and comfortable for adolescents.

Program characteristics

- adolescents should be actively involved in designing, assessing and providing health services by having the opportunity to share their experiences of seeking health services and express their need and preferences. They should participate in certain appropriate aspects of health service provision.
- a wide range of SRH services should be offered, including counselling about sexual and reproductive health, family planning, treatment of sexually transmitted infections, antenatal care, birth and postnatal care, and HIV counselling and testing.

Thus, adolescent-friendly health services should aim to improve the arrangement, provision and quality of sexual and reproductive health services so that they are attractive to and used by young people (McIntyre, 2002; WHO, 2012). Several studies worldwide have shown that the

implementation of adolescent-friendly standards improved satisfaction among adolescents and the performance of health facilities (Dickson, Ashton, & Smith, 2007; Larke et al., 2010; Sanci et al., 2000; Yadav, Mehta, Pandey, & Adhikari, 2009). A study conducted in India showed that more than 80% of adolescents visiting adolescent-friendly health facilities there were satisfied with such facilities, owing to reduced waiting times, more suitable clinic hours and easily accessible health workers (Yadav et al., 2009).

Despite the positive feedback that AFHS have received in several countries, in Nepal AFHS has not brought significant change in the utilisation of SRH services by adolescents. The Nepal Demographic and Health Survey (NDHS) 2016 showed that 34.9% of married adolescents had unmet family planning needs, with 16.7% of married female adolescents already mothers or pregnant with their first child (MoH Nepal et al., 2017). Thus, there is a need to understand why utilisation rates are low so that measures to improve SRH service uptake among adolescents can be implemented.

1.4 Significance of this Research

Adolescent-friendly health services are considered a key strategy for improving access to SRH services for adolescents. In Nepal, adolescent-friendly health services were implemented over nine years (2009 – 2017) and scaled up in 1,134 out of total 4,000 public health facilities. These health facilities aimed to provide a friendly environment and conditions in which adolescents could comfortably and easily access friendly health services (MoH Nepal, 2011b). During this period, GIZ conducted adolescent-friendly health services baseline and final evaluations in 2011 and 2014, respectively (Teijlingen, Simkhada, & Acharya, 2012). These surveys were conducted among 2970 adolescents in four districts where adolescent-friendly health services were implemented by both government and GIZ. Both the baseline and end-line surveys covered 18 intervention and 12 control sites (Teijlingen et al., 2012). The survey findings revealed a significant increase in awareness and knowledge about adolescent-friendly health services among young people (Neupane, Pradhananga, Suwal, & Neupane, 2014). However, the number of young people visiting the health facility to seek services such as family planning and counselling did not change (Neupane et al., 2014). The detailed findings of this study will be discussed in Chapter 2, section 2.7.2. Another major study of adolescent-friendly health services by UNFPA in 2015, in 72 health facilities with AFHS in 12 districts of Nepal identified supply constraints affecting the quality of adolescent-friendly health services and barriers to service utilisation. That study found that 80% of participating adolescents had never visited the health facilities and, in contrast to the findings from GIZ evaluations, that none of the

participating adolescents, either male or female, knew about the AFHS (Kennedy, Tamang, Dhungel, Giri, & Shrestha, 2015). Despite the evidence that service utilisation had not improved, the scaling up of AFHS continued in Nepal, by government and with the support of external development partners (Save the Children, UNFPA, UNICEF, IPAS, ADRA Nepal, MSI) (MoHN, 2018). This continuous scaling-up of services that are underutilised could be perceived as a waste of resources for a country whose needs across the entire health sector are already enormous. Moreover, the long-run sustainability of the poorly utilised AFHS program is questionable. To date, none of the surveys undertaken have adequately explored the reasons for the underutilisation of these services. Several qualitative and mixed methods studies in Nepal, such as the recent UNFPA (2015) study (Kennedy et al., 2015), have only listed barriers encountered by unmarried adolescents in accessing sexual and reproductive health services, with none underlining any deeper understanding of individual barriers and their interaction with other factors. The available studies show a key barrier for adolescents accessing sexual and reproductive health services to be the judgmental and unfriendly behaviour of health workers (Kennedy et al., 2015; Regmi et al., 2008; Regmi, van Teijlingen, Simkhada, & Acharya, 2010b). Adolescents report that service providers treat them rudely or deny them services; further, they cited a lack of privacy and confidentiality in the health facilities and embarrassment about seeking the health services (Kennedy et al., 2015; Regmi et al., 2010b). Both Regmi et al. (2008) and Kennedy et al. (2015) suggested that health care providers may have neither the counselling and communication skills nor the adequate training necessary to deal with adolescents, which could account for poor perceptions of privacy and confidentiality. Further, Kennedy et al. (2015) emphasised the poor infrastructure of health facilities as a major aspect of poor privacy and confidentiality. That research did not, however, explore health care providers' attitudes towards providing SRH services to adolescents which may have resulted in the lack of privacy and confidentiality, instead focusing on service side challenges in providing SRH services. Also, the study's aim in interviewing adolescents was to explore their satisfaction with the AFHS and free-list the problems. Other issues nominated by adolescents were inconvenient opening hours of the health facilities which are the same hours as school, so adolescents were afraid of missing school because of needing to visit the clinics (Kennedy et al., 2015; Regmi, 2009).

While these barriers identified in the studies mentioned above give some indication of what hinders adolescents in utilising AFHS, adequate in-depth insight into the problem was not gained – only those factors that are easily observed were recorded. In this study, a more in-depth exploration is

made of root level causes which construct, shape and enable these surface-level manifestations. A deeper understanding of the issues surrounding young people's sexual and reproductive health service utilisation from adolescent-friendly health services would provide clarity about what should be done so that young people utilise adolescent-friendly health services. Therefore, this research aims to explore in depth the problems and challenges young people face in accessing sexual and reproductive health services in Nepal. In addition, the research looks at what health care providers think about delivering SRH services to adolescents to understand how their practices and attitudes might influence adolescents' decisions about SRH service utilisation. The information gathered will help to address the sexual and reproductive health challenges of young people in Nepal, and inform policymakers and planners, helping them to make relevant changes to the country's current adolescent-friendly health program.

1.5 Aim, objectives and research questions

This thesis aims to understand the factors contributing to the utilisation of adolescent-friendly health services in Nepal.

Research objectives

To achieve the aim of the thesis, the specific research objectives are to:

- Assess the level of utilisation of adolescent-friendly health services by young people in Nepal and the level of compliance of adolescent-friendly health services with the national standards;
- Understand the perceptions and attitudes of health care providers in delivering sexual and reproductive health services to adolescents at adolescent-friendly health services;
- Explore the practices of health care providers in their delivery of sexual and reproductive health services to adolescents;
- Explore the perceptions and attitudes of adolescents toward adolescent-friendly health services; and
- Explore community/stakeholder perceptions and attitudes towards Nepal's adolescent-friendly health program.

Research questions

There were seven key research questions posed by this study:

1. What is the current utilisation of sexual and reproductive health services by adolescents in adolescent-friendly health services?
2. To what extent do adolescent-friendly health services in Nepal comply with national standards?
3. What are the perceptions, attitudes and experiences of health care providers regarding the provision of sexual and reproductive health services to adolescents?
4. What are the adolescents' perceptions and experiences of the SRH services they received?
5. What does an adolescent-friendly health services mean for adolescents?
6. What are adolescents' experiences and challenges in accessing sexual and reproductive health services from adolescent-friendly health services?
7. What are the perceptions of community members (decision makers/gate keepers) of adolescent-friendly health services? Do they accept and support the adolescent-friendly health program?

1.6 Organisation of the thesis

This thesis has eight chapters. In this first chapter, I have provided a brief overview of the thesis and significance of the research, specifying the aim of the research, its objectives and research questions. I have also included some of my professional experience which has shaped the study.

In chapter 2, to set the context for the research, I give a background to Nepal, describing the country's relevant geographic, demographic, and political situation, its health status and health programs, and the adolescent health program. This chapter helps the reader to contextualise the findings. In this chapter, I argue that despite several challenges in the health sector, the country has made a significant attempt to address adolescents' sexual and reproductive health needs through adolescent-friendly health facilities – which are not, however, being utilised as they should be.

In chapter 3, I take a historical look at the development and importance of adolescent sexual and reproductive health in South Asia and in the global context. The determinants of sexual and reproductive health service utilisation by adolescents are reviewed and the issues within health system that impact sexual and reproductive health service utilisation are presented. I conclude the

chapter by discussing the socio-cultural factors relating to adolescent access to sexual and reproductive health services.

In chapter 4, I discuss the theoretical and methodological framework adopted in the study. Based on interpretive approach, this research is informed by social constructionist epistemology and pragmatism. The research methods, including data collection and data analysis, that I have employed are set out.

Chapters 5-7 contain my findings which I discuss in relation to the relevant literature. Chapter 5 addresses my first research objective, which is to assess the level of utilisation of adolescent-friendly health services by young people and the compliance with Nepalese national standards. This chapter uses health service audit information and observation of the health facilities. In this chapter, I also present three adolescent-friendly health services whose performance is categorised as good, medium and poor to provide an overview of adolescent-friendly health services in Nepal. For each of these I detail the physical settings, staff characteristics and competencies, available services, resources, health care providers' characteristics, and service utilisation information for each health facility. These three case studies of health facilities will enable the reader to better contextualise the findings presented in chapters 6 and 7. Chapter 5 concludes with my own reflections on these three health facilities.

In Chapter 6, titled "Barriers to accessing sexual and reproductive health services from adolescent-friendly health services," I address my study objectives 2, 3, 5 and partly objective 4. I present the perspectives of both adolescents and health care providers of the barriers and challenges, focusing on the perceptions and attitudes of health care providers delivering sexual and reproductive health services, the experiences of adolescents accessing these services, and community stakeholders' perceptions of adolescents and adolescent-friendly health program.

In Chapter 7, titled "Meaning of Adolescent-Friendly Health Services' I address the study's fourth objective, presenting findings from interviews with adolescents and focus group discussions of what adolescent-friendly health services mean to them. The findings presented draw not only on interview transcripts but also on drawings made by adolescents during the focus group sessions.

I discuss my findings in the light of relevant literature as well as their meaning in Chapter 8. I frame my discussions within the WHO's quality of care framework for adolescent-friendly health services.

I also place and discuss my findings within gender and moral frameworks. The chapter concludes with the strengths and limitations of the research and, finally, I discuss the implications of my research findings in the form of recommendations. Since the subject of this study is adolescent-friendly health services, which are predominantly for the purpose of promoting adolescent sexual and reproductive health, I have used the Ottawa Charter for Health Promotion's (WHO, 1986) action areas to frame both short- and longer-term recommendations.

CHAPTER 2: BACKGROUND AND CONTEXT OF NEPAL

This chapter provides the background and context for my study with an overview of Nepal's geography, demography, socio-cultural diversity, political and economic history, its health care delivery system, and the sexual and reproductive health status of adolescents and related policies and programs. To understand the issues around access to sexual and reproductive health services in the low-resource setting of Nepal, some knowledge of both the country's circumstances and its health programs is important. The information given in this chapter is based on a review of the literature and policy documents as well as on my own work experience of over 18 years in Nepal's health sector.

2.1 Geographical setting

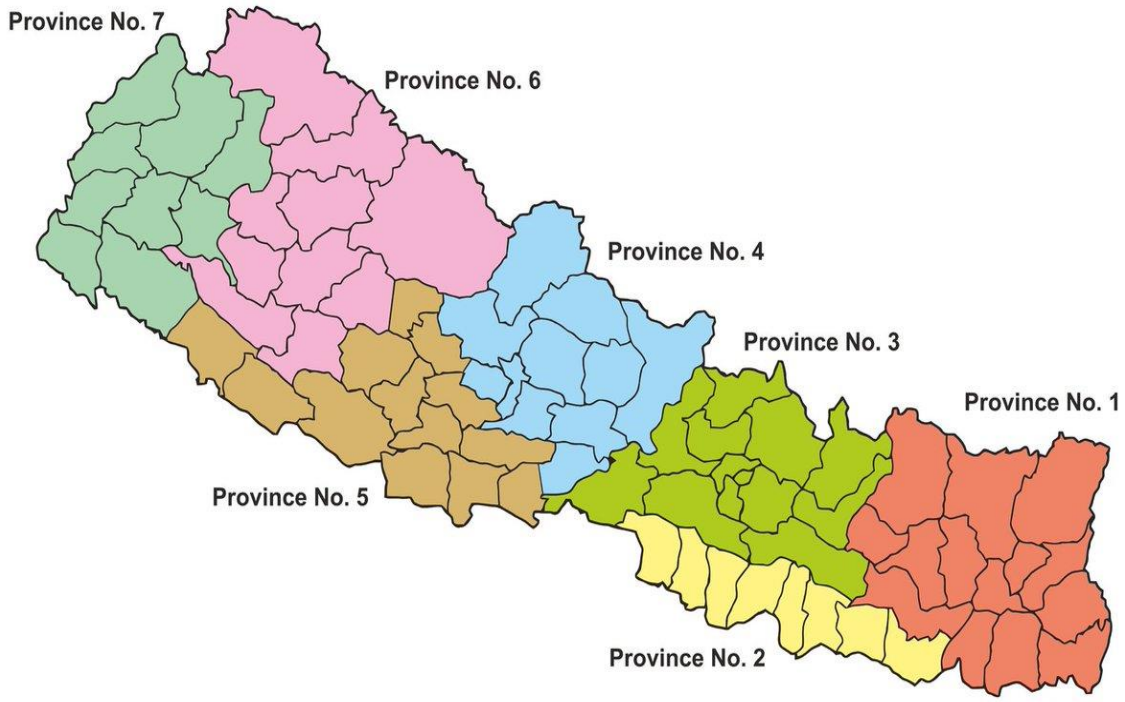
Nepal is a small, land-locked country in South Asia situated between two large and populous countries – India and China. The country is spread over 147,181 square kilometres of mostly mountainous terrain divided into three diverse geographical regions: mountains (*Himal*), hills (*Pahad*) and plains (*Terai*). The mountains region holds eight of the ten highest mountains in the world and borders China in the north. The hills region, in the centre, also has mountains ranging from 800 to 4000 metres high. Hills occupy around 64% of the total area of Nepal. The plains, or *Terai*, are as low as 59 meters above sea level and provide Nepal's fertile land bordering India in the south. Due to the rough terrain, there is only 65,500 km of both strategic and local road network, representing 0.44 kilometre per square kilometre of land but which is expected to rise to five kilometre per square kilometre by the end of Sustainable Development Goals (SDG) targets set by Nepal National Planning Commission by 2030 (National Planning Comission, 2015). The state of the available road network is mostly moderate during normal climatic conditions but is non-functional during the rainy season (World Bank, 2013). As a result, logistic supply to health facilities and people's access to them are challenged by commute times over long and exhausting distances.

Nepal's geographical location makes it highly vulnerable to climate change and natural disasters like floods, landslides and droughts, which regularly result loss of lives and damage to property and infrastructure (UN, 2018). Nepal is also vulnerable to earthquakes, especially around the capital city Kathmandu because of its position between two major tectonic plates, the Indian plate and the Eurasian plate (Amos, 2015). Historically in Nepal, there has been dangerous seismic activity every 70 to 100 years (UN, 2018). The latest major earthquake, in April 2015, killed nearly 9,000 people

(DRS, 2015) and injured 22,000 in Kathmandu and surrounding districts, and caused extensive damage to buildings, including health centres.

Five development regions, Eastern, Central, Western, Mid-western and Far-western regions, 14 administrative zones, and 75 districts were created in Nepal between 1972 and 2015.[2] With the new Constitution of Nepal in 2015 the federal government established seven federal provinces to replace the previous development regions. The federal provinces are named numerically, with only a few having had their names decided. At the time of writing this thesis, Province 4 has been named Gandaki Pradesh; Province 6 has been named Karnali Pradesh, and Province 7 has been named Sudurpashchim Pradesh. Figure 2.1 shows the geographic division of the provinces of Nepal.

Figure 2. 1 Map of Nepal



Source: Ministry of Foreign Affairs and Local Development website

[2] Then ruling King Birendra divided Nepal into four development regions in 1972. In 1982 he added the Mid-western region to fill the balanced or proportionate development gap between different parts of nation.

2.2 Political overview

Nepal has been through turbulent political and social movements. In 1769 Prithvi Narayan Shah united what were small kingdoms to form a greater Nepal. Since then, and until 1990, Nepal was an absolute monarchy. In 1990, a people's movement led by major political forces in the country, namely Nepali Congress and the United Left Front, led to the establishment of democracy in Nepal. The Constitution of the Kingdom of Nepal 1990 was then promulgated with the provision of multiparty democracy together with constitutional monarchy (Baral, 1994). The King was declared the symbol of unity of the Nepalese people among multi-religious, multi-ethnic and multi-lingual groups (Srivastava & Sharma, 2010). According to Sharma (2009), this constitution raised high expectations, particularly among marginalised populations in Nepal. Despite the new constitution, and the genuine economic growth and political progress delivered over the next three to four years, corruption spread massively (Dahal, 2017). There was little of the change promised by political parties in the political, societal and socio-economic conditions of excluded groups (Aryal, 2016; Sharma, 2009). From 1996-2006 another People's War was initiated by Maoists, who waged armed revolution against the constitutional monarchy, social and political inequalities, and the disparities and discrimination between caste and ethnicity (Srivastava & Sharma, 2010). During this ten-year civil war about 13,000 people died and an estimated 20,000 (one percent of the total population) were displaced (USAID, 2007). Over 1,000 health facilities in rural areas were destroyed (Mukhida, 2006), a dozen health care providers were killed, and many more left their posts to escape harassment, kidnapping, threats and persecutions by both the security forces and Maoists (Collins, 2006; Mukhida, 2006). The conflict also slowed down the development activities, especially in rural areas, that had been implemented by government and NGOs; primary health care services were affected by lack of medical supplies and the unwillingness of health professionals to go to remote locations (Upreti, 2006). Further, Upreti (2006) reported that the national security budget invariably increased during this time while resource allocations for basic social services such as health, education and drinking water significantly decreased.

The war ended in November 2006 when Maoists and the government of Nepal signed a comprehensive peace agreement. The interim constitution was formed in 2007 and in April 2008 Nepal held its first constituent assembly election in which Maoists won the majority of votes. At the first meeting of the new constituent assembly in May 2008, Nepal was declared a "Federal Democratic Republic" which formally abolished the monarchy. The first constituent assembly could

not, however, finalise the constitution; following its dissolution, the second constituent assembly of November 2013 committed to drafting a new Constitution of Nepal (Dahal, 2017), which drew a line of federalism and established a multi-level political system in Nepal in September 2015 (Constitution Drafting Committee, 2015).

The new constitution restructured Nepal with three levels of government: a federal level, seven provinces and 753 local government (Acharya, 2018) shifting executive power to local and provincial level (Thapa, Bam, Tiwari, Sinha, & Dahal, 2018). While, the shifting of power to this decentralised level is aimed at local resource usage through participatory bottom-up planning, increased accountability and reduced bureaucracy in decision making, these arrangements also have several implications for Nepal's health delivery system in the transition period. Thapa et al. (2018) in their article noted that the number of sanctioned positions at the federal level has been downsized before the provincial health structure are fully functional and responsible and this has increased the workload of the health staffs at provinces. Similarly, the health care providers (paramedics) at the primary health care level were primarily trained to offer health care services and therefore, lack skills on management and procurement of medical supplies which might impact the quality of health service delivery (Thapa et al., 2018). However, it is worth noting that Nepal is under transition and hence, there is lack of evidences of the implication of the new federal structure.

2.3 Demography and socio-cultural overview

According to the National Population and Housing Census 2011, Nepal is home to 26.6 million people and has an annual growth rate of 1.3 percentage points. Adolescents aged 10-19 years constitute a quarter (24.2%) of the total population of Nepal with almost equal numbers of males and females (CBS, 2012). UNFPA (2014) reports that for young people in countries with such a high proportion of adolescent population, life chances are poor, and especially so when a country has development challenges. For example, there tends to be a large unmet need for family planning, and young people are more vulnerable to sexually transmitted infections, HIV and gender discrimination.

Until 2006 Nepal was officially the only Hindu country in the world; following the People's Movement it was designated as a secular country. There are 126 castes/ethnic groups in the country (CBS, 2012). Officially there are ten religions in Nepal with the majority of people being Hindus (81.3%), followed by Buddhist (9%), Muslims (4.4%), Kirats (3.1%), Christians (1.4%), and other

minorities – Prakriti, Bon, Jains, Bahai and Sikhism (CBS, 2012). Pragmatically, however, Hindu culture still predominates, and Nepalese society follows its patriarchal value system. The national code or *Muluki Ain* of 1854 promulgated the caste system; influenced by Hinduism, it is a major determinant of social stratification based on identity, social status and life chances (Bennett, Dahal, & Govindasamy, 2008). Based on the caste system, Brahmins, the priests, and Kshatriya, the warriors, occupy the higher castes; Vaisya, or traders, form the second category; and Dalit, or "untouchables", fall within the most marginalised and disadvantaged groups (Bennett et al., 2008). This system also guides the hierarchy of people in society and prescribes norms for inter-caste relations and behaviours, sexual relations, touchability/untouchability, purity/impurity rituals, and temporary personal impurity traditions during menstruation, childbirth and mourning.

Although caste-based discrimination is now punishable according to the country's constitution, at a practical level, it is still a central feature of life and social interaction among Nepalis (Lagerberg, 2017). Practices that are detrimental to the health of the population include, for example, discrimination by higher caste health workers against lower caste patients, or vice versa. Daniel, Hasham, Lanning, Shintani, and Yadav (2012) conducted ethnographic research using a participatory approach among 209 participants from a Dalit community in Nepal's *Terai* region and noted that Dalit participants often face discriminatory practices like the denial of services and referrals, and disrespectful treatment.

Together with labelling by caste/ethnicity in Nepal, more than 123 languages are spoken by the ethnic and indigenous communities (CBS, 2012). The official language Nepali (also called *Khas*, *Gorkhali* or *Parbatiya*) is spoken by 44.6% of the total population and is the connecting language for people with different languages in the country (CBS, 2012). Some ethnic groups, however, live in isolation with minimal or no interaction with larger mixed communities where Nepali is often spoken. In those contexts, language is often a barrier to communication between health service providers and patients from these ethnic groups. For example, I have worked in different parts of the country where menstruation, for instance, is referred to variously as *Masik, Mahinabari, Para Sareko, Chui,* and *Nachune Bhako*, among other terms. The range of terms denoting menstruation derive from different ethnic group and linguistic understandings which often makes communicating with health care providers difficult. This is, however, only the tip of the language iceberg when it comes to communicating, understanding and receiving appropriate care for health-related issues.

In Nepal, only 17% of the total population live in urban areas, and the remaining 83% in rural areas (CBS, 2012). Most of the people living in rural areas are connected via rural roads, trails and airports Transport infrastructure like road trails/dirt road are often travel time-consuming, and flying often too expensive for rural people (Bhandari, Shahi, & Shrestha, 2012). As mentioned previously, road infrastructure is seasonal and viable only during dry seasons due to landslides, poor road surface or flooding caused by lack of proper cross drainage (World Bank, 2013). This often isolates rural residents from basic public services for health, education and communication.

Agriculture is the economic backbone of Nepal. In 2015 approximately 69% of the labour force was employed in this sector, which contributes more than one-third of the country's GDP, (Central Intelligence Agency [CIA], 2019). With the migration of young people seeking work abroad, remittances also play a key role in Nepal's economy, accounting for around 30% of GDP (CIA, 2019). Nonetheless, Nepal is one of the poorest countries in South Asia with an estimated 25% of the population living below the international poverty line of USD1.25/day in 2011 (ADB, 2017). The current Human Development Report 2018 ranks Nepal as 149th on the Human Development Index (United Nations Development Programme [UNDP], 2018). The per capita GDP of Nepal is USD2,443 with health expenditure accounting for 6.1% of that figure (UNDP, 2018).

Regarding education, 61% of the population aged six years and above are literate. The literacy rate in urban areas of 77% compares with 57% in rural areas (CBS, 2011). There is also regional disparity, with literacy the highest in the western development region (66%) and the lowest in the central development region (57%), where the current study is set, in the district of Dhading (CBS, 2011). Another huge disparity in literacy rates is that between males and females, respectively 72% and 51%. (CBS, 2011). In terms of age, literacy is highest among adolescents aged 15-19 years with 93.6 % in urban areas and 87.7% in rural areas (CBS, 2011). The literacy rate declines with age for both males and females.

2.4 Health service delivery in Nepal

Health is a fundamental human right as established in the Constitution of Nepal (Constitution Drafting Committee, 2015). The state takes the major responsibility for providing health services in all areas, including for communicable and non-communicable diseases, maternal and child health, and timely management of unpredictable health disasters for all Nepali citizens (MoHN, 2018). Nepal's national health policy was revised in 2014, its stated goal to

> "Provide health services through an equitable and accountable health system while increasing access of every citizen to quality health services to ensure health as a fundamental human right to every citizen". (Government of Nepal, 2014, p. 8)

In line with the new national health policy, the Nepal Health Sector Strategy (NHSS) 2016/17-2020/21 has been formulated as an instrument to guide the health sector so that it "*carries the ethos of Constitution to guarantee universal access to health services to all Nepali people"* (MoHN, 2015) The NHSS has defined ten national level indicators to measure improvements in health status, with one of the indicators specifically targeted to the sexual and reproductive health of adolescent girls (15-19 years) with a goal of reducing the adolescent fertility rate (births per 1000 women aged 15-19 years) from 71 in 2015 to 55.6 in 2020 (MoHN, 2017a). To meet this indicator the NHSS plan involved scaling up adolescent-friendly health services in all health facilities across 75 (of 77) districts of Nepal and establishing adolescent-friendly information corners in schools near adolescent-friendly service centres (MoHN, 2017a). The NHSS adolescent fertility target is the only explicit objective that Nepal has addressed as recommended in the ICPD-POA of 1994. Other objectives, such as reducing the incidence of unwanted pregnancy, unsafe abortion, and sexually transmitted disease, including HIV/AIDS, among adolescents were part of the general adolescent health intervention.

2.4.1 Health service delivery structure in Nepal

Nepal has a diverse health system that also includes complementary health modalities such as *Ayurveda*, and traditional faith healing (also known as indigenous and folk medicine). The Ministry of Health is responsible overall for the delivery of modern medical and preventive health services through the network of the Department of Health Services (DoHS). With 83% of people living in often difficult to access rural areas, Nepal's health care system has rightly been set up to have basic health services dispersed throughout its 77 districts.

The DoHS has a network of district hospitals, primary health care centres and health posts (Figure 2.2 and 2.3). At the basic, peripheral/community level an extensive network of Female Community Health Volunteers (FCHV) operates. An FCHV is a local married woman who is specifically mandated to deliver health services for treatment of childhood pneumonia and diarrhea (Khatri, Mishra, & Khanal, 2017) and to educate, promote and distribute contraceptives to men and women, including adolescents (New ERA, 2008). One FCHV is responsible for one ward (New ERA, 2008) or in a

population-based ratio, the smallest political division of a district under the federal structure. At the time of writing, Nepal's administrative structure, including the Ministry of Health and Population, is in transition and, therefore, in this thesis I refer to the current health service delivery in place. These peripheral-level FCHVs are supported by a Village Development Committee (VDC), the smallest administrative unit of a district which covers nine wards. For each VDC there is one health post which supports and manages FCHVs and also runs primary health care outreach clinics, immunisation clinics in the VDC's ambit and basic primary health care services. Multiple health posts fall into the catchment of a primary health care centre (PHCC) which has a designated medical doctor and three in-patient beds including one for maternity. Each PHCC catchment represents one electoral area and is also known as a referral health centre. Above the PHCC level is a district public health office and district hospital, and multiple districts make up zones for which there are zonal and tertiary hospitals. Multiple zones form a region in which there are sub-regional and regional hospitals under a regional health directorate. This structure works as a referral mechanism, as well as a support and reporting system for logistics, finances, supervision and technical support from the central to decentralised levels.

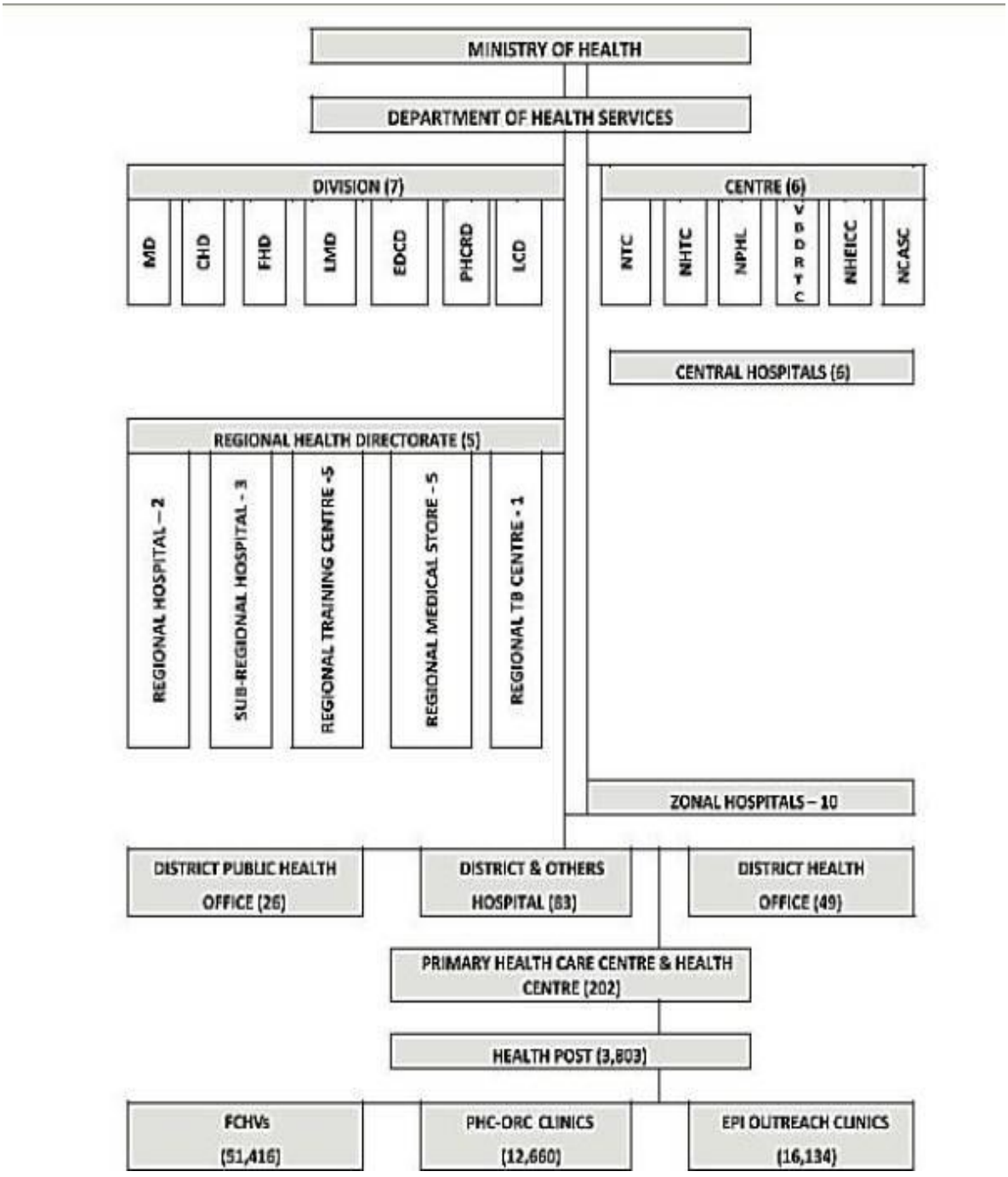
At the central level there are five centres and five divisions under DoHS in new federal system. Before the federal structure came in effect there were seven divisions and centre remain the same. These divisions are responsible for the overall management of the health programs they are responsible for from planning, implementation, to evaluation. The Family Health Division (FHD) which has recently changed to Family Welfare Division (FWD) is the one responsible for all components of sexual and reproductive health including adolescent sexual and reproductive health (ASRH) (MoHN, 2018, p. 105). FHD/FWD is also directly responsible for creating a friendly environment in public health facilities conducive to promoting adolescent access to ASRH services and scaling up adolescent-friendly health services (MoHN, 2018, p. 105). Similarly, the National Health Education, Information and Communication Centre cuts across all divisions and centres in supporting the behavioural change communication component, including for ASRH (MoHN, 2018, p. 249). In figure 2.2 and 2.3 the old and new organisational structure of DoHS is presented. The new organisational structure is not yet been officially finalised and endorsed and hence, both the structure are presented in transition phase of development into federal structure.

Although the health system is well set out, there are several challenges for health care delivery in Nepal, due particularly to financial inadequacies, lack of infrastructure and human resources, and

poor management and decision making at the central level. These challenges also result in disparities between districts, and even between facilities within districts in regard to program, staffing and available services. In Nepal, there are only 0.67 doctors and nurses per 1,000 population, significantly less than the WHO recommendation of 2.3 doctors and nurses per 1,000 people (Uprety & Lamichhane, 2016). This situation is aggravated when health care providers are not available at health facilities. In 2015, only 50% of the sanctioned position of medical doctors in primary health care centres and 58% in district hospitals were fulfilled (MoHN, New ERA, Nepal Health Sector Support Program [NHSSP], & ICF, 2017). Overall, 29% of health care provider positions in health facilities throughout the country were vacant (MoHN et al., 2017). In many instances, even where positions are filled the health service providers are not available to work during the facility's opening hours. A mixed method study of 416 students in Nepal's Puthyan district conducted by Upadhyay (2016) noted that unavailability of health care providers in the health facilities was one of the major reasons for dissatisfaction with services. Dissatisfaction for this reason might demotivate adolescents from returning to the service.

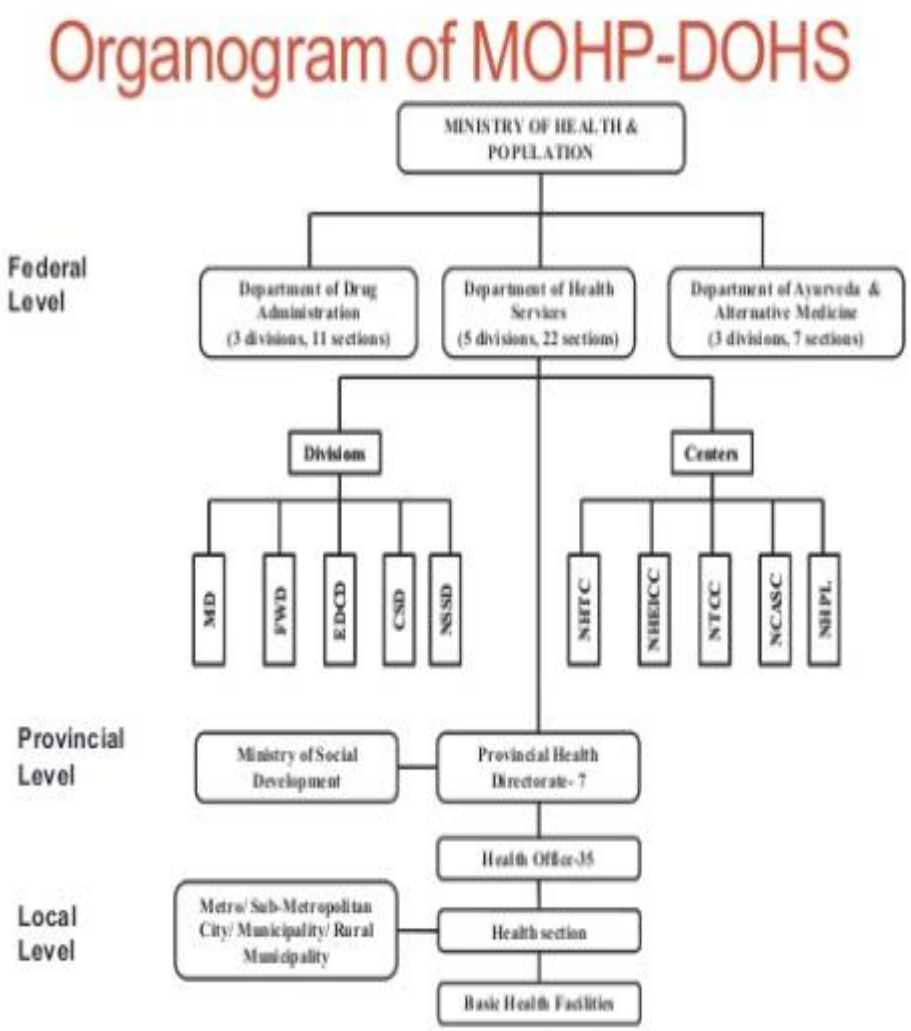
Per capita annual expenditure on health is USD40 and, despite universal health coverage, this expenditure represents out-of-pocket spending for the public (MoHN Nepal et al., 2017). This financial burden is also one of the major deciding factors for the population in accessing health services. Along with the government system of health care delivery, there are many private health service delivery points ranging from hospitals, nursing homes, private practitioners, NGO- or community-run health facilities. These private health facilities are recognised by the government and there has been attempts to streamline the service delivery information through information management system. However, there is lack of follow-up and no mandatory enforcement from the government for these facilities to report their service delivery. Due to this, there is poor and under-reporting of the health service delivery from these facilities. Hence, the information on the proportionate utilisation of private vs public services could not be estimated.

Figure 2. 2 Organizational structure of the Department of Health Services (before federalism)



Source: (DoHS, 2016)

Figure 2. 3 Organizational structure of the Department of Health Services (after federalism)



Source: (MoHP presentation 2018)

2.4.2 Health of people in Nepal

Nepal has made significant progress in its population's health over the last two decades. One of the major possible indicators is life expectancy at birth, which has increased from 59 years in 1996 to 71.3 years in 2018 – an annual growth rate of 0.50% (CIA, 2019). Further, Nepal achieved almost all of the Millennium Development Goals (MDG)[3] set in 2000, as shown in Table 2.1; in particular, there

[3] MDGs were the eight international goals for the year 2015 set by the Millennium Summit of the United Nations in 2000 for improving the lives of people in the world's poorest nations.

was significant progress in achieving health-related goals. The infant mortality rate (IMR) of 108 per 1,000 live births in 1990 decreased to 64 in the year 2000, and further to 33 per 1,000 live births in 2016, the under-five mortality rate of 162 per 1,000 in 1990 and 91 in the year 2000 had decreased to 38 per 1,000 live births in 2016 (CBS, 2015).Likewise, the maternal mortality rate (MMR) in Nepal, which was one of the highest in the world at 850 deaths per 100,000 live births in 1990, had declined to 281 in 2005, and to 259 per 100,000 in 2015 (MoHN et al., 2017). The steep reduction in MMR can also be associated with the fall in the total fertility rate (TFR) from 5.3 in 1990 to 2.3 in 2014 (CBS, 2015), due to increased use of contraceptives by married couples, from 24% in 1990 to 49.7 % in 2014 (CBS, 2015). Further, the reduction in MMR could also be partly attributed to the establishment of primary health care outreach and the introduction of maternal and child health programs and extended family planning programs in Nepal that were endorsed by national health policy in 1991. The decline in the fertility rate of adolescents (15-19 years) may have contributed to the total fall in fertility from 110 births per 1,000 in the year 2000 to 71 births per 1,000 in 2014 (CBS, 2015).

Similarly, another MGD indicator, for combating HIV/AIDS, was also achieved, with the HIV infection rate (15-49 years) beginning to reverse from 0.3% in 2000, to 0.2% in 2015. Condom use among 15-24-year-olds was, however, only 66% during their last sexual encounter, indicating that young people might remain at high risk for sexually transmitted infections (National Planning Commission, 2016).

Table 2. 1 Nepal's achievement of MDG targets, 1990-2015

Goals	Base year 1990	Target for 2015	Status in 2015
4. Reduce child mortality			
4A. Reduce under-five mortality by two thirds, between 1990 and 2015			
Infant mortality rate (per 1,000 live births)	108	36	33
Under-five mortality rate (per 1,000 live births)	162	54	38
5. Improve maternal health			
5A. Reduce the maternal mortality ratio by three-quarters between 1990-2015			
Maternal mortality ratio (per 100,000 live births)	850	213	259
Proportion of births attended by skilled birth attendants (percent)	7	60	55.6
5B. Achieve universal access to reproductive health by 2015			
Contraceptive prevalence rate (modern methods) – (percent)	24	70	49.6
Antenatal care coverage At least one visit (percent) At least four visits (percent)	na	 100 80	 68.3 59.5
6 Combat HIV/AIDS, malaria and tuberculosis			
6B. Achieve universal access to treatment for HIV/AIDS for all those who need it by 2015			
HIV prevalence among men and women aged 15-24 years (percent)	na	Halt & reverse the trend	0.03
Condom use at last high-risk sexual encounter (15-24-year old)	na	na	65.8
Percentage of population aged 15-24 years with comprehensive knowledge of HIV/AIDS	na	M:50 F:40	36.4

Source: (CBS, 2015; MoH Nepal et al., 2017; National Planning Commission, 2016)

Despite the clear progress made in MDGs, there is an unequal distribution of the health achievements by geography and socioeconomic status of people in Nepal. This means that marginalised and disadvantaged groups with poor indicators for health have been left behind. For example, although average institutional delivery throughout the country stands at 54.2 %, it varies with economic status, with the lowest wealth quantile at 27.9 % in comparison to 90.7% for the highest wealth quantile, making an equity gap of 62.8% (CBS, 2015). Similarly, although the national adolescent fertility rate decreased to 71 per 1,000 people in 2014, the fertility rate among rural adolescents remained 80, compared to 33 for the urban adolescent population (CBS, 2015).

2.5 Sexual and reproductive health of adolescents in Nepal

The sexual and reproductive health of adolescents has been recognised in Nepal since the Cairo ICPD in 1994 and has gradually become an integral part of essential basic health services. However,

Nepalese adolescents continue to face challenges in SRH matters because of socio-cultural values and norms. In this section, I will discuss the key areas of adolescent SRH in Nepal.

2.5.1 Legal Context of SRH for Adolescents

Nepal has defined health as a fundamental right of all citizens in its 2015 constitution. It states that every citizen has the right to basic health services free of cost from the state, and recognises reproductive health and other reproductive matters as the fundamental right of all women (Constitution Drafting Committee, 2015).

There are also several laws that regulate sexual and reproductive health and rights for young people. First of all, in Nepal children are categorised as those under 16 years of age (Government of Nepal, 1993). Sexual intercourse with a female child below the age of 16 years with or without her consent is legally considered as rape and is punishable (Nepal Law Commission, 2006). The law does not state anything about sexual intercourse with a male child. The legal age of marriage which in Nepal is 20 years for both men and women according to "An Act to Amend Some Nepal Acts for Maintaining Gender Equality, 2006" (Nepal Law Commission, 2006). Under this law, any person who is engaged in arranging a marriage for adolescents under 20 years of age, including adults who marry them, family member or other adults, is committing a crime and is subject to legal prosecution (Nepal Law Commission, 2006). Although the child is considered as under 16 years, many documents such as that from Human Rights Watch (2016) and Upadhyay (2016) refer to child marriage as marriage that occurs before 18 years of age. There are some governmental efforts to stop the practice of child marriage, but law enforcement is weak and monitoring mechanisms to take action over any marriage below the legal age are poor (Human Rights Watch, 2016; Pandey & Shrestha, 2012). One key national-level ASRH advocate told me that *"law enforcement institutions and employees attend underaged weddings; this means that despite being illegal these marriages are socially acceptable and results in no legal actions".* Thus, I would argue that still prevailing social norms that consider marriage to be acceptable following menarche contribute significantly to the difficulties in enforcing the Gender Equality Act.

Abortion has been legal since 2002 in Nepal under the 11th Amendment to the Civil Country Code (Thapa, 2004). The policy came in effect from 2003, and by mid-2014 there were 776 Comprehensive Abortion Care (CAC) service sites in Nepal (MoHN, 2014b). According to the law, only certified trained doctors or health care providers from registered health facilitates can provide

abortion services (Thapa, 2004). Women can have an abortion up to 12 weeks of gestation on request, 18 weeks of gestation in case of rape or incest, and at any time during pregnancy under medical approval in cases of risk to the life of the mother, or if the foetus has deformities that are incompatible with life. Abortion for adolescents under 16 years, however, requires the consent of a legal guardian (Samandari, Wolf, Basnett, Hyman, & Andersen, 2012).

2.5.2 Socio-cultural norms, attitudes and customs

In Nepal, several socio-cultural norms often affect the SRH of adolescents. Sex before marriage is culturally disapproved as there is a high value on virginity before marriage (Ghimire & Axinn, 2013). The concept of virginity mostly applies to females and less concern is accorded to males. In a recent youth-based digital platform, independent youth activist Jay Shah noted that in Nepal virginity is one of the many key reasons for child marriage because families do not want to risk their daughters engaging in sexual activity before they are later married (Shah, 2017). While remaining a virgin until marriage might help to reduce the SRH risk for some young people, customs like early marriage, early childbearing, dowry-related violence, the strong preference for sons, and sexual and gender-based violence are some of the major factors that often negatively affect the sexual and reproductive lives of adolescents.

In Nepalese society talking and learning about sex and sexuality is still taboo, and information often does not reach adolescents who need it the most (Puri, Shah, & Tamang, 2010). While there has been acceptance of the need to inform adolescents about SRH to prevent associated risks, this is only mentioned in health and education sector policies. Still today adolescents are given very little information about SRH either in schools or at home (Acharya, Thomas, & Cann, 2018). The scarcity of discussion about SRH at home or school limits the exposure of adolescents to SRH information and related services, contributing to the risk of poor sexual health outcomes.

Sexual education was one of the calls made to governments to promote the well-being of adolescents in the ICPD-Program of Action (UNFPA, 2004). A number of reviews and meta-analyses have documented effective sexuality education programs throughout the world (Michielsen et al., 2010; Paul-Ebhohimhen, Poobalan, & Van Teijlingen, 2008). Studies have reported that comprehensive sex education (CSE) is effective in reducing sexual risk among adolescents (Fonner, Armstrong, Kennedy, O'Reilly, & Sweat, 2014; Johnson, Scott-Sheldon, Huedo-Medina, Carey, & medicine, 2011; Mavedzenge, Doyle, & Ross, 2011). Fonner et al. (2014), in their systematic review,

noted that sex education programs have been effective in increasing knowledge about HIV, improved self-efficacy and condom use, and reducing the number of sexual partners among adolescent populations in low- and middle-income countries. In Nepal, CSE has been advocated by NGOs and international organisations for more than a decade. Recently, in technical support of UNFPA and Skill Information Society Nepal (SISo-Nepal), the Ministry of Education's Centre for Education and Human Resource Development (CEHRD), has developed a CSE package that includes teachers' resource materials and training curriculum (Ministry of Education Nepal [MoEN], 2017). The CSE package was developed in line with UNESCO's International Technical Guidance on Sexuality Education (ITGSE) and resource material to train teachers in the importance and implementation of CSE (MoEN, 2017). Although ITGSE recommends that CSE begins at age five, the CSE guidelines in Nepal designate sexuality education from the age of nine until 19 years. The CSE curriculum includes topics such as relationships, values, attitudes and skills, culture, society and human rights, human development, sexual behaviour, and sexual and reproductive health (MoEN, 2017). The efficacy of teacher training and its outcomes are yet to be evaluated, and Nepal still needs to revise its school curriculum in line with CSE. At present, while the school curriculum framework includes sexual and reproductive health education as part of the health, population and environment subject for grades 6-10, the subject is optional, which may not ensure that all adolescents receive SRH information at school. Furthermore, teachers may be reluctant to discuss sensitive topics such as sexuality and reproductive health because they are concerned about censure because of the social mores around this topic (Acharya, Van Teijlingen, & Simkhada, 2009). As noted by Acharya et al., (2018) in their qualitative research among 78 14-17-year-old adolescents in community-based schools in Nepal, the limited communication about SRH between teachers and students persists. This reticence is due to both students and teachers being too shy and embarrassed to talk about sex and sexual health (Acharya et al., 2018). Shrestha et al. (2013) reported inadequate teacher training and lack of necessary skills to teach topics on sexual health as one reason behind poor communication during SRH sessions in school. Nepal has the opportunity to build on the current nationwide implementation of the CSE as one possible solution to develop teachers' capacities for delivering sexuality education.

In the meantime, research from Nepal reports that Nepalese adolescents' main sources of information about sexual matters are the mass and electronic media such as glossy magazines, newspapers, radio, television shows, movies, CDs and DVDs (Adhikari, Adhikari, & Sulemane, 2018;

Bam et al., 2015; Regmi, Simkhada, & van Teijlingen, 2010a). In urban areas the internet has also become popular among Nepalese youth for accessing information about sexual matters (Thapa & Mishra, 2003). Similarly, peers are another main source of information (or misinformation) about sex for many young people (Adhikari et al., 2018; Bam et al., 2015; Regmi et al., 2010b).

Another important aspect of socio-cultural taboo in Nepalese society is associated with menstruation. Indicating the end of puberty among girls, the mean age of menarche in Nepal is 13.5 years, as reported in Nepal Adolescents and Youth Survey (NAYS) 2010/11 (Minstry of Health and Population Nepal [MoHPN], 2012). Menstruating females are considered impure in Nepal and during their menstrual period they must abstain from worshipping and cooking. They are also kept away from the family in a small, separate room for a certain number of days, making them vulnerable to infection and cold (MoHPN, 2012; WaterAid, 2009). Growing up in Nepal, I too had experienced being isolated for 12 days in a dark room during my menarche during which time I was not allowed to look at the sun (which is considered male) nor any male member of the family or community. After menarche, not only cooking or worshipping are forbidden – menstruating females are also expected to sleep on the floor in poor conditions for at least five days, even in educated families like mine. NAYS 2010/11 reports that 42% of girls had experienced being kept away from family during their menarche in one way or another (MoHPN, 2012). Many had similar experiences to mine, which even today include staying in a dark room, staying in a separate room, and being kept in a cowshed away from the house, not being allowed to touch any other human beings, plants or other materials until the ritual purification[4] takes place after several days (MoHPN, 2012). In the far-western region of Nepal especially, *Chhaupadi* is practiced. *Chapupadi* is the practice of isolating women during menstruation in a separate hut away from their homes and community (Ranabhat et al., 2015). During these seclusions, many girls and women are left alone without any social and family security which, as a result, puts them at risk of sexual assault, rape and violence (Amatya, Ghimire, Callahan, Baral, & Poudel, 2018). In addition to that risk, they are highly vulnerable to infections from living in poor, unhygienic conditions (Bhandaree, Pandey, Rajak, & Pantha, 2013; Upadhyay, 2017).

Very few studies have been made in the area of menstrual knowledge among adolescents in Nepal. However, available data suggests that socio-cultural norms prohibit discussing menstruation,

[4] Menstruating women undergo purification rituals such as sprinkling of holy water and oil after a shower on the fifth day of menstruation.

menstruation, being part of sex and sexuality, leaving many adolescents unprepared for this transition (Adhikari, Kadel, Dhungel, & Mandal, 2007; WaterAid, 2009). A study conducted in four districts of Nepal by WaterAid (2009) among adolescent girls in grades 8, 9 and 10 reports that 92% of adolescent girls knew about menstruation before their menarche from their mothers and sisters. What they were told, however, was mainly about using cloths as sanitary pads and the practice of rituals and restrictions around menstruation, rather than the physiology and management of menstruation. Hence, if the SRH of adolescents is to improve, socio-cultural norms and taboos in Nepalese society are important considerations.

2.5.3 Sexual Behaviour

As mentioned in the previous section, premarital and extramarital sex are socially unacceptable in Nepal (Adhikari & Tamang, 2009), as in other South Asian countries like India, Bangladesh and Pakistan. Studies conducted in Nepal have, however, consistently shown that despite social expectations, unmarried adolescents are becoming more sexually active at earlier ages (Adhikari, 2010; Niranjan, Prasad, & Kalpana, 2012). A possible explanation for young people becoming more sexually active could be Nepal's growing urbanisation, globalisation, and exposure to Western values and attitudes which are more accepting of sexual activity at a younger age (Garcia, Reiber, Massey, & Merriwether, 2012). As Regmi et al. (2010a) have discussed in their research among rural and urban adolescents in Nepal, exposure to mass media and internet could also explain increasing early-age sexual activity. Over the last two decades, telecommunication and internet services have expanded rapidly, adding services at cheaper rates. A news article by Neupane (2018) in the national newspaper *The Kathmandu Post* reported in January 2018 that internet penetration in Nepal was 62.94% in 2017, with 250 new users being added every hour. Many of these users are adolescents in both rural and urban areas. Adolescents, often curious by nature, can access sexual content more easily from the internet than from family or school. While technology can benefit adolescents as an educational tool, there are also several risks involved, particularly in their inability to differentiate good and bad quality resources or accurate and inaccurate information, which might lead them to experiment with sex. A recent cross-sectional study conducted among 522 male and female higher secondary students of Pokhara, a sub-metropolitan city of Nepal, found that 56.8% of research participants were exposed to pornographic movies. In an unadjusted analysis, the survey responses revealed a strong positive association (OR: 9.65) between exposure to pornography and premarital sex (Adhikari et al., 2018).

Studies from Nepal have consistently reported the increasing trend of earlier sexual activity among adolescents. The above study by Adhikari et al. (2018) in Pokhara further reported that 24.6% of respondents had had premarital sex. A study of college students in Kathmandu showed that 27% of adolescents (male and female) aged 15-19 were sexually active, and of those, 11% reported having had sex before the age of 16 (Adhikari, 2010). Similarly, another study which recruited male college students in Kathmandu reported that 32% of respondents had engaged in premarital sex before the age of 18 (Adhikari & Tamang, 2009). That study further reported that more than half of the respondents (55%) had had multiple sexual partners, and 23% of respondents had visited commercial sex workers (Adhikari & Tamang, 2009). Furthermore, another Nepali study among unmarried adolescent factory workers aged 14-19 found that 35% of males and 16% of females had experienced sex (Puri & Cleland, 2006).

These studies point to changing trends in Nepal and show that most young people no longer subscribe to the traditionally accepted views of waiting until marriage for sex. This also suggests that more adolescents are exposed to the risks of unwanted pregnancy, STI and HIV, which may have implications not only for their own health but also for the society and economy of the country. Although some of these studies were undertaken more than ten years ago, and given no significant changes have been made in the provision of health services, it is likely that the negative impacts on adolescent sexual and reproductive health will continue. Thus, the highlighted patterns point to a clear need to address adolescent sexual and reproductive health concerns.

2.5.4 Marriage and pregnancy

As mentioned in section 2.5.1, early marriage is common in Nepal despite laws stipulating 20 years as the legal age of marriage for both men and women (Nepal Law Commission, 2006). Early marriages are, however, on the decline (Choe, Thapa, & Mishra, 2005; Puri et al., 2010; Shrestha, 2002), although slowly. In 2016, Nepal Demographic and Health Survey (NDHS) reported that 27.1% of adolescent girls aged 15-19 years of age were married, only a slight decrease from 29% in 2011 (MoHN et al., 2017; MoHPN, New ERA , & ICF International Inc, 2012). Among women aged 20-24 years at the time of the study, 40.7% had been married before the age of 18 (MoHPN et al., 2012). The median age of marriage has not declined over the last five years. In 2011 the median age at first marriage for females was 17.5 years and for males, 21.7 years (MoHPN et al., 2012); in 2016 it was 17.5 years and 21.6 years females and males, respectively (MoHN et al., 2017).

Most early marriages occur in rural Nepal (Maharjan et al., 2012; Suwal, 2012) whereas in urban areas the trend for delayed marriage has grown (Arnett, 2002; Choe et al., 2005; Regmi, 2009). A study in Nepal of 100 pregnant teenage girls revealed that 70% had married early (Suwal, 2012). Alongside early pregnancy, early marriage has also been associated with gender-based violence and poor reproductive health in a Nepalese girl's life (Maharjan et al., 2012), thereby increasing her risk of less than optimal reproductive health.

Adolescent pregnancy is a high-risk sexual and reproductive health issue. A systematic review of studies from low- and middle-income countries documented that adolescent pregnancy is often associated with socio-cultural factors including poor socio-economic conditions, poor access to contraceptives, lower levels of education, ethnicity, and residence in rural areas (Pradhan, Wynter, & Fisher, 2015). A secondary analysis from NDHSs over the decade 2001 to 2011 reported that all those variables were significantly associated with adolescent pregnancy in Nepal (Pradhan, Wynter, & Fisher, 2018).

According to NDHS 2016, 16.7% of adolescent women aged 15-19 years were either already a mother or pregnant with their first child (MoHN et al., 2017). Although this figure has remained stagnant since 2011, it does mark a decline from 24% in 1996, indicating a possible change in sexual health knowledge amongst the adolescent population (Pradhan, Aryal, Regmi, Ban, & Govindasamy, 1997). A study conducted in one of the referral hospitals in Nepal showed that of 3,144 deliveries, 350 (11.1%) were by adolescents aged 15-19 years (Lama, Shrestha, Sharma, Upadhyay, & Pathak, 2013). Given that only 57% of births are taking place in health facilities (MoHN et al., 2017), the magnitude of adolescents giving birth could be an underestimation since only hospital deliveries were counted. A review of age-specific fertility rates among adolescents aged 15-19 years shows that the fertility rate decreased during the period 1996 to 2011: from 127 per 1,000 adolescents in 1996, to 110 n 2001, to 98 in 2006, and to 81 in 2011. In 2016, however, an increase in the adolescent fertility rate to 88 per 1,000 was recorded. The fertility rate in rural areas (125/1000 adolescents) is twice as high as it is in urban areas (66/1000 adolescents) (MoHN et al., 2017). There has been no further research into the reasons for the apparently increasing fertility rate among adolescents in Nepal, despite its being warranted.

An adolescent girl’s body is in a growing and developing phase, and pregnancy during this life stage has been associated with high risk of obstetric complications (Chandra-Mouli et al., 2015b). Hence,

many of those adolescents experiencing early pregnancy and childbirth have poor neonatal outcomes, such as pre-term delivery, low birth weight and birth asphyxia (Lama et al., 2013; Pun & Chauhan, 2011). The maternal mortality ratio in Nepal in 2016 was 239 deaths per 100,000 live births and adolescents aged 15-19 years contributed to 7.5% of these (MoHN et al., 2017).

2.5.5 Contraceptives and family planning

According to NDHS (2016), family planning knowledge among adolescents and youth is almost universal in Nepal (99.9%) (MoHN et al., 2017). Despite this, many sexually active Nepalese adolescents do not use contraceptives (Adhikari, 2010; Adhikari & Tamang, 2009). Only 14.5 % of married adolescent girls age 15-19 years are reported to use modern contraceptive methods (MoH Nepal et al., 2017), a figure which has remained almost stagnant since 2011 (MoHN et al., 2017). The discrepancy between knowledge and practice requires further investigation. One reason could be the acceptability of contraceptives. Although many married adolescents would like to delay or prevent further childbearing, they were often unable to obtain contraceptives before their last pregnancy, amounting to an unmet need as high as 34.9% among 15-19 year-olds in Nepal (MoHN et al., 2017). But accessibility alone does not account for this discrepancy. It is important to note that this data was collected from married adolescents only, which excludes information from a large number of adolescents who are not married. And it is likely that contraceptive use would be even lower among unmarried adolescents in a society where premarital sex is unacceptable and a matter of shame for families.

The Nepal Adolescent and Youth Survey 2010, a nationally representative household survey, reported that although 79% (n=14754) of sexually active adolescents had discussed using a condom to prevent pregnancy and HIV/AIDS with their partners, only a third of sexually active adolescent males reported using a condom at last sex (MoHPN, 2012). This result clearly shows there is much to be done to improve adolescent sexual and reproductive health in Nepal. The low rate of contraception and early-age sexual activity both exacerbate the risks and consequences to adolescent health. Thus, it is important that empirical research attempts to understand what, besides accessibility, contributes to poor contraceptive use so that appropriate measures that promote overall sexual and reproductive wellbeing of adolescents can be put in place.

2.5.6 Abortion

Abortion services are provided in both public and private facilities (Bell, Zimmerman, Choi, & Hindin, 2017). As noted previously, comprehensive abortion care services exist in Nepal; currently, all 75 district hospitals and over 50% of primary health care centres provide abortion care services (DoHS, 2016). However, according to the nationally representative NDHS (2016) only 40.9% of adolescents aged 15-19 years know where they can access safe abortions, knowledge which has decreased from 53.5% in 2011 (MoHN et al., 2017; MoHPN et al., 2012). Similarly, only 42.1% of adolescents aged 15-19 know that abortion is legal in Nepal (MoH Nepal et al., 2017). This indicates poorly devised health information initiatives to inform adolescents about the availability and legalisation of abortion services. Lack of knowledge of the legal status of abortion and where it can be safely accessed, in spite of its comprehensive availability, might result in adolescents seeking unsafe abortions. There is no empirical data available on the number of unsafe abortions sought by adolescents. However, the recent Department of Health Services Annual Report 2015/2016 recorded 89,214 safe abortions performed across Nepal, of which 16% were for adolescents (DoHS, 2016).

2.5.7 HIV and AIDS

There is no datas documenting the burden of HIV and sexually transmitted infections (STIs) among adolescents in Nepal. However, the NDHS (2016) reveals that only 18.3% of female and 24.3% of male adolescents aged 15-19 years have comprehensive knowledge about HIV (MoHN et al., 2017). Similarly, among sexually active adolescents, 15% of female and 2.7% of male adolescents reported STI and symptoms of STI in the past 12 months. These trends clearly identify that adolescent SRH is an important priority. While adolescent-friendly health services, as discussed in chapter 1, were intended to cater to the SRH needs of adolescents, it appears that this initiative has not adequately addressed the issue.

2.6 Sexual and reproductive health of adolescents in Nepal compared with neighbouring South Asian countries

This section presents comparative trends for key sexual and reproductive health indicators on the basis of demographic and health surveys (DHS) conducted in Nepal, Bangladesh, India, Pakistan and Sri Lanka over the past two decades. While all these countries have made international commitments to and national programs focused on sexual reproductive health, high numbers of early marriages, early pregnancies and unmet reproductive health needs, except in Sri Lanka, persist.

Nepal and Sri Lanka held their latest demographic and health surveys in 2016, India in 2015-2016, Bangladesh in 2014, and Pakistan in 2017-2018. Other successive health surveys have been conducted every five years consecutively since 1996 in Nepal, 1997 in Bangladesh, 1992 in India, 1992 in Pakistan, and since 1988 in Sri Lanka (USAID, 2019).

Demographic and health surveys from Nepal and Bangladesh reveal that the median age at first marriage for females in these two countries are less than 18 years, at 17.9 years and 16.1 years respectively. In India median age at first marriage for female is slighly higher at 18.7 years, Pakistan's at 20.4 years and Sri Lanka's is the highest at 23.7 years (Department of Census and Statistics & Ministry of Health, 2017; IIPS & ICF, 2017; MoH Nepal et al., 2017; NIPORT, Mitra and Associates, & ICF International, 2016; NIPS & ICF International, 2019). In these countries, the rate of change in the median age at marriage over two decades ranges from two to four years, and is owed to women's increasing access to education in these countries (USAID, 2019). The median age at first marriage for males has only been reported by Nepal, India and Pakistan in their recent demographic and health surveys. In all these three countries the median age at first marriage for men was above 20 years at 21.7 years in Nepal, 24.5 years in India, 25.9 years in Pakistan. There is currently no information for Bangadesh and Sri Lanka.

Early marriage goes hand-in-hand with having children at a young age. Recent evidence from inter-country DHS shows the rates of adolescents aged 15-19 who had already given birth or were pregnant with their first child are highest in Bangladesh (31%), followed by Nepal (17%), Pakistan (8%), and India (7.9%); these figures compare with 3% in Sri Lanka (Department of Census and Statistics & Ministry of Health, 2017; IIPS & ICF, 2017; MoHN et al., 2017; NIPORT et al., 2016; NIPS & ICF International, 2019). There is a direct relationship between early marriage and utilisation of

family planning methods and, thus, findings for contraceptive use among married adolescents in these countries show, inversely, that the lowest rate is in Pakistan (7.3%), followed by Nepal (14.5%), India (15%), Sri Lanka (37.5%), and the highest is in Bangladesh (46.7%) (Department of Census and Statistics & Ministry of Health, 2017; IIPS & ICF, 2017; MoHN et al., 2017; NIPORT et al., 2016; NIPS & ICF International, 2019).

Women who are sexually active but do not want to have a child or want to delay their next pregnancy, and do not use any method of contraception, are referred to technically as an unmet need for family planning. The unmet need among 15-19 year-old adolescents varies by country, with Nepal having the highest unmet need at 35%, followed by India at 22%, Sri Lanka at 21.4%, Bangladesh at 17%, and Pakistan at 17.9 % (Department of Census and Statistics & Ministry of Health, 2017; IIPS & ICF, 2017; MoH Nepal et al., 2017; NIPORT et al., 2016; NIPS & ICF International, 2019). These countries have however, collected data only for married adolescents, and a potential unmet need for contraception among unmarried adolescents might have been missed in these surveys.

Compared with other South Asian countries, Nepal has a similar rate of early age marriage among adolescents and a moderate rate of contraceptive use, but the highest unmet need for contraception among its adolescent population. This analysis indicates that despite the existing will, evident in initiatives for health service utilisation, there is a gap in service delivery.

2. 7 Sexual and reproductive health services in Nepal

In Nepal, as described in section 2.4.1 and 2.5.1, sexual and reproductive health services are provided by public and private health facilities (MoHN, 2014b). Hospitals, nursing homes, and private clinics are the main sites in urban areas whereas in rural areas, only public health facilities and community health workers are the key sources of SRH services (Regmi et al., 2010b). Family planning, safe maternity, legal abortion and STI/HIV services are a few of the major sexual and reproductive health services provided by public health facilities in Nepal (MoHN, 2014b). Since 2010, Nepal has initiated and scaled up adolescent-friendly health services in its public health facilities with the aim of providing SRH care for adolescents. In the next sections, the concept and scaling up of adolescent-friendly health services is discussed.

2.7.1 Adolescent-friendly health services

Nepal is a signatory to the ICPD-POA of 1994 (MoHN, 2000; Pradhan & Strachan, 2003), and through its Ninth Five Year Plan 1997 – 2002 and its Second Long-Term Health Plan (SLTHP) 1997 – 2017 has emphasized the need to develop a special program for reproductive health including that of adolescents (MoHN, 2000). The National Reproductive Health Strategy (NRHS) 1998 was developed in response to the SLTHP, in which adolescent health was recognised as a priority component of the reproductive health program (MoHPN, 1998).

Based on the NRHS 1998, the Nepal Adolescent Project (NAP) was implemented for the five years 1998-2003 in collaboration with international organisations like Engender Health, the International Center for Research on Women, and local Nepali NGOs New Era and BP Memorial Health Foundation. This project focused on encouraging community participation and addressing the needs of disempowered groups such as poor young women and ethnic minorities in the planning of programs to improve youth-friendly services, peer education and counselling at the community level. This project was implemented through four village development committees in Nepal and recommended the participatory approach as being successful in increasing community demand for information and services (World Bank, 2007).

In 2000, Nepal initiated its Adolescent Health and Development Strategy (AHDS) with the aim of expanding availability and access to adolescent health and development information and health services. The strategy further called for providing opportunities to build skills among adolescents, service providers, and educators to increase the accessibility and utilisation of health and counselling services by adolescents, and to create safe and supportive environments for them by adopting a multi-sectoral approach, to more effectively improve their legal, social and economic status (MoHN, 2000)

Until 2007, adolescent health programs were mostly supported by NGOs and private sector organisations. For example, UNFPA supported the Reproductive Health Initiative for Youth in Asia (RHIYA) project in Nepal during 2003-2006, in partnership with seven NGOs in 93 VDCs and seven municipalities in 19 districts (Valley Reserach Group, 2005). Similarly, USAID supported the Youth Friendly Services program which especially targeted married adolescents in two districts of Nepal during 2005-2007 (The ACQUIRE Project, 2008).

In mid-2007, Nepal's Ministry of Health (MoH) introduced an implementation guide, Adolescent Sexual and Reproductive Health for District Health Managers, to facilitate the rollout of the AHDS 2000 in public health facilities (MoHP, 2007). The implementation guide was developed for district health managers such as district public health officers, district health officers and reproductive health supervisors at the district level. Managers were guided step-by-step on how to implement the strategy in district and sub-district level health care settings, and given practical guidance on collaborating with educational institutions, NGOs and civil society organisations to carry out the adolescent health program (MoHPN, 2007).

During 2008-2010 the MoH piloted adolescent-friendly health services and tested the district health managers' guidelines in 26 of Nepal's public health facilities with the technical support of the German Agency for International Cooperation (GIZ) (MoHN, 2010). The pilot program included orientation of health care providers towards the needs and processes of adolescent-friendly health services and towards community stakeholders, to generate community support for implementing adolescent-friendly health services, and preparing health facilities with basic equipment useful for adolescents like weight and height scales, and waiting room furniture and reading materials (MoHN, 2010).

In 2010, the Ministry of Health and Population Nepal and GIZ conducted a process evaluation of adolescent-friendly health services with the objectives of documenting the process of introducing adolescent-friendly health services in public health facilities and identifying any gaps for improvement (MoHN, 2010). The process evaluation showed that the key implementers of the AFHS, such as district health managers and health care providers, accepted the program. This result was demonstrated in interviews held with the officials elected by the district health managers, who were in charge of the adolescent health program. In the interviews, all the officials expressed a high level of commitment to the program. The health care providers similarly revealed that they were strongly interested in providing services to adolescents.

Along with the positive feedback, a number of challenges to the adolescent-friendly health program also emerged, namely lack of logistic supplies, substandard health facility infrastructure, and poor monitoring and supervision. These challenges were further exacerbated by the frequent transfer of trained health care providers, which meant that trained health care providers were not always present in the facility but were often shifted to health facilities without the adolescent-friendly

designation. The report further stated that advocacy and governance stakeholders, such as the reproductive health coordination committee, and some health facility management committees were not aware of adolescent-friendly health program in their district and community. The evaluation found there was deficient recording and reporting due to a lack of appropriate mechanisms in line with health management information systems (MoHN, 2010). However, the process evaluation of the AFHS pilot intervention apparently provided enough evidence to support the scale-up of the program across Nepal.

2.7.2 Scaling up of adolescent-friendly health services

Included in the 2010 Nepal Health Sector Program Implementation Plan II (2010-2015) was the requirement to scale up adolescent-friendly health service interventions in 1,000 public health facilities by 2015 (MoHP, 2010). In 2011, the ministry finalised the National Adolescent Sexual and Reproductive Health Program – Program Implementation Guide to support district health managers, health facilities and health service providers in offering adolescent-friendly health services (MoHN, 2011b) in order to reach the target of implementation in 1,000 health facilities. The guide emphasised that adolescent-friendly health care should not be a separate or additional service, but rather it would manifest in a friendly environment and conditions in which adolescents could comfortably and easily access sexual and reproductive health care (MoHN, 2011b). Another important aspect of the SRH program mentioned in the guide was to invite adolescents to participate as members of health facility operational and management committees to represent an adolescent voice within the service system (MoHN, 2011b). In addition, the following key interventions of adolescent-friendly health services, as outlined in Table 2.1, show national standards for adolescent-friendly service intended to reflect the objectives of better access to and utilisation of contraceptives and reduction in the number of unintended pregnancies (MoHN, 2011b).

Table 2. 2 National standards for adolescent-friendly services in Nepal

Elements	Details
Service delivery package	• Services to be developed by district health managers as per the needs and demands of adolescents and youth at the local level
Organising effective services	• Service providers to be well trained and motivated to provide services to adolescents • Health facilities equipped with required essential supplies and equipment
Conducive environment at health facilities	• Physical environment, procedures and staff friendly to adolescents • Identify barriers to seeking health services and attempt to address these barriers in creating a conducive environment
Capacity building of service providers	• Appropriately building the capacity of service providers in technical competence and motivation to provide services to adolescents
Building enabling environment	• Address community barriers to support the effective delivery of health services to adolescents
Communication with adolescents	• Address the gaps in knowledge and awareness of health and sexual and reproductive health issues among adolescents • Peer education networks
Skills for health	• Provide adolescents and youth with skills-based sexual and reproductive health education in schools
Adolescents and youth enjoy their sexual and reproductive health and rights	• Protecting the sexual and reproductive health rights of adolescents including unmarried adolescents, lesbian, gay, bisexual, transgender and intersex (LGBTI) youth
Health management systems in place on site	• Monitoring systems • Feedback mechanism

Source: (Ministry of Health Nepal, 2011b)

The scaling up of AFHS in Nepal was achieved in phases, and by the end of 2017 adolescent-friendly services had been implemented in 1,134 health facilities across 70 districts in Nepal along with the orientation of health service providers to the processes and procedures of SRH services (MoHN 2018).

Table 2. 3 Scaling up of adolescent-friendly health services by year in Nepal

Fiscal year	2009	2010	2011	2012	2013	2014	2015	2016	2017	Total
No. of new districts	5	5	5	23	10	9	6	3	4	**63**
Total no. of health facilities	25	65	65	436	92	374	Number not available			**1134**

Source: (Ministry of Health Nepal, 2018)

In 2012 and 2014, the Ministry of Health and Population Nepal and GIZ commissioned baseline and final evaluations from the four districts of Nepal where adolescent-friendly health services had been initially implemented in 2011. Both the evaluations revealed the evidence of service utilisation, the level of satisfaction, and knowledge among adolescents about adolescent-friendly health program.

Data from these evaluations indicated that young people's knowledge about adolescent-friendly health services increased significantly in the intervention areas (baseline 50% to final evaluation 69%) in comparison to control areas (baseline 50% and final evaluation 56%) (Neupane et al., 2014; Teijlingen et al., 2012). Similarly, a significant percentage of young people in the intervention areas (baseline 36% and final evaluation 49%) reported that the health facilities now provided a separate room for adolescent counselling. In addition, a significant percentage of young people in the intervention area (baseline 45% to final evaluation 58%) reported that adolescent-friendly health services had maintained their privacy during counselling and treatment compared with control areas (baseline 41% and final evaluation 44%) (Neupane et al., 2014; Teijlingen et al., 2012).

However, the data also suggested there were no significant differences in service utilisation by young people between the intervention and control areas. Service utilisation in fact decreased by 3% in study areas (baseline 67% and final evaluation 64%), and 1% in control areas (baseline was 66% and final evaluation 65%). Similarly, the the percentage of young people who received information about puberty and bodily changes from health care providers in intervention areas (baseline 22% and final evaluation 31%) was not significantly different from the percentage in control areas (baseline 27% and final evaluation 31%) (Neupane et al., 2014; Teijlingen et al., 2012).

The data further showed no significant differences between intervention and control groups in young people's reported levels of satisfaction with adolescent-friendly health services and health care providers, at 61.6% and 59.8%, respectively (Neupane et al., 2014). The level of satisfaction among young people with AFHS was an add-on component in final evaluation.

2.8 Summary

In this chapter, I have provided the geographic, political and population health context of Nepal, as well as the SRH status of adolescents and the provision of service to address sexual health issues in the country. There is limited information available on indicators for SRH of adolescents in Nepal, but I have discussed what is available from national surveys and relevant research. Contextualising this study is important for my findings that relate to the influences on the sexual and reproductive health of the study's participants.

Nepal is a geographically and demographically diverse country which has recently transitioned to relative political stability after a long civil war. The poor economic status of its people and the country's challenging geography affect daily life in ways that are reflected in the nation's poor indicators on health. The government health system is designed to cater to the decentralised population, yet unequal distribution of health achievements persists. Nepalese adolescents aged 10-19 years face significant challenges associated with SRH, such as premarital sexual activity, early marriage, early childbearing, and poor contraceptive utilisation rates and high unmet needs. The issues around adolescent SRH in Nepal are intertwined with socio-cultural traditions, values and norms that make it difficult for them to seek SRH services. Further, an insufficient health budget, poor infrastructure and road networks, and inadequate health service provision in rural areas have significant implications for the SRH of adolescents in the country.

In this challenging context, Nepal has introduced and scaled up adolescent-friendly health services to improve access and utilisation of SRH services with the aim of reducing the rates of early-age pregnancy and childbirth and the implications they entail. While the MoHPN-GIZ process evaluation of 2010 gave evidence that supported scaling up the AFHS intervention, program evaluation in 2014 revealed minimal or no change to service utilisation rates. The 2010 report had not considered adolescents' perspectives on AFHS. Given the SRH status of adolescents as discussed in this chapter, seeking an empirical understanding of these issues is warranted. Therefore, this thesis focuses on the gap in understanding adolescent-friendly health services in Nepal to gain insights leading to possible solutions to their underutilisation.

CHAPTER 3: LITERATURE REVIEW

This chapter examines the current literature pertinent to adolescent sexual and reproductive health (ASRH) service utilisation, and establishes the importance of understanding what contributes to SRH utilisation by adolescents at global and national levels. The evidence is presented together with a synopsis of adolescent demographics, epidemiological information and related determinants of adolescent sexual and reproductive health, and highlights the noble opportunity that exists for adolescent-friendly health services to increase adolescents' engagement with them. This chapter begins with an introduction to adolescence as a period of transition from childhood to adulthood that includes various perspectives of adolescence in the contextual grounds of socio-cultural values and norms in Nepal and more widely. Following an exposition of the demographics of adolescents, who constitute the biggest share of the population worldwide and in the Nepalese context, I associate this information with relevant opportunities and challenges. Adolescent sexual and reproductive health is then explained from epidemiological perspectives, and other determinants, to demonstrate the importance of adolescent sexual and reproductive health. I discuss what is currently known about of the factors influencing ASRH service utilisation, as well as related theories at individual, social and health services levels. I conclude the chapter by identifying some of the major gaps in the literature and their significance for this study.

For this review, an extensive literature search has been carried out over the last four years. A search of the public health, medicine and social sciences databases including Medline, Pubmed, Scopus, EMBASE, Popline, and ProQuest, as well as Google Scholar was undertaken. The keywords used were: adolescent/adolescence, youth/young people, sexual and reproductive health, adolescent-friendly health services, youth-friendly health services, condom use, STI and HIV. Soft copies of book chapters were obtained from the UNSW Library and Google, and hard copies were obtained from the library. The search was limited to literature available in the English language, except for Government of Nepal documents in Nepali. The search was mostly confined to the last 20 years. Grey literature such as reports were obtained from the website of the Ministry of Health Nepal, United Nations, the World Health Organisation, UNICEF, UNFPA and GirlsNotBrides. Hard copies of the reports were collected from the organisations in Nepal. Further, the reports, manuals and program guidelines were obtained from peers, programmers and academics. Also, the reference list of journal articles was reviewed, and relevant references obtained and reviewed.

3.1 Concepts of adolescence and adolescents

As noted in chapter one, the World Health Organisation (WHO) defines adolescence as the period of life between the ages of 10-19 years (World health Organization, 1997). Adolescents are young people who are going through this period of transition, where neurological development and associated cognitive and emotional capacity grows, alongside their interaction with social environment. This helps shape the adolescents' learnings and capabilities that continue into adult life (Patton et al., 2016). Nepal has adopted the WHO's definition of adolescence, which embraces young people aged from 10 to 19 years (Ministry of Health Nepal, 2000). In my research, I have used the same age group and throughout this thesis, I will use, the terms adolescent and young people interchangeably to refer to the same group.

Notwithstanding the accepted definition, adolescence is difficult to mark precisely in terms of beginning and end. The onset of puberty varies by individual and between genders. Puberty is the period during which growth spurts occur, secondary sexual characteristics develop and fertility is marked together with psychological changes in the body of adolescents (Sawyer, Azzopardi, Wickremarathne, & Patton, 2018). UNICEF (2011) notes that normally, girls' puberty begins on average 12-18 months earlier than boys'. The median age of menarche (first period) for girls is between 12-14 years (Chumlea et al., 2003; Sunuwar, Saha, Anupa, & Upadhyay Dhungel, 2010; Tomova, Lalabonova, Robeva, & Kumanov, 2011); boys' first ejaculation generally occurs at 13-14 years of age (Tomova et al., 2011). While some girls may first menstruate as early as 8 years of age, these are exceptional cases (O'Grady, 2009). However, it should be noted that research now suggests that over the last century the age of puberty's onset has declined by four to five years (Pierce & Hardy, 2012; VitalRecord, 2018). While there is little in the way of research that documents puberty of adolescents in Nepal, the Nepal Adolescent and Youth Survery (NAYS) 2010/11, reported the mean age of menarche for girls as 13.5 years and the mean age of semenarche (first ejaculation) for boys as 14.5 years (Minstry of Health and Population Nepal [MoHPN], 2012).

Across the world, there are differences in how adolescents are perceived in terms of their maturity, reflected in national laws. In many countries "maturity" is based on the legal age of consent and for marriage (Dehne & Riedner, 2005; GirlsNotBrides, 2016; UNICEF, 2011). In many developing countries, the concept of adolescence has only recently been recognised – individuals in those societies were previously seen as moving directly from being children to adults. In some countries, this transition from childhood to adulthood is marked by institutional rites for male and female

children, after which they are deemed full members of their society and become eligible to participate in adult ceremonies (Andersen, Taylor, & Logio, 2015). These customary institutional rites vary among cultures and ethnic groups. Some of the rites relevant to SRH in Hindu cultures in South Asian countries like Nepal and India pertain especially to boys of the Brahmin caste;[5] following the threading ceremony,[6] between the ages of six and twelve years they are considered "grown-ups". Boys can then participate in adult religious responsibilities, and also marry (Penkower & Pintchman, 2014). For girls in the same culture, menarche is a sign of fertility indicating they are ready for marriage (Shrestha, 2002).

Researchers have tried to understand adolescents from different theoretical points of view, focusing particularly on biological and neurological development and the influence of socio-ecological environments as determinants of their behaviour. The following section looks at theories of adolescence to attempt a cohesive view of what it means to be an adolescent.

The sociological view understands adolescence emerging from the socio-economic changes resulting from the arrival of institutionalised schooling practices in the 20th century (Caldwell et al., 1998; Demos & Demos, 1969; Modell & Goodman, 1990). Recently, (Patton et al., 2016) in their publication present a neuroscience paradigm that has emerged in the last 20 years – changing cognitive and emotional capacities during adolescence. The biological view of adolescence highlights physical maturation due to hormonal and emotional changes at puberty as an important signal of this period (Gowers, 2005; Patton & Viner, 2007; Spear, 2012). The biological maturation perspective, introduced by G. Stanley Hall (Hall, 1916), explains that the development of the individual throughout adolescence is determined by biological and genetic forces. Patton et al. (2016) explains that during adolescence brain development occurs together with pubertial process including gonadal hormone change along with maturation of sub-cortical structure in brain that allows to understand sex differences. Yet socio-cultural, nutritional environmental context, and exposure such as substance use also influence adolescents' expressions and experiences of this period (Arnett, 1999; Patton et al., 2016; Steinberg, 2001). The biological maturity perspective is

[5] Brahmins are considered to be the upper class in the hierarchy of caste. The caste system in Nepal is explained in chapter 2, section 2.3

[6] The threading ceremony is a Hindu rite of passage for boys. It involves shaving the head, bathing, and wearing new clothes in a ceremony where he receives scarred-thread that needs to be worn for his lifetime, and vows to respect his parents, teachers and community.

also associated with elevated rates of risky behaviours due to the hormonal changes characterising this period (Kipke, 1999).

Ecological perspectives have similarly explained that contextual social and environmental factors like economic status, cultural background, and the general environment contribute to the social norms and values, opportunities and reinforcements the condition that determine the behaviours of adolescents (Millstein & Igra, 1995). Often, risky behaviours including high-risk sexual behaviour like early and unprotected sexual intercourse, forced sex and multiple sexual partnerships (Ssewanyana et al., 2018), and inter-generational sex, sexually transmitted infections and HIV (Underwood, Skinner, Osman, & Schwandt, 2011) are associated with family poverty, poor parental monitoring, peer influence and poor exposure of adolescents to SRH information.

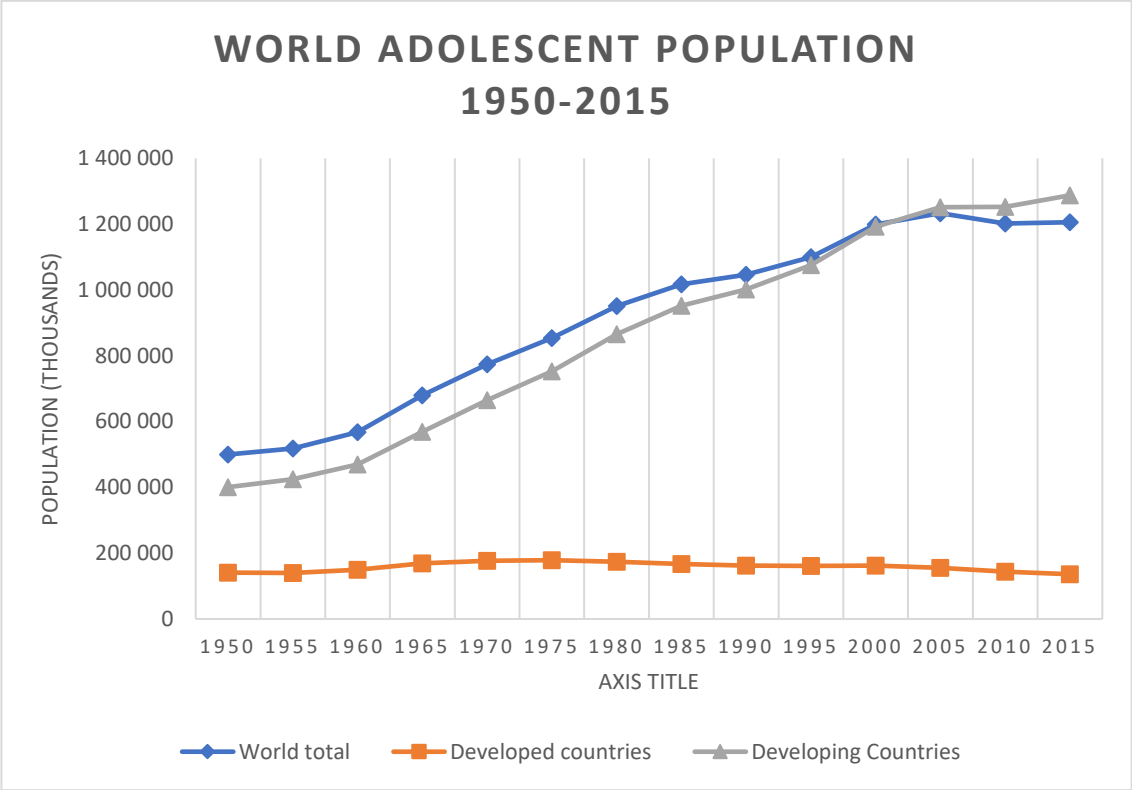
Although there are different understandings of young people according to the theoretical perspectives documented in the literature, the majority of these perspectives' present adolescence as a progressive period where the adolescent undergoes physical transformation towards maturation with vice-versa complex interactions with the socio-cultural environment. However, there is insufficient evidence, especially from developing countries, of how social and cultural settings influence the sexual health of young people. In this research, I look at adolescents' experiences and challenges while accessing AFHS, and here, I will also explore the socio-cultural influence on their access to these services.

3.2 Adolescent demographics

Worldwide there are 1.2 billion adolescents aged 10-19 years, equating to 16% of the world's population (UNICEF, 2016; WHO, 2018a). UNICEF (2016) estimates that more than half of these adolescents live in Asia, and of this number, around 340 million are in South Asia, and 227 million in East Asia and the Pacific. The increasing number of adolescents had been a growing trend, particularly in developing countries, up until the year 2000, but has remained stagnant since (Figure 3.1). Nevertheless, the adolescent population is still the highest in the history of the world and represents a huge number. Within and across the countries where they live there are disparities in indicators like education, health and economics. The UN reported in 2012 that compared to 20 years before, adolescents were healthier and more likely to attend school and delay entering the labour force or marrying and having children. However, many adolescents in impoverished environments

are likely to drop out of school and engage in risky sexual behaviour, marry early and bear children. This likely has negative effects on socio-economic development that is sustainable and equitable.

Figure 3. 1 Demographic trends of worldwide adolescent population (1950-2015)

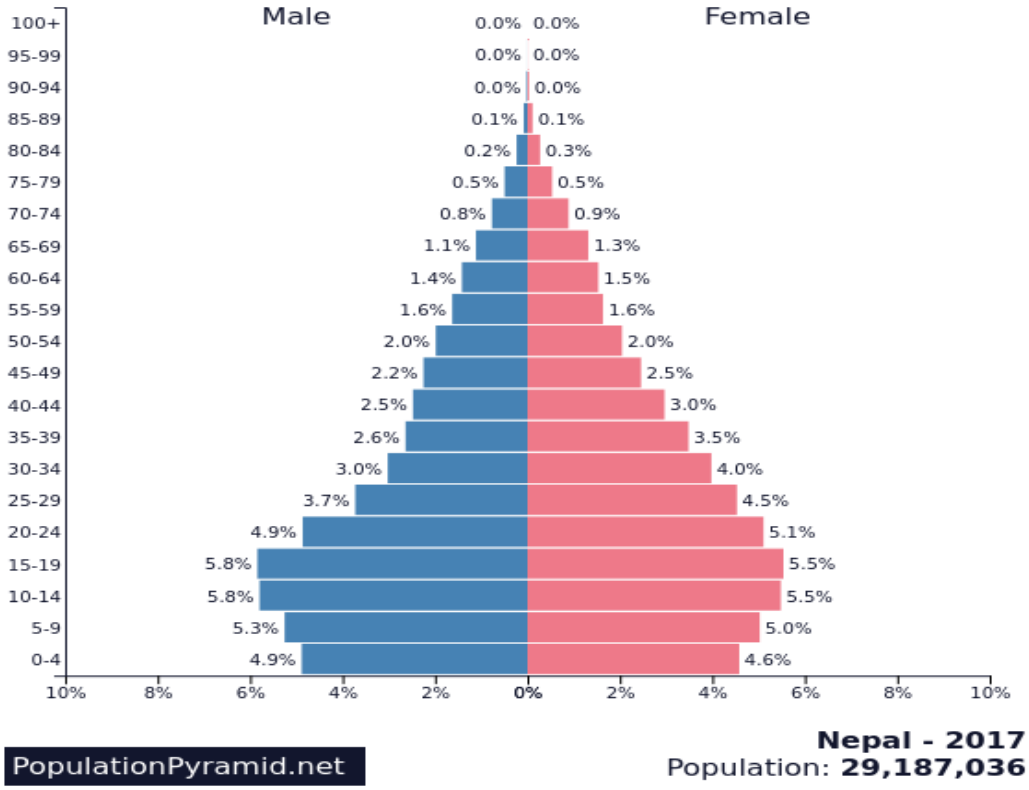


Source: (United Nations, 2017)

As mentioned in chapter 2, Nepal's adolescent population comprises of one-quarter of its total population (CBS, 2012). As illustrated by the population pyramid below (Figure 3.2), adolescents form the biggest bulge; and this is the population that will be contributing to the national economy in a few years' time. This bulge of the adolescent population in the current population of Nepal, similarly to other low and middle-income countries, is believed to have the potential to greatly improve the economies of these countries, and the health and well-being of adolescents are seen to be associated with future national development (Patton & Sawyer, 2015). UNFPA Nepal (2017) reports that Nepal is approaching "Stage III" of a demographic transition characterised by low fertility and low mortality. This means that a large number of adolescents will be a major part of the demographic with the responsibility for Nepal's future economic fortunes. However, with the high number of adolescents becoming sexually active, and a stagnant median age at first marriage for females in Nepal of 17.5 years (CBS, 2012), adolescents are at risk of being exposed to SRH problems

which may, ultimately, result in stagnant socio-economic development. The situation of Nepalese adolescents having poor access to SRH information and services will be aggravated if this situation is not addressed with some urgency. UNFPA Nepal (2017) reiterates that Nepal needs greater investment in adolescents by ensuring universal access to quality SRH and reproductive rights, education, and economic opportunities to minimise the potential consequences for future socio-economic development.

Figure 3. 2 Population pyramid of Nepal, 2017



Source: (PopulationPyramid.net, 2017)

3.3 An Epidemiological overview of adolescent sexual and reproductive health

Adolescence is the life stage crucial for the opportunity of lifelong good health, a time when future patterns of adult health are established (Sawyer et al., 2012). At the same time, adolescents are often associated with increased risk-taking behaviour due to hormonal changes, neurological changes and exposure to social environment during puberty (Galvan et al., 2006; Patton et al., 2016; Steinberg, 2011). During this period, adolescents seek greater independence and responsibility, and

more autonomy over their decisions and actions as they try to form identities and become conscious that choices can be of their own making (Marcia, 1980; Montgomery, 2005). Sawyer et al. (2012) define adolescence as a life phase that is mostly exciting and comes with numerous opportunities, where adolescents learn from peers, parents, society, and communication technologies which, as a whole, shape and direct their future. From another side, researchers emphasise that adolescence is also a phase when young people begin to explore their sexuality and may engage in early sexual activities as part of their sexual curiosity (Regmi et al., 2010a; Skinner, Smith, Fenwick, Fyfe, & Hendriks, 2008). Early-age engagement in sexual activities has been shown to be a strong marker for future poor sexual health and risk behaviour patterns (Cavazos-Rehg et al., 2010; Zuma et al., 2014). Sexual initiation at a younger age is often associated with unintended adolescent pregnancies (Baumgartner, Geary, Tucker, & Wedderburn, 2009; Idele et al., 2014; Magnusson, Masho, & Lapane, 2012), risk of sexually transmitted infections and HIV/AIDS (Shrestha, Karki, & Copenhaver, 2016; Stryhn & Graugaard, 2014), and subsequent risk behaviour in later life, including having multiple sexual partners (Li et al., 2015; Shrestha et al., 2016; Zuma et al., 2014) and more negative attitudes towards condom use (Sandfort, Orr, Hirsch, & Santelli, 2008). The ongoing decline in the age at which sex is first had, and an increased instance of sexually active adolescents in many countries has raised serious concerns amongst global public health experts, who associate these factors with negative health outcomes for these individuals as they reach adulthood.

When looking at the current concerns about the adolescent population's SRH, relevant statistics provide key markers that assist in extrapolating linkages between health, culture and society. A major marker in reproductive health complications amongst adolescents is associated with early marriage and early pregnancy, and sexually transmitted infections and HIV/AIDS.

3.3.1 Adolescent pregnancy and childbearing

There are global estimates that 21 million girls aged 15-19 years and two million girls aged under 15 years become pregnant, among which 16 million girls aged 15-19 years and around 2.5 million under 16 years give birth in low and middle-income countries (UNFPA, 2015). Early pregnancy and childbirth can result in pregnancy-related complications which have become the leading cause of death for adolescent females aged 15-19 years (WHO, 2016a). As Vogel et al. (2015) note, younger mothers are the age group most likely to experience complications during pregnancy and childbirth.

One of the major determinants of early pregnancy and childbirth occurring is the experience of lifelong gender-based discrimination, faced by adolescent girls particularly in low and middle-income countries (Jayachandran, 2015). Evidence shows that parental discrimination that favours care, attention and encouragement being given to sons over daughters results in girls having less educational opportunity (McCleary-Sills, Hanmer, Parsons, & Klugman, 2015), and less opportunity to complete their growth before they are married and given an adult role (Lal, 2015). In South Asia, although the gender gap in primary school enrolment is narrowing, it has widened between girls and boys completing secondary school, with boys now being 1.55 times more likely than girls to finish secondary school (UNESCO, 2015). One of the many factors associated with girls not finishing secondary school is their greater likelihood early marriage, leading to early maternity (McCleary-Sills et al., 2015). The high rates of adolescent pregnancy and childbirth are strongly linked to those countries in which adolescents have poor education, are married at an earlier age, and to living in rural areas where more traditional customs of early marriage are practised (Laski, 2015). UNFPA (2015) reports that 90% of births to adolescent girls occur within marriage. Early marriage exposes girls to SRH conditions like high-risk pregnancy, and sexually transmitted infections. South Asia (Bangladesh, Nepal, Afghanistan and India) have high proportions of adolescent pregnancies because early marriage is common in these countries and, socially, adolescents have minimal or no control over decisions about reproduction, thus early pregnancy is inevitable (Raj, Saggurti, Balaiah, & Silverman, 2009). In 2017, one in two, or up to 45% of adolescent girls were married before the age of 18 years, making (GirlsNotBrides, 2018). As discussed in chapter 2, in Nepal in 2016 27.1% of adolescents 15-19 years were already married; the figure of 17% for adolescent pregnancy was less than for Bangladesh (31%), but double that of other South Asian countries (MoHN et al., 2017). The huge numbers of adolescents residing in these countries contribute significantly to the high number of adolescent pregnancies worldwide.

Due to their young age, lack of SRH education, less power to negotiate safe sex (Challa et al., 2018), poor access to SRH services and information (de Castro et al., 2018a), and small decision-making voice within the family (Raj et al., 2009), adolescents have lower rates of using contraceptives and greater unmet need for contraception compared to any other age group (Godha, Hotchkiss, & Gage, 2013). The Guttmacher Institute (2018) reported that almost 20 million adolescent women aged 15-19 have an unmet need for modern contraceptive methods. Moreover, almost 85% of those are reported as not using any contraception, while 15% used less effective traditional methods like

withdrawal or periodic abstinence (Guttmacher Institute, 2018). Hence, these adolescents are at high risk of unintended pregnancy. Further, about half (49%) of adolescent pregnancies are unintended, and half of those are unsafely terminated (Guttmacher Institute, 2018). There are globally around 3.9 million unsafe abortions taking place among 15-19 year-olds each year (Darroch, Woog, Bankole, & Ashford, 2016); these abortions can be linked to lack of access to appropriate SRH services and the stigmatisation of adolescent sexual activity. In many developing countries abortion is not legal and may contribute to infections, as well the high proportion of maternal deaths among adolescents due to unsafe abortion procedures. In addition, in countries where discussion of sex is taboo (Sychareun et al., 2018) and the sexual activity of unmarried adolescents is stigmatised (Hall et al., 2018b), adolescents will have little access to SRH information and services (Kennedy et al., 2013). In their qualitative study among 341 male and female adolescents in Vanuatu, Kennedy et al. (2013) noted that stigma and shame associated with adolescent sexual behaviour was one of the most significant reasons that participants had difficulty in accessing SRH services. In another qualitative study conducted in Lao People's Democratic Republic among adolescents, participants indicated the socio-cultural norm of not discussing sex and reproduction as a contributing factor to their reluctance to discuss their SRH with HCPs, that would also lead to their missing antenatal and postnatal consultations, and in the case of unmarried girls, seeking unsafe abortions (Sychareun et al., 2018). Hence, poor access to SRH services can result in unintended pregnancy and unsafe abortion (Hall et al., 2018a)

3.3.2 Sexually transmitted infections and HIV/AIDS

In 2016 there were estimates of one million sexually transmitted infections (STIs) being acquired every day, and an estimated 376 million new cases globally each year caused by one of the four STIs chlamydia, gonorrhoea, syphilis or trichomoniasis (WHO, 2018c). According to the Centre for Disease Control, young people aged 15-24 years have a high share in the numbers of people infected with STIs, acquiring half of all new STIs including HIV and AIDS. There was a total of 590,000 young people aged 15-24 newly infected with HIV in 2017 of whom 250,000 were adolescents aged 15-19 years (UNICEF, 2018b). UNICEF (2018b) further estimates that in 2017 about 1.8 million adolescents around the world aged 10-19 years were living with HIV, of which two-thirds were adolescent girls. Among all HIV infections affecting adolescents, most occur in sub-Saharan Africa and South Asia (UNICEF, 2018b). Statistics also indicate that adolescent deaths due to HIV and AIDS-related causes tripled between 2000 and 2015 globally, and that this age group was the only one to experience a

rise in deaths from these causes (UNICEF, 2015), with all other groups showing a decrease of 51% during the same period (UNAIDS, 2018). A total of 38,000 adolescents aged 10-19 years died due to AIDS-related causes in 2017 (UNICEF, 2018a).

There are several reasons that might contribute to the increasing rate of STI and HIV infections among adolescents globally, for example, inadequate knowledge of STI and HIV (Idele et al., 2014), negative attitudes to condom use (Bermúdez et al., 2012), and cultural attitudes toward sex (Sychareun et al., 2018). Poor knowledge about HIV and how to prevent infection has remained one of the major reasons for the persistence of HIV among adolescents. A review of epidemiological data on the burden of disease and prevalence of HIV and AIDS conducted at global and regional levels reported that in most of the countries surveyed, less than half of adolescent girls and boys had any basic understanding of HIV and ways to prevent it (Idele et al., 2014). That review used data from UNFPA's global database, Demographic and Health Surveys, and Multiple Indicator Cluster Surveys (MICS), and other national surveys taken between 2007 and 2012. In Nepal (as discussed in chapter 2, section 2.5.7) only 18.3% of female and 24.3% of male adolescents aged 15-19 years had comprehensive knowledge about HIV (MoHN et al., 2017), highlighting the unmet need for better SRH services. Sex and sexuality is a sensitive topic in many developing countries' societies (Puri et al., 2010; Sychareun et al., 2018), and the result of limited sex education at home and school is poor knowledge of HIV transmission, its consequences, and prevention. Lack of knowledge about HIV leads to low rates of condom use during sex among adolescents. A recent study conducted among 1322 college students in Nepal noted that the poor HIV knowledge of young people was significantly associated with inconsistent use of condoms and low perceptions of HIV risk (Farahani, Akhondi, Shirzad, & Azin, 2018).

To prevent STI and HIV, condoms are one of the most effective methods for sexually active adolescents, and consistent and correct use has been reported to reduce up to 80-90% of HIV infection by heterosexual transmission (Cayley Jr, 2004; Nyembezi et al., 2014). However, negative attitudes towards using condoms can result in low utilisation, and that is identified as risk factor for HIV infection (Simbayi et al., 2005). A cross-cultural assessment and analysis of adolescent behaviour in Spain, Colombia and Panama reported that despite having higher levels of knowledge about HIV, male adolescents had negative attitudes towards condoms (Bermúdez et al., 2012), which might result in their poor utilisation.

In some cultures, people have a liberal attitude towards pre-marital sexual activity, but in others, as mentioned in the previous section, discussions about sex and sexual issues remain taboo (Sychareun et al., 2018). This prohibition results in poor knowledge and access to services even though adolescents in such societies may be sexually active. Hence, adolescents remain at high risk of STI and HIV. Further, as discussed earlier, the relative powerlessness of adolescent girls in decision-making and negotiating safe sex with their partners exposes them to unsafe sex (Challa et al., 2018). The evidence as presented above suggests that there is a burden of STIs and HIV and AIDS that surely needs to be addressed, and one avenue is to improve adolescents' knowledge of and access to SRH services.

3.4 Global responses to adolescent sexual and reproductive health

3.4.1 Realising sexual and reproductive health care as a human right for adolescents

A range of human rights enshrined in core human rights treaties is relevant to the SRH of adolescents. These include the right to health, the right to privacy, the right to decide freely on the number and spacing of children birthed, the right to education and information, and the right to be free from discrimination. These rights were stated in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) adopted in 1979 by the United Nations General Assembly (UN, 1979). Meanwhile, the right to express one's view as a child and the right to be protected against violence and harmful practices were stated in the UN Convention on the Rights of the Child (UN, 1989). Age at marriage is articulated in the Convention on the Rights of the Child (CRC), which states that any marriage taking place under the age of 18 years is considered a child marriage (UN, 1989), and this age has been accepted as the minimum legal age of marriage in many countries (GirlsNotBrides, 2019). There are, however, variations between countries; according to a 2013 mapping of minimum-age-of-marriage laws conducted by the World Policy Analysis Centre, 93 countries still allowed girls under 18 years to be married with parental consent (Heymann & McNeill, 2013). In this area, Nepal has been progressive, setting the minimum age of marriage at 20 years for both males and females, and at 18 years with parental consent (Nepal Law Commission, 2006).

The 1994 Cairo ICPD program of action especially backed the right of adolescents to reproductive health care, stating that "Information and services should be made available to adolescents that can help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility" (UNFPA, 2004, p. 58). In its 2012 resolution

on adolescents and youth, the Commission on Population and Development of the United Nations urged all governments "to protect the human rights of adolescents and youth to have control over and decide freely and responsibly on matters related to their sexuality, including SRH, free of coercion, discrimination, and violence, and regardless of age and marital status"(UNFPA, 2014b). Governments in many countries have since supported SRH services for adolescents, with 96% of the Americas, 90% of Europe, 80% of Asia (including Nepal), and 54% of Africa making some efforts towards developing programs to ensure young people's access to SRH information and services that warranted and respected their privacy, confidentiality and informed consent (UNFPA (2014a).

3.4.2 Millennium development goals (MDGs) and sustainable development Goals (SDGs)

Human rights leaders from 189 countries recognised the rights of adolescents to SRH care in the Millennium Declaration at the UN Millennium Summit in the year 2000, which set eight development goals for world's poorest countries (WHO, 2018b). Millennium Development Goal (MDG) 5, to improve maternal health included two targets, 5A and 5B. Target 5B, to "achieve, universal access to SRH services by 2015" was primarily relevant to the SRH of adolescents, with the goal of reducing the adolescent childbirth rate (World Health Organization, 2018b). However, despite significant global progress in reducing maternal deaths in poor countries by 45% between 1990 and 2013 (from 380 to 210 maternal deaths per 100,000 live births) (UN, 2015a) and better global access to reproductive health care, there was little improvement in adolescents' access to SRH services during this period. The birth rate among adolescent girls 15-19 years was reported to have decreased only from 59 births per 1000 adolescents to 51 between 1990 and 2015, and maternal mortality among adolescent girls remained the leading cause of death in this demographic (MDG Monitor, 2016). This indicates that the lack of universal access to SRH services persists for this particular group, as well as inequality of access. In Nepal, the adolescent birth rate had decreased from a previous 110 births to 71 per 1,000 in 2014 (National Planning Commission, 2016). This achievement could be attributed to greater attention being given to improving access to SRH services; disparities in rate of reduced births between rural and urban areas of the country remain, however (CBS, 2015).

In 2015, UN member states agreed on a blueprint for peace and prosperity for people and the planet containing 17 sustainable development goals (SDGs), calling for action and global partnership among all countries, developed and less developed (UN, 2015b). Goal 3: Good Health and Well Being

once more recognised the high adolescent birth rate in developing countries and included targets for increasing universal access to SRH care services across all age groups.

It is evident that the importance of SRH has been well recognised through commitments made internationally and nationally. Yet progress on achieving universal access to SRH for adolescents has been slow. There is a range of factors that may potentially be affecting adolescents' access to SRH services, and these are discussed in the next sections.

3.4.3 Introduction of adolescent-friendly health services

One of the major contributions made in response to the SRH care needs of adolescents came from the health sector with the adolescent-friendly health service initiative. As mentioned in Chapter 1, section 1.3, the concept of adolescent-friendly health services was introduced following the 1994 Cairo conference that prioritised the SRH of adolescents and young people (UN, 1995). Since then, attempts have been made globally by the health sector to address young people's SRH issues. The introduction of adolescent-friendly health services into the current health delivery system is one example of healthcare improvements that were recommended, particularly for developing countries. The WHO defined adolescent-friendly health services as "an approach which brings together the qualities that young people demand, with the high standards that have to be achieved in the best public services" (McIntyre, 2002). The features of AFHS were discussed in chapter 1, section 1.3.

Recognising the importance of friendly health facilities for adolescents worldwide, a number of countries have introduced health services based on adolescent-friendly principles. Several developed countries like the United States, Canada, United Kingdom, Australia, Germany, and Netherlands have "youth information centres" or "youth-friendly clinics", which have been largely successful (Baltag & Mathieson, 2010; Kang et al., 2005; Manlove, Fish, & Moore, 2015). Meanwhile, among African countries, South Africa was a leader in implementing AFHS through its National Adolescent-Friendly Clinic Initiative started in 1999 (Ashton, Dickson, & Pleaner, 2009). Other countries including Ghana, Uganda, Tanzania, and Kenya have also introduced AFHS through international donor-supported programs (Daniels, 2007; John snow Inc, 2007b; JSI, 2007; Williams, Mullen, Karim, & Posner, 2007). Following these nations, countries of the South Asian region such as Nepal, India, Bangladesh, and Sri Lanka began to focus on adolescent health in 2000, with the support of the WHO, by developing national strategies on adolescent health (WHO, 2008). India,

Bangladesh and Sri Lanka began adolescent-friendly programs in 2002 (WHO, 2008) and Nepal, later, in 2009 (HSSP, MoHPN & GTZ, 2010).

There are several models for AFHS, and different countries have adopted different models and approaches (Denno, Hoopes, & Chandra-Mouli, 2015). For example, in some countries adolescents are offered services at health facilities in drop-in arrangements (Geary, Gómez-Olivé, Kahn, Tollman, & Norris, 2014) after school hours, while elsewhere a separate day and time is allocated for young people to visit (Goicolea, Coe, Hurtig, & San Sebastian, 2012).

Some countries like Bangladesh, Mongolia, Botswana, Ghana, Tanzania and Uganda provided AFHS in combination with awareness-raising activities in schools and communities (Bhuiya, Rob, Chowdhury, Rahman, & Haque, 2004; Daniels, 2007; John snow Inc, 2007b; JSI, 2007; Lou, Wang, Shen, & Gao, 2004; Sovd, 2004; Williams et al., 2007). These included, among other strategies, reaching adolescents through peer educators, and mobilising teachers with behaviour change communication (BCC) materials to publicise AFHS. In Bangladesh, HCPs were trained in non-judgmental attitudes, and some modifications were made to facility infrastructures to improve waiting times and provide privacy and confidentiality. Also, adolescents' questions were answered via telephone hotlines, and HCPs coordinated with teachers to refer adolescents to the health facility. Evaluation of this model found increased service utilisation by adolescents especially in areas where the schools were involved. Also, adolescents demonstrated improved knowledge about SRH. There was, however, no evidence of increased condom use (Bhuiya et al., 2004). In an evaluation of programs in four African countries – Botswana, Ghana, Tanzania and Uganda – all reported improved SRH service utilisation by adolescents and, for example, increased modern contraceptive use among female adolescents (Daniels, 2007). Mongolia's program showed improved SRH service utilisation by adolescents compared to intervention and control sites (Sovd, 2004), but no pre-intervention data was available in the evaluation report. In the absence of pre-intervention data, it is not possible to determine whether the intervention sites were already better-performing facilities. Nevertheless, it is clear from the experiences of these countries that adolescents would benefit from AFHS where community-level interventions such as community awareness and school education are conducted.

Nepal and India in South Asia, and Equador and Peru in South America are some of the countries that integrated AFHS within the health care system by building the capacity of health care providers

to deliver them (Goicolea, Coe, San Sebastián, & Hurtig, 2017; Neupane et al., 2014; Yadav et al., 2009). Other countries such as Indonesia, Malawi, Moldova, Ukraine, along with earlier-mentioned Bangladesh and Tanzania, also integrated AFHS within their national health care system (Chandra-Mouli, Chatterjee, & Bose, 2016). Chandra-Mouli et al. (2016) conducted a review (Chandra-Mouli et al., 2016) of published and unpublished documents from eight low and middle-income countries who had integrated AFHS within the health system. Improvements in health service utilisation in Malawi, Moldova, Mongolia and Ukraine were reported, but in countries like Bangladesh, utilisation was found to decrease compared to control sites. As discussed in chapter 2, section 2.7.2, in Nepal there too was reported a decrease in AFHS utilisation by adolescents (Neupane et al., 2014). In most developing countries health facilities operate with limited resources and health workers are often responsible for delivering a wide range of primary health care services. Hence, it is likely in that context that service delivery to adolescents and their acceptance of the available services would be impacted. However, besides resource constraints, there are many other factors that affect SRH care utilisation, and these are discussed in the next section of this chapter.

Although there are different ways of delivering health care to young people, there seems to be a common understanding that access to friendly health services is vital for ensuring their SRH and general wellbeing (Brittain et al., 2015; Denno et al., 2015; Nath & Garg, 2008; Tylee, Haller, Graham, Churchill, & Sanci, 2007). Moreover, it is widely accepted that adolescent health services should be clear, accessible, equitable, acceptable, appropriate and understandable (Berg-Kelly, 2003; Engender Health, 2002; Tylee, Haller, Graham, Churchill, & Sanci, 2007; WHO, 2012).

Also, while the widespread implementation of adolescent-friendly health services indicates that the overall concept is understood to be valuable in many different countries, how such services are conducted will influence the success and shortcomings of programs on a local scale. In the West, the US, the UK, and others have made significant achievements in adolescent health over the last 40 years. In the US, as shown in the analyses of different periods of the National Survey of Family Growth between 1995-2013, teenage pregnancy has steadily decreased since 1990 (Boonstra, 2014; Lindberg, Santelli, & Desai, 2016). Researchers suggest this steady decrease was due to improved access to contraceptive services (Boonstra, 2014), together with improved social outcomes of programs focusing on adolescents in areas like education opportunities and policy (Lindberg et al., 2016). Similarly, the UK and other Western nations have recorded significant drops in adolescent pregnancy since the 1980s due to their focus on adolescent health and improving access to

contraceptives and incorporation of sexual education in school curricula (Arie, 2014). (Hadley, Ingham, & Chandra-Mouli, 2016) conducted a detailed documentation search of policy, strategy and action plans of the UK government to understand what had contributed to the drop in the teenage pregnancy rate. They concluded that the UK's success in reducing teenage pregnancy by 51% between 1999 and 2014 (Toynbee, 2013) was due to their focus on adolescent-oriented sexual health services in their policies and guidelines. The review noted that the UK government had invested in actions targeting healthcare providers and adolescents equally, with HCP training in all facets of adolescent health, especially in communication skills, consent and confidentiality, and the development of youth-friendly practices to ensure that patients felt comfortable, happy and encouraged to use services. Improvement of services for adolescents has facilitated building partnerships with a wider range of stakeholders including schools, parents, local government and youth workers to target youth directly through a variety of outlets (Hadley et al., 2016).

Most programs in developing countries, on the other hand, have not taken a comprehensive approach, and the involvement of young people in the SRH decision-making has been largely ignored (Chandra-Mouli, Lane, & Wong, 2015a). As discussed in chapter 2, section 2.7.1, while Nepal's national adolescent SRH program recommended the inclusion of adolescents in health facility operational and management committees, only a quarter of health facilities have involved adolescents at this level (Kennedy et al., 2015). As such, the effectiveness and impact of standalone AFHS is questionable (Denno et al., 2015).

3.5 Factors influencing access to and utilisation of adolescent sexual and reproductive health services

Despite the focus given to the provision of SRH services, adolescents continue to face challenges in accessing reproductive health services (Chandra-Mouli et al., 2015b). The challenges that impact on SRH utilisation are often a result of complex social, environmental, cultural, economic and psychosocial factors (WHO, 2011). A review conducted by Tylee et al. (2007) for a *Lancet* series on adolescent health noted that research, mainly from developing countries, has indicated that almost 70-90% of young people visit primary health care facilities at least once a year, but rarely for SRH issues; the major reasons were for treatment of respiratory or dermatological problems. The review further noted that in developing countries young people are not willing to seek professional help for sensitive SRH issues and, furthermore, it is adults who would decide their SRH needs (Tylee et al., 2007).

There could be various reasons why young people are not willing to seek services for SRH issues, and research that endeavours to understand this non-utilisation is key to improving the quality of life for young people. This understanding could help prevent SRH morbidity, and provide an evidence base for designing health promotion interventions. The complexity of SRH service utilisation could be clarified by different models of health care utilisation. There are several models that explain health care utilisation. For example, the psychosocial health belief model (Rosenstock, 1974) is based on individuals' beliefs about health problems and perceptions of the benefit that motivates health seeking; the Andersen-Newman behavioural model of health service use (Andersen & Newman, 1973) emphasises social determinants, the health service system and individual determinants that influence health service utilisation; and in Kroeger's model (Kroeger, 1983) the major elements are the characteristics of the patient, of disorder perception, and of the health service.

The health service utilisation of adolescents is embedded in complex contextual elements related to demographics and social structures, and health system factors that influence adolescent SRH. Hence, the focus in discussing SRH service utilisation is on identifying factors that may influence the health-seeking behaviours of adolescents. The health belief model of Rosenstock (1974) centres on an individual's belief and perceptions and omits the environmental influences and social structures that might influence the decision of adolescents to utilise SRH services. Therefore, this model is not appropriate to understanding the factors affecting adolescent SRH service utilisation. Andersen and Newman (1973) emphasises social determinants, and Kroeger (Kroeger, 1983) emphasises patient characteristics and demographic and social variables, and hence, these two models might best explain factors associated with adolescents' SRH service utilisation. However, these models are not sufficiently comprehensive when considered on their own. Health service utilisation is likely to be better understood when a combination of both models is applied.

The Andersen-Newman (1973) model of health service utilisation established that an individual's health care seeking is influenced by three components: predisposing, enabling and need as factors that facilitate or impede utilisation of services by individuals. In this model predisposing factors are demographic and social structures; enabling factors are those allowing the use of services such as income, access to service and availability; and need factors such as conditions of ill-health or disease motivate service seeking. This model has been previously applied and tested in investigations of a range of health services and in health systems research, including adolescent SRH care seeking.

Azfredrick (2016), using this model to examine reproductive health service utilisation by adolescent girls, showed that enabling factors like parental support, finances, and type of health facility were important determinants of adolescents deciding to seek SRH services. Shabani, Moleki, and Thupayagale-Tshweneagae (2018), in their exploratory descriptive and contextual qualitative research among 20 male adolescents in South Africa, noted that predisposing factors like health belief, and enabling factors like the availability of quality ASRH services were important for SRH service utilisation.

Similarly, Kroeger's (1983) model emphasised patient characteristics, which embrace features of predisposing factors from Anderson-Newman (1973), and demographic and social variables. It then considers the characteristics of disorders such as the nature and severity of a disease. The third most important aspect of the framework which is particularly relevant for adolescent SRH service utilisation is the focus on the enabling environment of health facilities, including geographical accessibility, acceptability, quality of care, and cost associated with services (Kroeger, 1983).

While the Anderson-Newman and Kroeger models provide comprehensive frameworks for looking at the factors associated with adolescents' SRH service utilisation, the WHO's "quality of care" framework expands on Kroeger's enabling factors. The quality of care framework is a guide to improving health services provision such that patients' service utilisation improves (WHO, 2006b). This framework was utilised to define the AFHS domain for quality health care that includes accessible, acceptable, equitable, appropriate and effective services (WHO, 2012). Components include accessibility and acceptability, which also feature in Kroeger's model, but in addition, quality of care includes equitable, appropriate and effective service. Since this research investigates utilisation of SRH services by adolescents, I present the relevant literature guided by the Anderson-Newman (1973) model, Kroeger's (1983) model, and the WHO's domains of adolescent-friendly health services.

3.5.1 Individual factors for adolescents sexual and reproductive health service utilisation

Although there are several individual-level determinants associated with health service utilisation, by young people, the literature emphasises education level and sexual relationship status, as major factors.

3.5.1.1 Education

Education has often been associated with adolescents' utilisation of SRH services. A number of studies have identified that adolescents who are educated at least up to higher secondary level are more likely to use SRH services, especially family planning and voluntary counselling and testing services (Feleke, Koye, Demssie, & Mengesha, 2013; Hutchinson & Mahlalela, 2006; Nwachukwu & Odimegwu, 2011). Feleke et al. (2013) in their study of adolescents in northwest Ethiopia noted that adolescents with secondary education were three times more likely to use VCT services compared to those who did not have formal education. The most likely explanation is that educated adolescents had better access to information, more knowledge about the availability of the services, and a better understanding that their sexual health could benefit from preventive health care (Bam et al., 2015; Feleke et al., 2013). However, the findings from a quantitative cross-sectional study based on a self-administered questionnaire among 15-19-year-old higher secondary school adolescents conducted by Bam et al. (2015) would contradict this rationale, since 94% of the adolescents surveyed were attending school and knew about SRH care availability from various sources like television, radio, family and youth clubs, yet only 9.2% of that sample had used any SRH services. Given that most research shows a positive correlation between education and SRH service utilisation, it is imperative to get a better understanding of Nepal's anomalous situation of persistently low adolescent utilisation of SRH services.

3.5.1.2 Adolescent sexual relationships

Young people's sexual relationships are strongly associated with SRH service utilisation, and hence, this has led researchers to look more closely at this link. Falling in love, being in a romantic relationship, and the first experiences of sexual intimacy and sex are universal and normal during adolescence. In fact, being in an adolescent relationship is a powerful predictor of sexual activity. These relationships are central to young people's lives and play an important developmental role, signalling implications for their future health and adjustment (Furman & Shaffer, 2003). Although premarital relationships and sexual activities have traditionally not been acceptable in Nepal, urbanisation and exposure to international media and the internet have slowly changed the way Nepalese young people think about sex and relationships (Regmi, van Teijlingen, Simkhada, & Acharya, 2011). Young people now have more liberal attitudes towards relationships and sex (Regmi et al., 2011). A qualitative study by Regmi et al. (2011) among 15-24-year-old school and college-going and school drop-out participants in both rural and urban areas of Nepal observed that young

people in education tend to find their partners at school and in college; those who do not attend school or college meet their partners in their communities during local events like marriage ceremonies, worship, fairs and festivals, and sometimes while working in the fields or forest. Some of these sexual relationships are between unmarried young people. The Nepal Adolescent and Youth Survey 2011 showed that 36% of adolescents aged 15-19 years had had their first sex with boyfriend or girlfriend before marriage (MoHN, 2012). Regmi et al. (2011) also found that adolescent girls in romantic relationships often tend to feel intimacy with their male partners more intensely than their partners and prefer long-term relationships, while males prefer short-term relationships that fulfil their sexual desire (Regmi et al., 2011).

Being in a sexual relationship is reported to be a powerful catalyst for young people to seek SRH care, especially for contraceptives (Feleke et al., 2013). Relationship length, partner communication, and intimacy are also consistently associated with contraceptive practices (Feleke et al., 2013). In their community-based quantitative cross-sectional study, Feleke at al. (2103) observed that adolescents aged 15-19 years who were in long-term, romantic sexual relationships were 6.5 times more likely to use family planning services from health care facilities compared to those who were not. Similarly, Bam et al.'s (2015) research in Nepal showed that adolescents who had been sexually active in their relationships within the past year were more likely to use SRH services compared to non-sexually active adolescents (Bam et al., 2015). That study was conducted in urban areas of Nepal where both public and private SRH services are often available; the utilisation patterns of rural adolescents, whose health care options are more limited, were not determined. However, Regmi et al. (2010b) in their qualitative study covering rural and urban areas of Nepal noted that adolescents found it difficult to talk about using reproductive health services with their partners, naming poor negotiating skills and fear of refusal. These difficulties of expression were more common among female than male adolescents, again pointing to the imbalance of power in gender roles.

Marriage also influences SRH service seeking. A lower likelihood of using SRH services, especially family planning services, has been associated with marriage, with an increased likelihood of adolescent girls' sexual activity (Mmari & Sabherwal, 2013). To the contrary, however, in Nepal, it has been observed that married adolescents were six times more likely to use SRH services compared to the unmarried (Bam et al., 2015). This situation has often been associated with the social acceptability of married, as opposed to unmarried, adolescents using family planning and

contraceptive services. Hence, this highlights the need for deeper insight into the social circumstances influencing married and unmarried Nepalese adolescents' SRH decision making.

3.5.2 Social and structural factors contributing to adolescents' SRH service utilisation

Adolescents' attitudes and behaviours around their sexual and reproductive health and health care service utilisation are often associated with several social and structural factors like socially defined gender inequalities, the influence of peers and family, and socio-cultural conditions.

3.5.2.1 Gender Norms

Both Anderson-Newman and Kroeger models place gender in their frameworks as one of the factors influencing health-seeking behaviour. Whether one is male or female, gender norms are likely to have an influence on various SRH behaviours and health service utilisation. Generally, girls use more SRH services at health facilities since they offer more contraceptive options, and for maternal health care services. However, gendered norms often give men a dominant position which they can use to limit women's ability to control their own SRH (Pulerwitz, Michaelis, Verma, & Weiss, 2010). Several studies have demonstrated that gender differences and unequal power relationships between men and women hinder communication between partners about SRH issues, which may be an obstacle for women's access to SRH services, resulting in poor sexual health (Pulerwitz et al., 2010; Puri et al., 2010; Woog, Singh, Browne, & Philbin, 2015). Woog et al. (2015) in their review of 70 national representative surveys of developing countries highlight that in most of these countries, husbands or partners are the primary decision makers on the use of reproductive health services for adolescent women, overriding the female voice in those decisions. Much of the evidence to date indicates that this lack of power in decision making results in poor utilisation of SRH services by women. However, a study conducted among 1290 male and female adolescents in northwest Ethiopia found that more than half of sexually active adolescents who used voluntary counselling and testing (VCT) services were females (Feleke et al., 2013). Although that study did not discuss the reasons behind this, it is possible that sexually active adolescents visiting the health facility for contraceptives may also have used the VCT services as a result of exposure to VCT.

In Nepal, men are generally the primary decision-makers in matters relating to sexual activity, fertility and SRH service use, and also often regulate access to health information and services, finances and other resources for women (Puri et al., 2010). Simkhada, Porter, and Van Teijlingen (2010) argue that mothers-in-law also influence their adolescent daughters-in-law in access to SRH

services. This influence is positive in their seeking antenatal care, but often negative for seeking contraceptive services (Acharya, Bhattarai, Poobalan, Teijlingen, & Glyn, 2010; Simkhada et al., 2010), demonstrating married adolescents' lack of power within the family. Comparing male and female adolescents in Nepal, Bam et al. (2015) observed that young women used SRH services at a rate three times less than young men. Interestingly, the most frequently used SRH service was obtaining emergency contraceptives, a service for females. This study was undertaken in a school setting, and 97.3% of the participants were unmarried. Thus, it is likely that male partners in unmarried sexually active adolescent couples were accessing emergency contraceptives for their female partners. This also demonstrates the greater authority of males and their easier access to SRH services. Moreover, it is also likely that while sexual activity among unmarried adolescents is socially frowned upon in Nepal (Puri & Busza, 2004; Regmi et al., 2011), boys attract less social stigma than girls do in seeking SRH services.

Although the literature argues that gender roles influence girls' access to SRH services, it is imperative to continue investigating the enabling and inhibiting factors that influence female adolescents' access to SRH services in Nepal.

3.5.2.2 Peer influence on adolescents' SRH service utilisation

There is extensive literature explicating the influence of peers on adolescents' SRH. Peers are a crucial element in adolescence; adolescents often pay close attention to their peers' behaviour to gain their approval, and peers' opinions often hold the most weight (Drolet & Arcand, 2013). A descriptive cross-sectional study conducted in Nepal among 522 higher secondary school adolescents noted that 70.5% of adolescents had sex-related conversations with their peers (Adhikari et al., 2018). The support system offered by strong peer connections has been documented as leading to positive health strategies such as protecting against a broad range of risky behaviours during adolescence (Viner et al., 2012).

Additionally, peers are often the main source of information about sex for young people and influence the way that information is spread (Bam et al., 2015; Regmi et al., 2010b). However, peers are also associated with increased risk, since they not only provide information on sex but may also encourage and pressure friends to initiate sexual activities (Adhikari et al., 2018; Regmi et al., 2010b; Salih, Metaferia, Reda, & Biadgilign, 2015). Adhikari et al. (2018) in their research among Nepalese adolescents noted that adolescents who had discussed sexual matters with their peers had a 2.6-

fold higher chance of having pre-marital sex compared to those who had not discussed sex. However, the authors did not explain the kind of information provided by peers. It is possible that peer-provided information about sex may not necessarily be accurate, and this can place adolescents at higher risk for STI and unplanned pregnancies, as well as impacting on their utilisation of SRH services. For example, Hodgson, Ross, Haamujompa, and Gitau-Mburu (2012), in their qualitative exploratory study conducted among 111 adolescents with HIV, noted that participants could not trust the information provided by their peers since these peers had provided inaccurate information which could be harmful in the case of HIV. Researchers also highlight that aspects of adolescent friendship, like friends' sexual behaviour, the level of involvement with friends, and perceptions of friends' sexual behaviour (Collazo, 2005; Sieverding, Adler, Witt, & Ellen, 2005) influence the sexual behaviour of young people (Buhi & Goodson, 2007; Sieving, Eisenberg, Pettingell, & Skay, 2006). In Nepal, a study has shown that more than half of sexually active adolescents who had had premarital sex perceived that their close friend had also had premarital sex (Adhikari & Tamang, 2009).

Although the literature demonstrates a strong relationship between the influence of peers on the sexual health behaviour of young people, only a few studies have looked at the relationship between peers and health service utilisation. To the best of my knowledge, there is no empirical research in Nepal that has established a relationship between peer influence and health service utilisation. One study from the United States showed that the main concern of adolescents accessing sexual health services were their peers, fearing that they might be seen by friends going to a SRH clinic, and as a result might be stigmatised by the presumption of having a sexually transmitted infection or HIV (Lindberg, Lewis-Spruill, & Crownover, 2006). Thus, further contextual research is needed to explore the relationship between peer influence and SRH service seeking by young people to better understand their reasons for poor utilisation.

3.5.2.3 Family influence on adolescents SRH service utilisation

The literature consistently shows a clear and strong link between the family environment, adolescent sexual behaviour and SRH service utilisation (Adebayo Ayodeji, Ajuonu Ezidinma, & Betiku Benson, 2016; Challa et al., 2018; Feleke et al., 2013). For example, a descriptive cross-sectional study conducted in southwest Nigeria among secondary school students showed a significant association between mother-child communication, parental monitoring and parental disapproval of sex and the sexual experience of adolescents (Adebayo Ayodeji et al., 2016). Similarly,

parent-child communication about sexual matters has also been associated with the likelihood of using SRH services, including obtaining contraceptives, among African adolescents (Biddlecom, Awusabo-Asare, & Bankole, 2009; Feleke et al., 2013).

Family structures such as single-parent households, changes to parents' marital status through divorce or remarriage, and having an older sexually active sibling at home, have all been closely related to early initiation of sexual activity among adolescents (Adebayo Ayodeji et al., 2016; Aseltine, Doucet, & Schilling, 2010; Zimmer-Gembeck & Helfand, 2008). Conversely, adolescents raised in two-parent households are more likely to postpone their sexual activities and use contraceptives when they have sex (Manlove, Ikramullah, Mincieli, Holcombe, & Danish, 2009). This has been demonstrated in Feleke et al.'s (2013) Ethiopian study in which adolescents living with both of their parents were found to be 1.5 times more likely to use SRH services. No similar studies have been done in Nepal to establish parental influence on SRH service utilisation by adolescents. However, one study conducted among Nepalese male college students (n=573) demonstrated that a lack of parental presence increased sexual activity among adolescents (Adhikari & Tamang, 2009). That study did not look at the health service utilisation patterns of those adolescents. While the actual mechanisms of the relationship between family structure and adolescent sexual behaviour have not been comprehensively explained, lower parental supervision and greater independence has been proposed as a potential conditioning factor for early initiation of sexual activity and poor preventive health care seeking (Adhikari & Tamang, 2009; Biddlecom et al., 2009; Marchand & Smolkowski, 2013). This suggests that parental monitoring and involvement in young people's lives plays a supportive role in adolescent development and sexual behaviour (DeVore & Ginsburg, 2005).

Parental education has been linked to age of sexual initiation among adolescents. A study conducted by Manlove et al. (2009), based on retrospective information from the 1992, 1997 and 2002 National Survey of Family Growth in the United States, found higher levels of parental education were associated with later sexual initiation, increased use of contraception, and lower odds of adolescent pregnancy. Similarly, a study from northwest Ethiopia has linked maternal education with the utilisation of SRH services by adolescents (Feleke et al., 2013). This could be because educated mothers are more open to discussing SRH issues with their adolescent children and are more flexible in dealing with the problems faced by their children (Feleke et al., 2013). In their study from Nepal, Choe et al. (2005) found higher levels of parental education to be associated with a lower probability of early marriage and delayed sexual initiation of their adolescents. Parental education is often

linked with a strong emphasis on children's education, encouragement of career development, and postponement of sexual activity and childbearing for the adolescents within the family environment (Sales & Irwin Jr, 2009).

Parent-child communication about sexual risk has been linked with sexually risky behaviour and young people's use of contraception. Parents are often the key informants for young people about sexual health (Gray, Klein, Noyce, Sesselberg, & Cantrill, 2005). Hutchinson, Jemmott, Jemmott, Braverman, and Fong (2003) found that higher levels of mother-daughter communication about sexual risk decreased daughters' incidence of sexual intercourse and unprotected sex. While evidence linking parent-child communication to sexual risk behaviours exists, most of the research has not looked into the quality of parent-adolescent relationships, the frequency of communication, or the influence of parental sexual values. Knowledge of these areas would help to highlight the extent to which parents influence adolescents' SRH service utilisation and would be useful in advocacy and health education interventions among parents.

As mentioned earlier in this section, there is no empirical evidence from Nepal that attempts to explain the connection between parent-child communication and health service utilisation. Regmi et al. (2010b) noted that in a closed society like Nepal, parents rarely communicate with their adolescent children about sexual health issues. However, research shows that in the case of married adolescents, parents expect them to access SRH services to prevent unwanted pregnancies and STI (Moktan, 2004).

The literature clearly shows that the family environment is important in determining adolescent sexual behaviour. In a country like Nepal the role of parents and parent-adolescent communication and their impacts on the SRH of young people has never been a subject of research. This is, however, an area in which further exploration could be made to better understand adolescents' sexual health service utilisation. One of the aims of the current study is to explore the perceptions of key community members, including parents, about the utilisation of adolescent-friendly health services.

3.5.2.4 Socio-cultural beliefs and values influencing the SRH of adolescents

The socio-cultural environment of many societies is the container of norms around what are acceptable and unacceptable sexual behaviours, especially for unmarried adolescents. Those who do not observe these social norms may face social ostracism which effectively acts as a form of social control over adolescents' sexual behaviour (Marston & King, 2006). The literature shows that social

norms and measures of social control impact on adolescents' access to SRH services. For example, in most Asian societies, sex before marriage is not socially acceptable (Adhikari et al., 2018; Regmi et al., 2011), and the idea of unmarried young people seeking SRH services remains somewhat inconceivable. Bearinger, Sieving, Ferguson, and Sharma (2007) noted that in many such conservative societies, unmarried adolescents seeking sexual health services are stigmatised, discriminated against, and socially isolated. Discrimination, which may be self-, socially- or institutionally-imposed, can hamper young people's access to SRH services (Campbell, Foulis, Maimane, & Sibiya, 2005; Swendeman, Rotheram-Borus, Comulada, Weiss, & Ramos, 2006). Adolescents may then avoid seeking health care or utilising sexual health services, even if they have health concerns, due to a fear of being chastised or punished for being sexually active before marriage (Bearinger et al., 2007).

Senderowitz (2000) reported that in developing countries the provision of reproductive health information, education and counselling services has been challenging because these are matters of great cultural sensitivity. In some societies, including Nepal, providing SRH information is considered taboo because this is believed to encourage premarital sexual activity (Pradhan & Strachan, 2003; Puri et al., 2010; Ross, 2006). Therefore, many societies tend to withhold sexual health information from young people until it is felt necessary to provide it, typically during puberty or on marriage (Senderowitz, 2000). While schools and health workers could act as mediators of SRH information for young people (Bearinger et al., 2007), several studies reveal that the cultural background of teachers and health workers significantly influences the way they provide such information. In Nepal, although school curricula include reproductive health education for grades 9 and 10 (adolescents aged 15-16 years), teachers are often reluctant to discuss sensitive topics such as SRH because they are concerned about being censured by their own colleagues and society for teaching these topics (Pokharel, Kulczycki, & Shakya, 2006). Researchers have also found that some health workers refuse to provide contraceptive services because they do not approve of premarital sexual activity (Challa et al., 2018; Rivera, Cabral de Mello, Johnson, & Chandra-Mouli, 2001). In a qualitative study conducted by Challa et al. (2018) among 72 school-attending female adolescents, participants noted that health care providers were unwilling to examine or provide services to unmarried pregnant adolescents. This reluctance was related to the fear that providing SRH services to adolescents would encourage premarital sex. This is concerning because such beliefs and attitudes can negatively affect the prevention of sexually transmitted infections and unplanned

pregnancies. According to Senderowitz (2000), the idea that SRH provision promotes adolescent premarital sexual activity contributes to maintaining societal attitudes, including of health workers, that young people have no need of reproductive health services at what is thought to be the healthy and still innocent stage of life in which sexual activity has no part.

In summary, the socio-cultural environment, on the one hand, perpetuates norms that prevent high-risk SRH outcomes for adolescents, but on the other hand disempowers young people, teachers and health workers from carrying out activities which promote young unmarried people's SRH. Denno et al. (2015) emphasise that strategies designed to address the SRH needs of adolescents must be tailored to meet a unique set of needs and should be implemented with community involvement. A fuller understanding of the socio-cultural context of adolescents' utilisation of SRH services is therefore necessary.

3.5.3 Health service system factors affecting SRH service utilisation

As mentioned earlier, components of both Kroeger's (1983) model of health service utilisation and the WHO's (2006) quality of care framework reflect aspects of health systems that affect the utilisation of health services. In this section, some of these important components are presented in a discussion of contemporary health system determinants of SRH service utilisation. Some of the major issues highlighted by empirical research on adolescents' utilisation of SRH services are related to availability, accessibility, acceptability and quality of health services (Chandra-Mouli, McCarraher, Phillips, Williamson, & Hainsworth, 2014; Sawyer & Patton, 2015; Tylee et al., 2007).

3.5.3.1 Availability of SRH services

The availability of health services and adequate supplies to support these services are considered essential components for fulfilling young people's rights to health care. However, in many developing countries, adolescents are unable to obtain health services for their SRH, and one of the most commonly cited reasons is that primary health care services are not available in their communities and/or they live in areas where restrictive laws and policies might prevent access (for example, laws prohibiting the supply of contraceptives to unmarried young people) (Tylee et al., 2007; World Health Organization, 2001). Adolescent-focused health services in developing countries have often been introduced as adjuncts to existing primary health care settings. In some cases, however, they have been introduced in only a few health facilities, compared to the number of young people requiring the service (Denno et al., 2015). For example in Sri Lanka, Agampodi,

Agampodi, and Ukd (2008) found that young people aged 17-19 years reported a lack of SRH services as a major reason for not using health services.

Several studies have shown that increased availability of SRH services for young people has increased access and utilisation through improved health facilities (African Youth Alliance, 2005a, 2005b; Aninanya et al., 2015; Bhuiya et al., 2004; John Snow Inc, 2007a, 2007b; Larke et al., 2010; LaVake, 2003; Lou et al., 2004; Mbonye, 2003; Okonofua et al., 2003). A study in Uganda of four AFHS found that utilisation by adolescents had doubled following AFHS implementation (Mbonye, 2003). That evaluation was undertaken during the intensive pilot stage of the USAID's AFHS intervention. During a pilot stage, it would be expected that a lot of resources would be invested to ensure service quality. Thus, it is likely that during this "honeymoon" stage of a project, service utilisation would markedly increase. Whether such utilisation rates could be sustained once USAID pulled out their resources is questionable. Another study of countries including China, Uganda, Ghana and Tanzania, where youth-friendly health services were provided together with awareness activities showed that contraceptive and condom use among young people significantly increased compared to control areas (Daniels, 2007; John snow Inc, 2007b; JSI, 2007; Lou et al., 2004; Williams et al., 2007). Similar increases were reported in a community-randomised control trial conducted in northern Ghana in 26 communities where adolescent-friendly health services were provided along with community mobilisation, peer- outreach and school-based SRH education (Aninanya et al., 2015). The increase in service utilisation from health facilities in areas where these types of supporting activities were part of the program was perhaps due to enabling environment created through these activities. Aninanya et al. (2015), in their research, further noted that community mobilisation activities like meetings and seminars with elders, chiefs, religious leaders and NGOs at the local level helped to create a supportive environment for adolescents; that school-based SRH education helped to increase SRH knowledge; and mobilising peer outreach workers, reached out-of-school adolescents with information and counselling.

The availability of SRH services has not always been found to increase young people's health service utilisation in South Asian countries. For example, in Bangladesh adolescent-friendly services linked with a community and school-based education program did not show any significant difference between 15-19-year-old males' use of health services or of condoms in intervention and control areas (Bhuiya et al., 2004). Similarly, a study conducted in Nepal showed no difference in service utilisation by young people in intervention areas where AFHS was integrated into public health

facilities in comparison to control areas where there was no AFHS (Neupane et al., 2014). Recalling the study by Bam et al. (2015) in Nepal, while 94% of the adolescents knew about SRH services, only 9.2% had ever used them. Similarly, a qualitative study involving ethnographic methods and focus group discussions conducted by UNFPA in Nepal showed that 80% of the adolescent participants did not use SRH services (Kennedy et al., 2015). This UNFPA study was carried out in 12 districts and included 72 AFHS. The results of the above studies clearly show that having knowledge of the existence of AFHS did not lead to better service utilisation. None of the current studies has explored in depth what facilitates adolescents' use of AFHS; what is evident is that AFHS utilisation in Nepal is poor. Shaw (2009) argues that although governments in South Asian countries may be progressive in their AFHS initiatives, there may be several other social and cultural issues which impede young people's access to SRH services. The existing literature shows there is a gap in understanding what these factors might be in the case of Nepal. This thesis addresses that gap.

3.5.3.2 Accessibility of health services

It is obvious that for young people to utilise SRH services, they need to be adolescent-friendly. At the same time, it is essential that these services are accessible to young people. Accessibility of health services is explained in relation to costs associated with the services and the distance that people need to travel to reach them (Sawyer & Patton, 2015; Tylee et al., 2007). Available services may not be accessible to young people for a variety of reasons. First of all is cost, as discussed by Morreale, Kapphahn, Elster, Juszczak, and Klein (2004). Kennedy et al. (2013) noted in their study that cost is associated not only with the services and commodities provided by the facility but also with transport. Young people, as a group affected by high rates of unemployment and having little access to household resources, are particularly vulnerable to cost. A large-scale population-based survey conducted in Kenya and Zimbabwe showed that low cost was one of the most important features for young people deciding whether to use reproductive health services (Erulkar, Onoka, & Phiri, 2005).

The WHO (2012) has emphasised the need to make the cost minimal for young people and inform them about the availability of services and cost in advance via leaflets and other information channels. In Nepal, the government officially abolished fees for primary health care in 2007, making AFHS part of free primary health care. However, despite being free of cost health service utilisation among young people has not increased significantly (Bam et al., 2015; Neupane et al., 2014). It is

clear that in Nepal, there are other issues besides cost that contribute to adolescents' underutilisation.

A major concern for Nepalese adolescents is physical access to the facilities. As noted in chapter 2 section 2.1, health facilities in Nepal are not always located in areas easy for young people to access. And it is not just young people – many communities must travel long distances, often on foot, through difficult terrain because there are no health facilities located close to where they are living, studying or working (Sawyer & Patton, 2015; Tylee et al., 2007). However, the degree to which distance affects utilisation of AFHS has not been empirically explored.

3.5.3.3 Acceptability of health services

Health services might not be acceptable to adolescents even if they are available and accessible, because of a perceived lack of confidentiality at the service and judgemental attitudes of HCPs (Sawyer & Patton, 2015; Tylee et al., 2007). Confidentiality and privacy go hand in hand, and health professionals have understood for a very long time that confidentiality is essential for patients with sensitive issues like mental health, sexual health, and drug abuse. However, confidentiality is one of the most neglected areas of concern in health service provision in much of the developing world (Sawyer & Patton, 2015). Several research studies have documented that adolescents rate confidentiality as the most important feature in deciding whether to use SRH services, and they are eager to use health services where practitioners can assure them of confidentiality (Ambresin, Bennett, Patton, Sanci, & Sawyer, 2013; Atuyambe et al., 2015; Erulkar et al., 2005; Hällström, Ranjbar, & Ascher, 2017; Thomas, Murray, & Rogstad, 2006). For example, in their qualitative study among 11 female and 12 male adolescents in Sweden, Hällström et al. (2017) noted that for adolescents, confidentiality at health services was utmost in their decisions to seek services. Regmi et al.'s (2010b) study from Nepal indicated that young people perceived HCPs to be judgemental, and not offering confidentiality, making them hesitant to visit SRH services (Bam et al., 2015; Regmi et al., 2010b).

Adolescents' fear of their confidentiality being breached so that parents and other family members are informed of their visit has often been associated with their poor acceptance of SRH services (McIntyre, 2002; Sawyer & Patton, 2015; Tylee et al., 2007). A study in the US noted that young people would go without using SRH services if parental involvement was required for access (Reddy, Fleming, & Swain, 2002). The authors observed that 59% of the 1,118 young people surveyed

indicated they would stop using all sexual health care services if parental consent or notification was required. However, in an African context, as previously noted, parental involvement and discussion with adolescent children resulted in better utilisation of SRH services (Biddlecom et al., 2009; Feleke et al., 2013). There remains a gap in understanding how, in the Nepalese socio-cultural context, parental involvement influences adolescents' SRH decisions.

Lack of privacy and confidentiality at health facilities also suggests that young people do not trust health services and health care providers. For adolescents, trust is an important element in their decisions about SRH services, especially in a culturally conservative society where unmarried sexual activity is not acceptable (Daley, Polifroni, & Sadler, 2017; Hardin, McCarthy, Speck, & Crawford, 2018; Kennedy et al., 2013). A meta-ethnography study conducted by Daley et al. (2017) noted that 11 out of 12 studies had highlighted that trusted relationships with HCPs are key to adolescents' experience of a health service as either positive or negative. Furthermore, this study showed that only a positive experience that fulfils adolescents' expectations will result in their engaging in SRH service seeking behaviour (Daley et al., 2017).

Age and gender differences between HCPs and adolescents have been highlighted as major determinants of acceptability of SRH services (Atuyambe et al., 2015; Erulkar et al., 2005; Regmi et al., 2010b; Smith et al., 2018). Alli, Maharaj, and Vawda (2013) argue that in many developing countries, HCPs are often the same age as adolescents' parents, which makes adolescents hesitant to discuss SRH related concerns. Studies in South Africa by Smith et al. (2018) and in Nepal by Regmi et al. (2010b) lend further support to the need for narrower age gaps between HCPs and adolescents. In both these countries, both male and female adolescents wanted young HCPs in the health facility. In regard to gender, both male and female adolescents preferred to receive SRH services from an HCP of the same sex (Godia, Olenja, Hofman, & van den Broek, 2014; Mazur, Brindis, & Decker, 2018). A qualitative study among young people aged 10-24 years in Kenya noted that not having an HCP of the same sex available at the health facility for SRH services was considered by both males and females to be a negative experience (Godia et al., 2014). Unavailability of an HCP of the preferred sex at the health facility might discourage adolescents from visiting the facility, as Mayeye, Lewis, and Oguntibeju (2010) note in their research set in South Africa, where 98% of adolescents seeking services were females and the majority of HCPs in the facility were also female.

In discussing the acceptability of services, it is also important to determine whether SRH services are more acceptable if provided as a standalone service or integrated within other health services. This is a matter of contention in the existing literature. Some scholars argue that it is difficult for young people to seek SRH services when they are not a discrete entity, or where the existing services in the community such as family planning or abortion clinics are already stigmatised (Geary et al., 2014). These arguments support standalone services as being more acceptable. Yet other studies suggest that standalone SRH services for young people could increase stigma and marginalisation (Delany-Moretlwe et al., 2015). Adolescents in Nepal reportedly felt uncomfortable using SRH services for fear of being judged for having sex-related problems, which would bring shame to them and their families (Regmi et al., 2010b). What is interesting is that while Nepalese adolescents feared going to a standalone SRH service, in the US some adolescents were more comfortable visiting a standalone STI clinic, for example, rather than a general health practice, believing that because everyone going to the STI clinic had similar issues, there was less shame and stigmatisation (Lindberg et al., 2006).

Some studies from Nepal have shown the integration of SRH services into existing general health services to be more acceptable. For example, the study by Bam and colleagues (2015) found that adolescents were seven times more likely to use SRH services situated within emergency health services departments rather than in health facilities designated as adolescent-friendly health facilities that are standalone SRH services. The arguments for and against standalone or integrated SRH services point to a need for further research on adolescents' acceptance of adolescent-friendly health services that explores the views and perceptions of young people themselves.

3.5.3.4 Quality of health services

Quality of service is an important element of health care provision (Goddard & Smith, 2001). Alderman and Lavy (1996) observed from their research that even low-income households are willing to pay fees for better health services, basing their decisions on several factors such as availability of drugs, doctors, clinical service hours, adequacy of equipment, and the physical status of facilities. Components of quality linked to poor utilisation of SRH services by young people include long waiting times, administrative hassles, negative attitudes towards their SRH needs, lack of medical supplies, and unfriendly behaviour of HCPs (Tylee et al., 2007).

Studies have consistently noted adolescents' dissatisfaction with long waiting times at health facilities (Mazur et al., 2018; Schriver, Meagley, Norris, Geary, & Stein, 2014; Shabani et al., 2018).

A systematic review conducted by Mazur et al. (2018) noted that long waiting times were unacceptable for adolescents. Adolescents perceived that shorter waiting times at the health facility indicated it was a good clinic (Schriver et al., 2014)

The capacity of health care providers to deliver SRH services is another important factor that determines the quality of service delivery to adolescents. Although HCPs in many countries are provided with specific training to provide SRH services to adolescents (Atuyambe et al., 2015; Wadhwa et al., 2018), the quality of training remains suboptimal. In many places, HCPs do not receive training at all (Geary et al., 2014; Nash et al., 2019; Weiss, Elouard, Gerold, & Merten, 2018) or receive an inadequate amount of training (Mulaudzi et al., 2018). Weiss et al. (2018), in their qualitative study conducted among 365 nurses in the Democratic Republic of Congo, Burundi and Rwanda, noted that almost half of the nurses have never received training in youth-friendly services despite their being responsible for providing SRH services to adolescents in their respective health facilities. On the one hand, lack of training or inadequate training for in-depth counselling and consultation with adolescents might make HCPs feel poorly equipped (Mulaudzi et al., 2018); on the other hand, adolescents may not use the services because they perceive them to be of poor quality (Shabani et al., 2018). Further, in many situations, in health facilities designated as adolescent-friendly, staff who are trained in AFHS are not available or are too few in number (Geary et al., 2014). A study from Nepal documented that the frequent transfer of trained health workers often resulted in untrained health workers being placed in adolescent-friendly facilities (Baral et al., 2013).

In summary, the quality of health service delivery directly affects adolescents' use of SRH services. Mostly, aspects of quality relate to the health system and the health workers. Therefore, health workers' experience, practices and procedures are key to understanding young people's attitudes to seeking SRH services.

3.6 Conclusion

The following conclusions can be drawn from this literature review:

- Adolescents are people aged 10-19 years, the period of the phase of life called adolescence. How adolescence is defined will vary according to perspectives such as biological development and social and ecological factors that shape the behaviour of adolescents. There is, however, limited information available in a developing country like Nepal about how the socio-cultural context shapes the sexual health of adolescents.

- Adolescents in developing countries face negative consequences due to gender inequality, less educational opportunity, early marriage and early childbearing, and vulnerability to STI and HIV/AIDS as risks to their SRH and well-being.
- AFHS is a one of the global responses to the need to address adolescents' SRH issues. Over time, AFHS has been bundled with additional interventions such as community engagement, school education and peer support programs to fit unique cultural contexts respective to country and geography. In Nepal, AFHS was implemented as a health system approach with only indirect random engagement of the education sector. Literature suggests that AFHS alone has not brought about significant SRH service utilisation by adolescents; hence, there is a dearth of research to understand the socio-cultural context in Nepal.
- Studies to date suggest utilisation of SRH services is influenced by education, adolescent sexual relations, social and structural factors, and gender norms.
- Health system factors also significantly affect SRH service utilisation by adolescents. The available research does not, however, explain the association between health system factors and socio-cultural determinants.
- A number of studies have looked at the socio-cultural factors influencing adolescent SRH. However, the literature review conducted for this PhD study has not found any noteworthy studies that have explored adolescents' perspectives of the essential attributes of AFHS that would encourage them to utilise available SRH services, or what AFHS means for them.

The current evidence emphasises the importance of context-specific research to understand the issues around adolescents' SRH and health service utilisation. Such research would provide an evidence base for the design of health programs to increase utilisation of health services by young people (Agampodi et al., 2008; Bearinger et al., 2007; Kennedy et al., 2013). This study therefore aims to understand what contributes to adolescents' SRH service utilisation from AFHs in Nepal. Adolescents' perceptions and experiences of seeking SRH services, and the meaning of AFHS will be explored using qualitaitve research methods. Health care providers' and key informants' attitudes towards SRH services will also be examined to understand the barriers for adolescents. This research will provide an essential evidence base that can inform the development of recommndations for policy makers, managers and planners to address the challenges faced by adolescents in seeking SRH services. It will also allow for current AFHS to be modified for greater acceptance by adolescents.

CHAPTER 4: METHODOLOGY

This study aimed to understand the reasons for young people's poor utilisation of existing sexual and reproductive health services provided by adolescent-friendly health facilities in Nepal. While previous studies have identified significant increases in awareness and knowledge about adolescent-friendly health services amongst young people (Bam et al., 2015; Baral et al., 2013; Neupane et al., 2014; Teijlingen et al., 2012), this progress has not translated to increases in the number of adolescents seeking services like family planning and counselling (Bam et al., 2015; Neupane et al., 2014).

Health service provision to young people is embedded in complex health service structures and the socio-cultural context of Nepal. This research, therefore, set out to obtain a rich understanding of these issues and the context in which sexual and reproductive health services are provided to young people in Nepal. To this end, I used qualitative approaches to understand these complex realities. As noted by Creswell (1998), research studies which require a detailed view of the topic and need exploration should use qualitative methods. Qualitative methods enable rich description of what is happening in the real context and deeper understanding of the background procedures that come into play (Sofaer, 1999).

In order to create an understanding of what contributes to the utilisation of sexual and reproductive health services from adolescent-friendly health services, the study focused on five specific research objectives and respective research questions, as presented in the table below.

Table 4. 1 Research objectives and the respective research questions

Research objectives	Research questions
1 To assess the level of utilisation of adolescent-friendly health services by young people, and compliance of the adolescent-friendly health services with the national standards.	1.1 What is the current utilisation of sexual and reproductive health services by adolescents in adolescent-friendly health services? 1.2 To what extent do adolescent-friendly health services in Nepal comply with national standards?
2 To understand the perceptions and attitudes of health care providers in delivering sexual and reproductive health services to adolescents from adolescent-friendly health services.	2.1 What are the perceptions, attitudes and experiences of health care providers regarding the provision of sexual and reproductive health services to adolescents?
3 To explore to what extent health care providers' delivery of sexual and reproductive health services is considered adolescent-friendly.	3.1 What are the adolescents' perceptions and experiences of the SRH services they received?
4 To explore the perceptions and attitudes of adolescents towards adolescent-friendly health services.	4.1 What does an adolescent-friendly health services mean for adolescents? 4.2 What are adolescents' experiences and challenges in accessing sexual and reproductive health services from adolescent-friendly health services?
5 To explore community/stakeholder perceptions and attitudes towards adolescent-friendly health program.	5.1 What are the perceptions of community members (decision makers/gatekeepers) of adolescent-friendly health services? Do they accept and support the adolescent-friendly health program?

The first objective, to assess the level of utilisation of adolescent-friendly health services (AFHS) by young people employed a quantitative record review of health management information systems in order to gauge the health service coverage of adolescent-friendly health services to young people. Information was also collected through observation and measured against the nationally approved standards for maintaining optimal quality of health services. This assessment helped to ascertain whether health facilities were adolescent-friendly as per the national standards, and was used to explore issues affecting young people's utilisation of health services.

The second objective was to explore the perceptions and attitudes of health care providers in their delivery of sexual and reproductive health (SRH) services to adolescents from adolescent-friendly health services, and bring to light factors underlying those attitudes and perceptions that may influence young people's decisions about using SRH services.

The third objective of exploring the experiences of adolescents in using sexual and reproductive health services helped in understanding service-related factors that may affect or determine health services use by young people.

The fourth objective of exploring the perceptions and attitudes of adolescents towards adolescent-friendly health services was to gain insight into what AFHS means from the recipients' point-of-view.

The fifth objective of exploring community perceptions and attitudes towards adolescent-friendly health services helped to understand community preparedness for sexual and reproductive health services for young people.

Overall, these five objectives were formulated to understand the reasons behind young people's poor utilisation of sexual and reproductive health care provision from adolescent-friendly health services in Nepal.

4.1 Qualitative approach to inquiry

Qualitative research takes a naturalistic approach concerned with understanding reality and assumes that reality is a complex and dynamic phenomenon which is constructed through the interactions of human agents in their social world (Creswell, 1994; Ritchie & Lewis, 2003). In this PhD study, I was interested in understanding the reasons for the low utilisation of sexual and reproductive health services by adolescents from adolescent-friendly health services. Thus, a qualitative approach is well-suited to achieving this insight.

Creswell (2013) reiterates that qualitative researchers typically gather data in multiple forms and, drawing on Creswell, I chose to apply data collection methods such as interviews, observations, focus group discussions, and analysis of health facility data. As Creswell argues, employing multiple forms of data collection, rather than relying on a single source of data is an aid to making sense of the issue under study, in this case, the complexities surrounding the utilisation of adolescent-friendly health services.

This research is a field-based study, since I aimed to engage with research participants in their natural setting, talking directly to adolescents, health care providers and community stakeholders to obtain data. This allowed participants to share their experiences in a natural setting, providing a holistic picture of the issues to answer my research questions, as Creswell (2013) suggests. The goal of this study was not to test or verify any existing theories or hypotheses, but to understand the practical reasons why young people do or do not utilise sexual and reproductive health services and gather their views and ideas to help develop a model for the services young people desire.

4.2 Research paradigm

My study is informed by two different epistemologies: the first is the social constructionist epistemology; and the second is pragmatism. The method of applying social constructionism and pragmatism in a single research was termed "social constructionism with a twist of pragmatism" by Marshall, Kelder, and Perry (2005). As both paradigms have significant implications for my research, I will provide a brief overview of these paradigms and the context within which my understanding of the chosen methodology for the study is located.

4.2.1 Social constructionist epistemology

Ritchie and Lewis (2003, p. 13) state that epistemology is concerned with "ways of knowing and learning about the social world" and focuses on questions such as *how can we know about the reality and on what basis does our knowledge stand?* Thus, epistemology deals with the nature of knowledge, its scope and general basis.

My research assumed that there might be a variety of reasons for adolescents' poor utilisation of SRH services from adolescent-friendly health services. These reasons may be related to the social system, cultural values, attitudes, and beliefs in Nepalese society. The experiences or subjective meanings given by the participants about SRH may have been influenced by how these young people were socialised at home, through the school system and the broader community, through historical and cultural systems, and the way adults view the SRH of adolescents. The epistemological underpinning of this study recognises the importance of social factors, the context in which participants are living, and processes of interaction among individuals around the SRH of young people.

Social constructionist epistemology assumes that human beings do not find or discover knowledge, but rather that it is constructed in the light of historical and socio-cultural values and norms. The interpretations and construction of knowledge are based on shared understandings, practices, languages used to describe, explain and account for the understandings attached to the values and actions of a society (Denzin & Lincoln, 2000).

Crotty (1998) described social constructionism as an interpretive paradigm for understanding reality, emphasising that truth is not there waiting for us to discover it but rather, "Truth, or meaning, comes into existence in and out of our engagement with the realities in the world. There is no meaning without a mind. Meaning is not discovered but constructed" (Crotty 1998, p. 8). Crotty (1998, p.42) further describes reality as a social construction whereby:

> *All knowledge and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of the interaction between human beings and their world, and developed and transmitted within an essentially social context*.

Thus, social constructionism is based on meanings created through a process of interpretation, in turn based on shared description, explanation and understandings to give meaning to social beliefs, contexts and actions that are presented symbolically in the society. This approach would, therefore, help me to answer my research queries by clarifying: a) the different realities adolescents experienced when they utilised SRH services; b) the content of different interactions in the society which produced interpretations of SRH services; and c) the lessons adolescents had taken from their social context that influenced their decisions about accessing SRH services. Thus, my study acknowledges that adolescents' decisions about seeking SRH services and the meanings associated with them are not objective, but rather constructed through adolescents' social interactions with peers, parents, teachers, and service providers, and their interpretations of these interactions occurring through the processes of socialisation, negotiation and renegotiation (Crotty, 1998).

4.2.2 Pragmatism

Creswell (2013, p. 28) states that "individuals holding an interpretive framework based on pragmatism focus on the outcome of the research – the actions, situations, and the consequences of the research". It is also highlighted that in pragmatism the concern is more on applications of "what works" and to find the solution to the problem (Patton (2002), as cited in Creswell (2013)).

This research is underpinned by the pragmatic framework since my purpose is to look for possible solutions to improving the current low utilisation of SRH services by adolescents in Nepal. The pragmatic approach postulates that practical relevance and usefulness is developed in dialogue with stakeholders (Marshall et al., 2005). In my research, the reasons identified as potentially influencing the adolescent's decision to utilise SRH services from adolescent-friendly health services were put forward to the key stakeholders working in the field of adolescent sexual and reproductive health (ASRH) in Nepal, which is discussed in detail in section 4.10.3 of this chapter. This process resulted in the formulation of practical recommendations for policy and program implementation for adolescent health in Nepal. As informed by pragmatism, I took the liberty of using multiple methods of data collection, and a case study methodology to answer my research questions, which will be discussed in section 4.3 of this chapter.

4.3 Research design and method

4.3.1 Research methodology

Methodology is defined as a strategy, plan of action, process, or design behind the choice and use of particular methods (Crotty, 1998). It is also a procedure of gaining knowledge, and in qualitative research it is often characterised as inductive, emerging, and shaped by the researcher's experience in collecting and analysing the data (Creswell, 2013). Informed by an interpretive research framework, the main methodology of this research is a qualitative case study. My research is also influenced by and draws on some principles of grounded theory, which will be discussed below.

4.3.1.1 Case study

According to Stake (1995), the case study methodology is a strategy of inquiry in which the researcher explores in depth a program, event, activity process, or one or more individuals. As this research aimed for a comprehensive understanding of the current poor utilisation of AFHS, a case study seemed an appropriate methodology allowing in-depth study of the AFHS program, the policies related to the program, and what was actually happening in the delivery of AFHS in Nepal (Simons, 2009). Moreover, the case study approach helped me to gain an in-depth understanding of the perspectives of the various actors, in this case the adolescents who are the target of AFHS, the health care providers delivering the services, and key informants who influence the SRH service utilisation by adolescents. I also attempted to collect data from AFHS within public health facility settings over a period of six months using multiple data collection methods to get an overall picture

of what was going on. Thus, this also fits the notion of cases being bounded by setting, context, time and activity, and the use of a variety of data collection procedures over time (Creswell, 2013; Stake, 1995). A case study is also appropriate because my research is an attempt to understand in depth why adolescents are not utilising the services despite initiatives to make these services adolescent-friendly (Yin, 2014).

Case studies are also flexible; they may be qualitative, or combine qualitative and quantitative approaches (Starman, 2013; Yin, 2014). For this study, I collected detailed information, both quantitative and qualitative, using a variety of data collection methods, between September 2016 and March 2017. Further details of the data collection methods are provided in section 4.10.

4.3.1.2 Grounded Theory

My study was influenced by, and drew on some of the principles of grounded theory, especially during data collection and analysis, which allowed me to stay close to my data. In grounded theory methods, the researcher continuously interacts with their data while being immersed in the emerging analysis. Further, the essence of the grounded theory is the simultaneous proceeding of data collection and data analysis, one informing and streamlining the other (Bryant & Charmaz, 2007).

I particularly benefited from the grounded theory principle of "improvis[ing] methodological and analytic strategies throughout the research process" (Charmaz, 2008, p. 403). Data analysis began with data collection and throughout the collection period I was constantly analysing and looking at the patterns and themes arising from the data. I improvised my research questions and approaches to seek answers by iteratively analysing how I questioned and approached participants, looking at whether they were meaningful or not. My approach to the analysis was to stay close to the data and use a completely inductive approach.

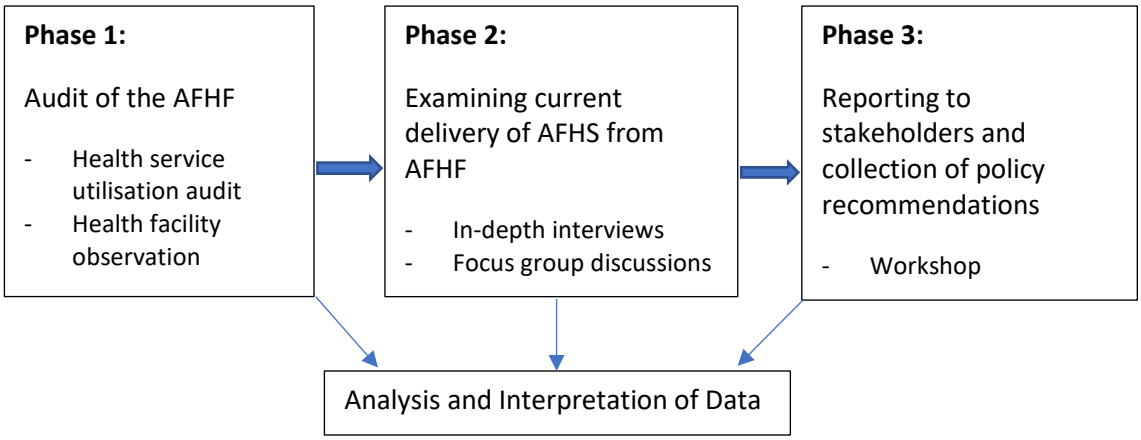
While I drew upon the elements of a grounded theory approach mentioned above, my methodology differed from a grounded theory approach in that I was not aiming to develop a model and did not use theoretical sampling.

4.3.2 Research design

A research design is a logical plan for conducting the study or answering the research questions (Yin, 2014). This research was conducted in three different phases comprising of three interdependent

research processes connected with the outcome of individual studies. I considered this phased approach to research practical to follow in order to address the research questions. The following figure 4.1 illustrates the phases of my research:

Figure 4. 1 Sketch of research phases



The first phase of the research was an audit of the 26 adolescent-friendly health services (AFHS), using quantitative health service utilisation data collected from the health facilities and from observation of health facilities against national standards for AFHS. The information collected in this phase quantified adolescents' utilisation of SRH services. This phase helped in identifying AFHS for further in-depth study in the second phase, described in section 4.6 of this chapter.

The second phase of the research examined the current delivery of sexual and reproductive health services utilising the case study approach to understand in depth the reasons for poor utilisation of AFHF by adolescents. In this phase, adolescents' experiences of accessing AFHS, and their perceptions immediately following their visit to the SRH service were explored. The aim here was to understand what adolescent-friendly health services meant to these adolescents and what their actual experiences were like. In addition, the perceptions and attitudes of health care providers towards ASRH service provision, and community perceptions and support of AFHS were explored. To achieve my research objectives, I chose a multiple case study design (Yin, 2014) with a total of six AFHS chosen as cases for the study. In-depth interviews and focus group discussions (FGDs) were used for data collection.

The in-depth interview was chosen because it allowed "face to face and one-on-one interaction" between me, the researcher, and my participants, and the gathering of "rich information" about

various issues relating to AFHS from the participants' perspectives (Liamputtong, 2013, p. 52). In-depth interviews, as explained in section 4.10.2, were conducted with health care providers, adolescents and key informants.

To better understand how health care providers delivered their services, client exit interviews were carried out. These were conducted at the point when the patient exits from a consultation with a health care provider (Geldsetzer, Fink, Vaikath, & Bärnighausen, 2018). Client exit interviews are an important form of data collection that assesses patients' satisfaction with the health services they received (Chimbindi, Bärnighausen, & Newell, 2014; Islam et al., 2015).

Focus group discussions are small-group discussions facilitated by a moderator focused on a particular topic (Liamputtong, 2013, p. 75). FGDs are useful for obtaining data on social norms as well as a range of perspectives that exist within the community or sub-groups (Mack, Woodsong, MacQueen, Guest, & Namey, 2005, p. 51). FGDs typically have six to ten people who share similar experiences and often come from similar social and cultural backgrounds (Liamputtong, 2013, p. 75). FGDs were chosen as one of the methods of data collection because they provided me with an opportunity for "interactive discussion" with adolescents and to obtain a range of adolescent perspectives on AFHS and SRH service utilisation (Hennink, 2014, p. 4). This was also a good approach for understanding the adolescents' views on what an adolescent-friendly health service meant for them.

Drawing on a pragmatic interpretive framework, the third phase of the study was aimed at engaging the research participants and policymakers in a consideration of the findings of the research to come up with practical and feasible recommendation for action. For this purpose, a half-day workshop was organised to share the preliminary findings of the first and second phases of the study. Details of this event are given in section 4.10.3.

Table 4. 2 Research framework

Thesis Aim	Research Phases	Study No	Objectives	Areas of exploration/ research questions	Methods	Tool	Number
To understand what contributes to the utilisation of adolescent-friendly health services in Nepal.	Phase 1: Audit of the AFHF	NA	To assess the level of utilisation of AFHS by young people and compliance of the AFHS with the national standards.	What is the current utilisation of sexual and reproductive health services by adolescents in AFHS?	Health service utilisation audit	Monthly service utilisation assessment form stratified by age	26 health facilities
				To what extent do AFHS in Nepal comply with national standards?	Health facility observation	Observation checklist adopted from the National Standards for Adolescent-Friendly Health Services	26 health facilities
	Phase 2: Examining current delivery of adolescent-friendly health services	Study 1	To understand the perceptions and attitudes of health care providers in delivering SRH services to adolescents from adolescent-friendly health services.	What are the perceptions, attitudes, and experiences of health care providers regarding the provision of SRH services to adolescents?	In-depth Interviews with health care providers	Semi-structured interview questionnaire	9 health workers
		Study 2	To explore to what extent health care providers' delivery of SRH services is considered adolescent-friendly.	What are the adolescents' perceptions and experiences of the SRH services they received?	Client-exit interview with adolescents	Exit-interview questionnaire	2 adolescents
		Study 3	To explore the perceptions and attitudes of adolescents towards adolescent-friendly health services.	What does an adolescent-friendly health service mean for adolescents?	Focus group discussion with young people	Vignettes, mapping exercise, guiding questions	6 FGDs with 8-10 adolescents in each group
				What are adolescents' experiences and challenges in accessing sexual and reproductive health services from AFHSs?	In-depth interviews with adolescents	Semi-structured interview questionnaire	14 adolescents who are using and who are not using AFHS
		Study 4	To explore community stakeholder perceptions and attitudes towards the adolescent-friendly health program.	What are the perceptions of community members (decision makers/gatekeepers) of AFHS? Do they accept and support the adolescent-friendly health program?	In-depth interviews with key informants	Semi-structured interview questionnaire	13 key informants
	Phase 3: Reporting to stakeholders	NA	To share with the research participants, stakeholders and policymakers the preliminary findings (draft) of the study; and to obtain stakeholders' input into the recommendations for policy on ASRH program.	What do the research participants feel about the research results? What are their recommendations?	Workshop	Workshop schedule	1 half-day workshop with national level stakeholders and policy makers

4.4 Study setting

The study was conducted in the Dhading district of Nepal, where adolescent-friendly health services have been implemented since 2010. There were two reasons why I selected Dhading as the study site. First, Dhading is one of the districts where the AFHS program was initiated during its preliminary phase in 2010, with the Ministry of Health and Population taking the lead in implementation, whereas in other districts of Nepal external development partners lead the implementation. To date, there has been no research in Dhading on adolescent-friendly health services even though it was one of the first districts where these services were implemented (Kennedy et al., 2015; Neupane et al., 2014). Second, being only 130 km from the capital city, Kathmandu, Dhading represents both rural and urban populations and blends rapidly growing urbanisation with upholding of traditional culture. While the major Prithvi Highway runs from the middle of the district connecting to major cities, the district encompasses the Himalayas and rural areas which take several days to reach by public transportation and on foot. This area is categorised as the rural districts of Nepal (MoHN, 2014a). Hence, I purposefully chose this district that spreads from the Himalayas to the plains, has a mix of rural and urban population, was accessible from Kathmandu, and was a district with an adolescent-friendly health program implemented solely by the government of Nepal.

According to the new federal system outlined in the new constitution of Nepal (Constitution Drafting Committee, 2015), Dhading district lies in Province No.3 and is a hilly district. It consists of two municipalities and 11 rural municipals. These municipalities and rural municipals consist of 53 towns and villages (figure 4.2). The latest population census in Nepal was in 2011, when it recorded Dhading district having a total population of 336,067; and that one in every four people were adolescents (CBS, 2012). Dhading district has a total of 52 health facilities, of which 26 provide AFHS. Of these 26 facilities, 24 are Health Posts (HP) and only two are Primary Health Care Centres (PHCC) (Chapter 2, section 2.4.1 details the status of HP and PHCC). Table 4.3 given the brief profile of Dhading district.

Figure 4. 2 Map of Dhading district

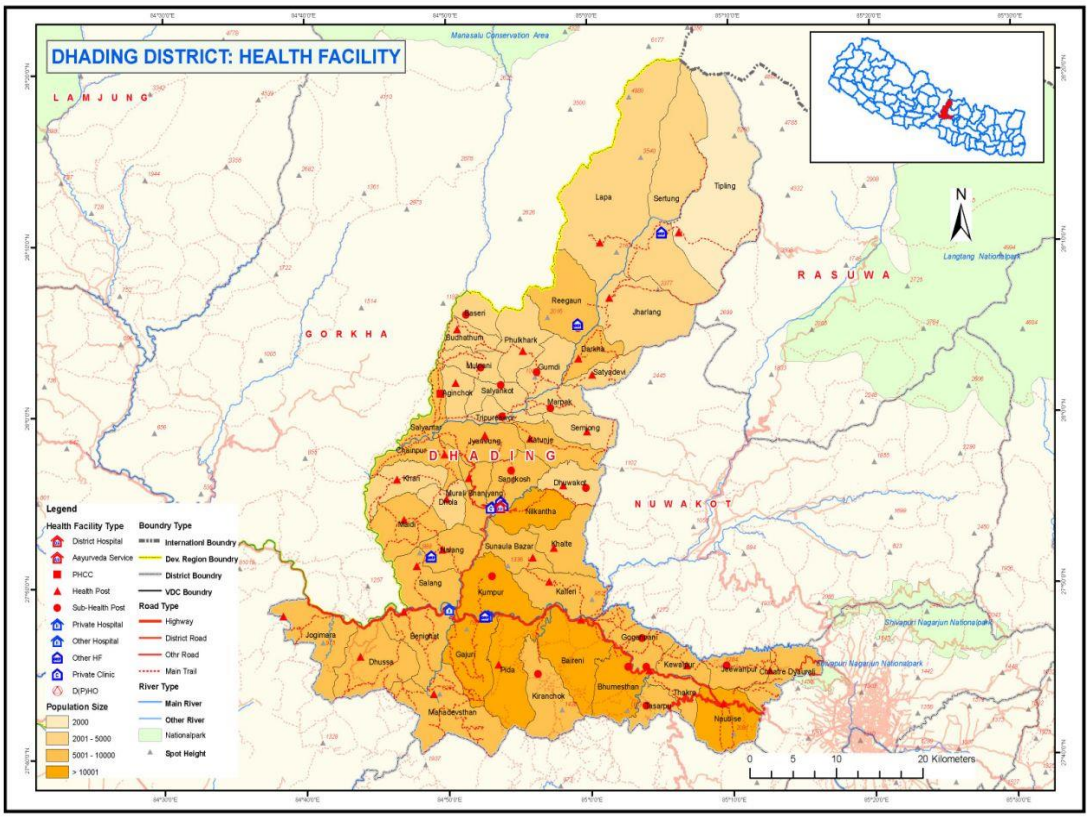


Table 4. 3 Dhading district profile

Total population	336,067 (F:177,233)
Adolescent population	86,056 (F: 45,609)
Literacy percentage	63% (F: 56%)
Brahmin and Chettri population	99,803 (29.7%)
Ethnic group population (Newar)	31,587 (9.4%)
Ethnic group population (Tamang and Chepang)	88,729 (26.4%)
Dalit population (marginalised)	14,048
Total number of health facilities	52
Total number of adolescent-friendly health facilities services	26
Selected adolescent-friendly health services for this study	6

Source: (Central Bureau of Statistics, 2012)

4.5 Study sites and the selection process

All 26 AFHS were selected as study sites for the **first phase** of the research, the health facility audit, conditional on their meeting the following selection criteria:

a. Health facility had operated AFHS for at least two years; and
b. Health facility in-charge was willing to participate in the study.

The two-year criterion was applied to ensure that adolescent health program had had enough time to implement in the catchment area. The health facility audit involved collecting service utilisation data and observing each health facility using the standard observation checklist. To do this, the consent of the particular "health facility in-charge" was necessary. In Nepal, the health care provider responsible for administration, management and decision making of the health facility is called health facility in-charge. Medical officers in primary health care centres and health assistants in health posts hold this position.

I approached the District Public Health Officer of Dhading district and explained to him the details of my research. He invited me to attend one of his monthly health facilities in-charge meetings in the District Public Health Office. I participated in one of these meetings, provided them with information about my research and invited the health facility in-charges to participate in the research and, if they were interested, to contact me. All the health facility in-charges expressed interest in participating in the research. I then went to each of the 26 health facilities to collect service utilisation data and to conduct observation. Further information about the health facility audit is given in section 4.10.1 of this chapter.

This audit guided the selection of health facilities for the **second phase** of the research. Based on the Nepal national standards for adolescent-friendly health services (*Appendix A.1*), the selected health facilities were assessed and scored against compliance standards and assigned to one of three categories. I drew on Chandra-Mouli et al. (2016) to undertake this categorisation. Chandra-Mouli et al. (2016), in their study of eight low- and middle-income countries, analysed the quality standards for AFHS and developed three categories: ≥70% compliance = Good or performing well; 40-69% = Medium or needs some improvement and ≤39% = Poor or needs considerable improvement. For my study, I took a similar approach, using an observation checklist ***(****Appendix A.2****)*** that consisted in 20 variables, each variable scoring one point. In addition, I considered health service utilisation data which was calculated as a percentage of adolescents visiting the out-patient department of the health facility out of the total projected adolescent population for two fiscal years 2014/2015 and 2015/2016. To

determine the health service utilisation scores, records of the health management information system were used. Dependent upon service utilisation information, the health facilities were categorised as: ≥70% utilisation = Good or performing well; 40-69% = Medium utilisation and ≤39% = Poor utilisation.

Using two different approaches to categorisation revealed interesting differences in compliance and health service utilisation. For example, some health facilities had high service utilisation but low scores based on observation; some had high observation scores but low service utilisation; some were popular ASRH services in the district, but scored as medium in both service utilisation and observation. Because of this, I considered only the health service utilisation scores to categorise health facilities and then choose six adolescent-friendly health services (two each from good, medium and poor categories) as study units for examining health service delivery. Therefore, these six health facilities regardless of their good, medium or poor levels of service utilisation were selected purposively to bring different perspectives and understandings of service utilisation. These six adolescent-friendly health services were my study sites for **case studies**. Table 4.4 sets out the demographic profile of each of these six case study sites:

Table 4. 4 Demographic profile of six case study sites

	VDC 1	**VDC 2**	**VDC 3**	**VDC 4**	**VDC 5**	**VDC 6**
Total population	10035	14553	9,838	7,253	7,892	8,789
Adolescent (15-19 years) population	1148	1681	1190	840	962	1019
Literacy rate	64.28	64.91	69.32	63.49	66.33	62.81
Brahmin and Chettri population	2477	6424	5593	2271	1663	4290
Ethnic group population (Newar)	646	1010	272	1920	1253	666
Ethnic group population - Janajati (Tamang, Magar, Gurung, Rai, Chepang, Danuwar, Gharti, Jirel)	4159	5402	2711	962	3523	2496
Dalit (marginalised) population (Kami, Damai, Sarki)	1563	1096	497	1156	678	1086
Others	1193	621	765	944	775	251

Source: (Central Bureau of Statistics, 2014)

The six case study sites for the second phase of the research are now discussed in brief.

Village Development Committee 1

Village Development Committee (VDC) 1 occupies a fairly large section of Prithvi Highway, a national highway connecting Kathmandu with many parts of the country, thus it is a semi-urban town. It is also a business trade centre for adjoining municipalities, where people bring agriculture products to trade. The health facility for VDC 1 is centrally located in the town, which people visit for various purposes related to business and health, transportation and health, and trade and health. The health facility is a primary health care centre, thus a referral centre for adjoining health facilities. This health facility also provides comprehensive emergency obstetric care services such as C-section for a complicated pregnancy and has a resident doctor present 24/7. Due to the availability of a doctor and comprehensive services, this was the health facility of choice for many people, not only VDC 1 locals but also people from adjoining communities where such services were not available. The total population of VDC 1 is 10,035; its level of literacy[7] (64.3%) is high in comparison to other VDCs of the district (Central Bureau of Statistics, 2014). There is a diversity of castes within the area; Tamang (22.2%) is the predominant caste, followed by Brahmin (17.8%), Chepang (14%), Chhetri (13%) and others. Nepali is chiefly used as the language of communication; local dialects are also spoken among similar ethnic castes.

Village Development Committee 2

VDC 2 is also a semi-urban town along the Prithvi highway, but the settlement is sparse and scattered across the rough terrain. The 2011 census recorded the population as 14,553, with majority Chhetri (22.7%) and Brahmin (21.4%) castes, followed by Newar (6.9%), and minority Dalits (7.5%) (Central Bureau of Statistics, 2014). All basic services such as electricity, communication, roads, schools, and water supply seemed to be well established in this VDC. The health facility is located on the highway but the commute time to the health facility for communities in the VDC 2 catchment area varies from a few minutes to two hours' walking. The earthquake in April 2015 damaged the health facility, and at the time of this research, health services were delivered from the temporary structure of a prefabricated building.

Village Development Committee 3

VDC 3 is located at a distance of two to three hours' drive from district headquarters. The total population of the VDC in 2011 was 9,838 (Central Bureau of Statistics, 2014). This VDC also has

[7] Literacy rate refers to the ability to read and write.

a diversity of castes with Chhetri (40.3%), Tamang (19.6%), Brahmin (16.6%), Chepang (3.9%) and others. Scheduled public transport from district headquarters to this VDC is available mornings and evenings. The health facility is located in the central area of VDC 3 but reaching the health facility from some areas of the catchment is a challenge; due to uneven walking trails, it may take from a few minutes to over three hours. On the day of my visit, I observed a pregnant mother waiting for her scheduled ANC visit. Talking to her and accompanying women, I found that it had taken them "four hours with rest" to get to the facility. As it was afternoon, returning to their village that same day was not possible so the pregnant mother was going to "stay overnight with relatives and to home [the following] morning," an experience showing how challenging a task it may be for some to access the health facility.

Village Development Committee 4

VDC 4 is the closest of the six study sites to the district headquarters. The total population of this village was recorded at 7,253, its caste composition Newar (26.5%), then Brahmin (17.5%), Chhetri (13.8%), Tamang (3.2%), and others (Central Bureau of Statistics, 2014). The health facility in VDC 4 can be reached in 30-45 minutes by public transport from the district headquarters. It straddles both sides of the road connecting Dhading district to another on the border of China. The health facility is close to the road, but is isolated from the village, thus the commute distance for the communities in its catchment ranges from a few minutes to three hours. The facility was damaged during the 2015 earthquake and was replaced by a temporary prefabricated building. During the data collection I observed the facility for over three hours; during this time, I saw many school children and adolescents passing by the health facility along the walking trail that runs along one side. It was interesting to note that some also stopped at the facility to seek services, and sometimes to collect medicine and supplies for themselves and/or their families.

Village Development Committee 5

VDC 5 is three hours distant by bus from Dhading district headquarters. The road condition, at that time, during the dry season, was okay but according to study participants is inaccessible in the rainy season, when no public transport runs. The total population of this VDC of 7,892 comprises of majority Kumal (28.4%), Newar (15.9%), followed by Brahmin (11%), Chhetri (10%) and others (CBS, 2014). Settlement around the health facility is fairly dense, perhaps because the higher secondary school is also located near the health facility. However, some communities are more than three hours' walk from their village. Since there is no internal public

transportation within the village, the majority of people would walk to the health facility. The health facility was damaged during the 2015 earthquake and new construction was being undertaken around the health facility. Outpatient services were still operating from tents outside the buildings. The offices and inpatient services were still located within the earthquake-affected buildings however that the health facility had been warned the buildings were in a fatal condition.

Village Development Committee 6

VDC 6 is the furthest of the six VDCs from district headquarters. Its population of 8,789 has a Brahmin majority (27.7%), followed by Chhetri (21.1%), Tamang (16.4%), and others (Central Bureau of Statistics, 2014). The population settlement in this VDC was sparse and scattered. The secondary school and the health facility were located away from the main area of settlement, respectively one and a half hours' and two hours' walk. On the day I visited the health facility, over a two-hour period I only saw two patients, who had come for their regular immunisation. On speaking to the patients, I learned that they had been lucky to get a lift in a private vehicle on this occasion. Otherwise, for them to get to the health facility, it was an uphill climb on foot with children on their backs.

4.6 Study participants

With the objective of my research being to understand the utilisation of SRH services from AFHS, for the second phase of the study I selected participants who could provide rich information (Liamputtong, 2013, p. 14). To help me achieve in-depth understanding I chose those who provided services at AFHS; those who utilised AFHS; and those who could influence the kind of services provided by the AFHS and how they were provided. Thus, I recruited health service providers at the adolescent-friendly health facilities; adolescents who had used the AFHS, and also those who were eligible, but had not visited the health facilities; and community key informants, who included school teachers, health facility operation and management committee members, female community health volunteers, religious leaders, and parents of adolescents.

4.7 Sampling procedures and sample size

Purposive sampling was used to select the research participants for this study. As stated above, these included adolescents (aged 15-19 years), health care providers, and key informants, who were included in the study based on the selection criteria listed below.

The inclusion criteria for the research participants were as follows:

1. Health care provider/s (HCP)

   Inclusion criteria for health workers: 1) government employees; and 2) working in the AFHS for at least six months preceding the study
2. Adolescents

   Inclusion criteria for young people: 1) aged 15-19 years; 2) living in the catchment area of the health facility for at least last six months.
3. Key Informants (KI)

   Inclusion criteria for key informants: from the district and national level including, but not limited to: health facility operational and management committee members; school teachers; local leaders; parents of adolescents; female community health volunteers (FCHV); and non-government organisation (NGO) and government employees.

Applying the inclusion criteria, the health workers from the six case study health facilities were purposively selected for in-depth interviews. Nepal's adolescent health program trains at least two health workers, one male and one female from each AFHF and, hence, both health workers from each health facility were interviewed. However, in three of the health facilities, there was only one health worker who had been trained in AFHS, which restricted the number of health workers included in the study.

The selection of adolescents and key informants for in-depth interviews and focus group discussion was also purposeful, in that belonging to the respective VDC where the health facility was located, they would have knowledge relevant to the health facility.

To gather thick, rich description for the case study, it was important to include various adolescents and key informants. Thus, I used the principles of maximum variation sampling (Patton, 1990, p. 172) to ensure that participants of different socio-economic, age, gender, and educational status were selected for a diversity of viewpoints. Participant selection continued until I was satisfied that adequate data would be provided to respond to the research questions (Fusch & Ness, 2015). Table 4.5 presents a synopsis of the sample sizes and distribution among study methods.

Table 4. 5 Sample sizes: in-depth Interview, exit interview and FGD participants

	Type of Respondents	Male	Female	Total
In-Depth Interview	Adolescents	6	8	14
	Health Care Providers	4	5	9
	Key Informants	8	5	13
Exit Interview	Adolescent	0	2	2
Focus Group Discussion (6)	Adolescents 3 FGD with female adolescents 3 FGD with male adolescents	25	24	49

4.8 Recruitment of research participants

4.8.1 Health Care Providers:

During my visits to health facilities, I explained to the health facility in-charge that I would be selecting health facilities for in-depth interviews with health care providers after completing my first phase of research and requested him/her to distribute my research flyer *(Appendix A.3*) to colleagues in the health facility. The in-charges agreed to distribute it to the health care providers. Once the health facilities had been selected, the health facility in-charge invited the facility staff to participate in the study. HCPs from the selected facilities who were interested in being interviewed then called me, and interviews were organised at a mutually convenient time and place. The inclusion criteria were discussed with the participants, and those meeting all criteria were included in the interviews.

4.8.2 Adolescents:

Recruiting adolescents for in-depth interviews was more challenging. As the first step, I posted my research flyers (*Appendix A.3*) in the health facilities with my contact number. This was done so the adolescents would see it and contact me directly to express their interest in participating in the research. However, none of the adolescents contacted me directly. I then engaged the HCPs and asked them to distribute the information to adolescents who came in for SRH services in the health facilities. This resulted in only two adolescents getting in touch with me. Hence, I had to change my recruiting strategy. In a few instances, I went to schools, explained my research to the teachers and requested that they inform all their grade 9 and 10 students of my research. Some teachers read out my flyer to the students, and some asked me to tell the students about my research. This way, the students approached me for both in-depth interviews

and FGDs. To get more participants, I also explained about individual interviews at the end of the FGDs, and a few of the FGD participants volunteered to participate in in-depth interviews.

It was important that I capture the voices of adolescents from disadvantaged groups in accordance with maximum variation sampling. Hence, I choose to have FGDs with Chepang and Tamang adolescents. Chepang are one of the indigenous groups living in the central part of Nepal, namely, Chitwan, Makawanpur Gorkha and Dhading districts (Limbu & Adhikari, 2014). Chepangs are categorised as a *highly marginalised indigenous* community of Nepal (Piya, Maharjan, & Joshi, 2012). According to the population census in 2011 there are a total of 68,300 Chepang people in Nepal (Central Bureau of Statistics, 2012). Gurung (1990), quoting Rai and Chaudhary (1976:12), tells us that Chepangs formerly led semi-nomadic lives in forests but began to adapt to settled farming life due to the impact of deforestation beginning a century ago. Their distinct language derives from the Tibeto-Burman language group (Lamichhane, 2015). The Dhading district has several settlements of Chepang people in its various VDCs.

Tamang is the largest indigenous group of Nepal at 5.6% of the total population of Nepal (Central Bureau of Statistics, 2012). Tamang had historically migrated from Tibet and mostly settled in the hilly regions of central and eastern Nepal (Acharya, 2017). Like Chepangs, Tamangs also have their own distinct language, Tamang, of Tibeto-Burman origin (Kukuczka, 2011). Although quite a few Tamang hold senior positions in politics, the bureaucracy and in other fields, their community is one of the most deprived in Nepal, reflected in their low literacy and human development index (Acharya, 2017). The Dhading district has one of the largest shares (22.09%) of the Tamang population (Central Bureau of Statistics, 2012).

I approached a Chepang leader and a Tamang female community health volunteer in their village, explained my research and enlisted their help in recruiting adolescents for the study. Once they passed on the research information onto the adolescents in their communities, I was approached by adolescents wanting to participate, and I was also invited to their village. I was able to conduct two FGDS with both male and female adolescents from the Chepang community, one FGD with Tamang female adolescents, and also one in-depth interview with a female adolescent of the Chepang community.

To recruit adolescents for client exit interviews, I gave health care providers copies of the information flyer, which included my contact number for interested adolescents, to distribute to adolescents who came to seek SRH services. However, since only two adolescents contacted me for an exit interview during the data collection process (which were duly conducted), I had

to drop this as a data collection strategy and rely on the in-depth interviews for insights into health care providers' practices in delivering SRH services to adolescents.

4.8.3 Key Informants:

I applied different approaches to recruiting the key informants for my study. First, I requested the HCPs to distribute my research flyer (written in the local language) to potential participants such as health facility operation and management committee (HFOMC) members, female community health volunteers (FCHV), parents, school teachers, and leaders of the community. I also used the snowball technique (Atkinson & Flint, 2004), asking my interviewees to inform other potential participants of my research and to get in touch with me if they were interested. Key informants were also recruited through NGO personnel, who distributed flyers to potential participants.

HFOMC members, both male and female, health and non-health teachers of both private and government schools, FCHVs, and the local priest were all included in the key informant interviews. In addition to these, I was able to meet one FCHV who was the president of District FCHV committee of Dhading district. The FCHV was informed of my research by one of the health care providers I had interviewed. The FCHV called me to indicate her interest in participating in the research and I subsequently interviewed her as she was actively involved at the district level in adolescent health discussions.

The key informants at the national and district level were sent a formal email invitation to participate in the research; when they accepted, I set up interviews at their preferred location.

4.9 Research tools

For the first phase, two kinds of research tools were developed. First, in order to assess the level of utilisation of SRH services, an audit tool was developed to map the services adolescents used in fiscal years 2014/2015 and 2015/2016**.** This tool included service information such as total number of adolescents visiting the health facility, by gender and per month, for contraception, ante-natal care, hospital birth, postnatal care, abortion services, and sexually transmitted infections and HIV (*Appendix A.4*). Second, to assess the compliance of adolescent-friendly health facilities against Nepal's national standards, a health facility observation checklist adapted from the National Standards for Adolescent-Friendly Health Facilities in Nepal (MoHN Nepal, 2011b) was used (*Appendix A.2*). Observation of AFHS against the national standards has been previously undertaken in Nepal, and was successful in recording health facility compliance (Kennedy et al., 2015). The health facility observation checklist documents environmental and

facility characteristics, availability of basic equipment, amenities and essential drugs, and the facility's promotion of the ASRH program. Both of these tools were pre-tested in similar settings, but in different districts, to ascertain whether they were sufficiently clear and comprehensive to collect health service utilisation and observation data from the health facilities. As a result, no changes to either the audit or checklist were required.

Guidelines for the semi-structured in-depth interviews and FGDs were developed to collect data from each group of participants ***(****Appendix A.5*).

The interview guide for adolescents who had previously used AFHS, and those who were yet to attend these services, covered three main areas:

a) challenges in accessing health services from adolescent-friendly health services;
b) experiences of using sexual and reproductive health services from AFHS; and
c) enabling and inhibiting factors for adolescents accessing and utilising AFHS arising from their previous visits to health facilities.

For client exit interviews (section 4.10.2) the interview guide covered two main areas:

a) recent experiences of using SRH services; and
b) satisfaction with services received on that particular day.

The guideline for FGD with adolescents explored two main areas:

a) expectations of the service and health service providers; and
b) what adolescent-friendly health service means for adolescents.

The interview guide for health service providers covered two main areas:

a) perceptions and attitudes towards providing SRH services to adolescents; and

b) experiences in delivering health services to adolescents.

Similarly, the guidelines for key informant interviews covered two main areas:

a) perceptions and attitudes towards adolescent-friendly health services; and

b) socio-cultural beliefs and understandings about AFHS.

As suggested by (Ritchie & Lewis, 2003), the interview guide was pre-tested before the fieldwork began with similar participants from another district testing its logistical aspects,

comprehensibility of the questions, and the potential for in-depth exploration of the issues. On this basis, the guide was revised. For example, pre-testing showed that when asked the first question, *I understand you have used sexual and reproductive health services from the health facility; how did you feel about the service?*, the participant remained silent. The guide was then revised so that participants were eased into the interview by first asking when they last visited the health facility, followed by what that visit was like.

4.10 Data collection

The first and second phases of the data collection for the research were conducted between September 2016 and March 2017, and the third phase, a workshop to collect policy recommendations based on the research findings, in August 2018.

4.10.1 First phase of the research

4.10.1.1 Health facility service utilisation data collection:

The main aim of collecting health facility service utilisation data was to assess the level of utilisation of AFHS by young people. I visited all 26 health facilities to provide health facility coordinators with a support letter from the District Public Health Office. The written consent of the coordinators was also obtained before the records were assessed.

Adolescent-friendly health service delivery information was recorded and reported as an add-on format to the Health Management Information System. (Although AFHS was an integrated program, its integration into HMIS was not done.) This add-on format is only for health facilities that are adolescent-friendly, thus the Dhading 26 AFHS use this format along with HMIS. It was observed during the observation data collection period that in all 26 health facilities, the add-on AFHS forms and data entry formats were incomplete and/or poorly recorded. Meanwhile, the AFHS health facilities were maintaining their data by recording their service delivery to adolescents in the areas of family planning, ante-natal care, obstetric services and counselling under HMIS registers specific to these services. I further reviewed these registers in individual AFHS facilities, which I again found to be incomplete and/or poorly recorded. Poor recording of HMIS data has also been documented by Baral et al. (2018) in health facilities of Nepal. Thus, in consultation with my local supervisor, I decided to utilise the reporting information submitted by AFHS to the district health office as part of their regular reporting. I contacted the statistics officer of Dhading District Public Health Office and requested the monthly summary sheets of all 26 health facilities for the 24-months period July 2014 – June 2016. After several follow-ups, I received the monthly data for the health facilities from the statistics officer. To assure myself

of the reliability of that data, I then contacted the HMIS Director in the Management Division of the Department of Health Services with a request for the overall HMIS data for Dhading District. When the director had provided me with the data, I then compared the monthly data for the health facility with the aggregated yearly data to ensure its reliability. All identifying information for individual health facilities was removed from the data before entering them into the computer.

4.10.1.2 Health facility observation:

Health facility observations were carried out during September and October 2016. While visiting the study sites to collect adolescent service utilisation data I also conducted observations of each facility, using the observation checklist adapted from the National standards of AFHS (*Appendix A.2*). I first explained the checklist to the health service providers. Initially, I had booked an appointment with the health facility coordinator prior to my visits so that they would be available on the day, and allow me to review their records. Many of the health care providers knew me from my previous work and had also seen me at their monthly meeting in the district health office, as noted in section 4.5. During the presentation, I informed all the health facility in-charge that I wanted to observe the health facility as is, without any cosmetic or other changes for my visit. I also made it clear that the visit was for the purposes of research, and not to evaluate and judge their facility. Nevertheless, it is likely that my background and prior experience in Nepal (*see chapter 1*) may have influenced how they set up the facility for my visit. For example, in one facility, I felt that the HCP had placed adolescent-friendly signs for my benefit. The signs looked like they had just been placed. Therefore, I visited this facility twice more, unannounced. Learning from this, for the balance of my visits I did not provide an exact date, but rather indicated a tentative time during a particular week.

At a few of the sites, a new prefabricated building housed the facility because of earthquake damage in April 2015. In those cases, health workers took me to their pre-earthquake building and show me how they had run adolescent-friendly corners there. However, I scored the health facility based only on the present situation. In a few places, I continued with informal observations of the health facilities and on other occasions, when I attended for in-depth interviews with HCPs. To validate the data collected I recruited an independent observer to make observations and score the health facilities according to the observation checklist. This observer scored seven (27%) of the health facilities, and the observation scores were compared. This comparison showed no significant differences in scores, thus verifying the collected data.

4.10.2 Second phase of the research (qualitative interviews)

4.10.2.1 In-depth interviews

As noted in Chapter 2, some documented evidence for levels of utilisation of AFHS in Nepal exists. However, as also noted in that chapter, there are gaps. For this PhD research, I felt that the in-depth interview method would give me the opportunity to explore my research concerns more deeply, ask for clarification and probe further to elicit rich data (Liamputtong, 2013). The interviewer–interviewee relationship should be reciprocal and permit the emergence of ideas and issues unique to each participant, so that the researcher gains interesting leads, can clarify details, and accurately describe participants' perspectives, meanings and interpretations (Charmaz, 2006). For example, in my research I was careful to examine what the participants said and clarify what they meant. I would respond by paraphrasing and summarising their responses and ask if had reflected their meanings accurately.

Sometimes, because of my role in SRH services in Nepal, participants would leave things unsaid, assuming that I would know what they meant. For example, during my first interview the participant would give a short answer and connect it to my background by saying things such as, "you already know about this, Didi [sister]... (*giggle*)". The participant was right in that I knew what she was saying, and I did not probe further. My supervisor, Husna Razee, on reading the transcript picked this up and observed that in these instances I did indeed need to encourage interviewees to elaborate their viewpoint to minimise researcher influence on the data collection process. Thus, in subsequent interviews when a similar response was given, I would politely thank them for acknowledging my experience and knowledge but then say, "I would like hear from you what your thoughts and experience are on the topic."

The in-depth interviews with adolescents were conducted in their preferred locations such as a vacant classroom of their school, open and secure places in the fields and, some, in their residences. With health service providers interviews were conducted in their workplaces except in two cases; one HCP invited me to her house, and the other invited me to his private pharmacy. The key informants were interviewed in their residences, apart from teachers, whom I met in their offices. All the interviews were face–to-face and lasted from 35 minutes to 1.25 hours.

At the beginning of each interview I followed the ethics protocol described in section 4.13. Participants were also given the opportunity to ask any questions about the study before I began the interview. Partly for reciprocity purposes, and partly to establish rapport and gain trust, I shared information about myself – my name, where I was from, where I am studying, and my

study's purpose. As mentioned earlier in section 4.10.1, some HCP already knew me as a person working as an ASRH expert in Nepal. To them, I made it clear that I was no longer in that position and was undertaking a PhD study over the next four years, explaining my research and its purpose.

Before each interview, with the participant's approval, I audio-recorded their consent, and then the entire interview for accurate transcribing. I also made handwritten notes during each interview, to keep track of key points raised and help me to follow up in more detail later in the interview and also to highlight the main points for summarising participants' responses.

The semi-structured interview method using an interview guide (*Appendix A.5*) helped me keep track of the major themes I wanted to explore. I used vignettes (detailed in the next section) as a way to initiate conversations with participants to make them more comfortable discussing topics considered taboo in the Nepalese cultural context. Probing and follow-up questions were used whenever elaboration or clarification of the response was needed (Denzin & Lincoln, 2000). Throughout the interviews, I would start the conversation with broad questions which, as the interview proceeded, became more focused.

The in-depth interviews with adolescents, health workers and key informants were conducted during November 2016 – March 2017.

4.10.2.2 Client exit interviews

In this research exit interviews were conducted with adolescents who had received SRH services from health care providers in adolescent-friendly health facilities. An exit interview guideline (*Appendix A.5.2*) was used to keep track of information I wanted to collect. A participant information and consent sheet were read out to the participants explaining the purpose of the exit interview. Both verbal and written consent was obtained. The client exit interviews were held in a vacant room of the health facility where visual and auditory privacy could be maintained.

In my initial study design of the study, I had not planned client exit interviews. I had thought to observe health care providers in their interactions with adolescents to see how they actually practised elements of adolescent-friendly service. However, Nepal Health Research Council did not approve this method, pointing out that having someone observing and listening during consultations would be too sensitive for adolescents. Instead, they suggested I interview adolescents immediately after their consultation to capture their experience of HCP practices. I

adopted this suggestion but, as mentioned earlier, I was only able to conduct two client exit interviews over the following three months as the contact rate was very low.

4.10.2.3 Focus group discussions

For this research, six FGDs were conducted with adolescents to explore their perspectives on AFHS. This helped me to understand what AFHS really meant from the recipients' perspective. Because individual views and experiences will differ, this method offered diversity of perceptions (Mack et al., 2005). The groups were organised for homogeneity across demographic indicators, so members felt comfortable to share their ideas, and to encourage free and open expression about sexual health matters. Hence, I held separate groups for male and females, for 15-16-year-olds and 17-19-year-olds, reflecting different developmental stages, and for adolescents from disadvantaged groups.

FGDs were conducted in vacant school rooms or in fields in the village according to participants' preferences. School authorities' permission was obtained in a case when a school classroom was used for the FGD. At the start of each FGDs, I followed the ethics protocol described in section 4.13 of this chapter. During the FGDs, I had a note-taker who helped during the FGDs, but I also made some handwritten notes during the discussion, which enabled me to keep track of key points of the FGD.

In addition to using a set of guiding questions (*Appendix A.5.5*), some creative methods were also used for eliciting responses, such as vignettes and storyboard. Vignettes have been successfully used to prompt sharing on sensitive topics when participants are not comfortable talking directly about their own experiences but can discuss the situation of the vignette character with reference to their own feelings (Barter & Renold, 2000; Hughes & Huby, 2002). I found that participants would eagerly talk about the character of a story. In the group, participants were told a vignette (that I had written using local Nepali names to make it relevant to the discussion) about a 15-year-old girl and a 19-year-old boy who were in love and wanted to have sex with each other. Participants were asked to think about what information and support this couple might need, where they could seek support, and what barriers and challenges they might face. Based on this vignette, the group was also asked to share similar stories that they had heard of, or from their own experience.

The storyboard technique (Cross & Warwick-Booth, 2016) was also used in the focus group research. This involved participant drawing and using pictures to illustrate what an adolescent-friendly health service might mean for them. A white sheet, board markers, sticky notes and

colourful paper were provided for participants to use in their storyboards to illustrate their ideas of adolescent-friendly health service. The focus groups were all conducted in Nepali and were between 2-2.5 hours long. Following are few of the figures (4.3 and 4.4) of the FGD process

Focus group discussion process

Figure 4. 3 Focus group discussion with female adolescents, printed with participants' consent

Figure 4. 4 Participants presenting a storyboard exercise during FGD, printed with participants' consent

4.10.3 Third phase of the research (reporting to stakeholders and collection of policy recommendations)

The third phase of the research was conducted on 3 August 2018 in Nepal. The main objectives of the workshop were to:

a. share with the research participants and policymakers the preliminary findings (draft) of the study; and
b. obtain stakeholders input into the recommendations for policy on ASRH program.

The workshop participants were stakeholders working in the field of ASRH in Nepal, including from international NGOs, NGOs and the UN, parents of adolescents, adolescents, governments and freelance consultants. During the planning phase of the workshop my supervisors and I agreed that an adequate maximum number of workshop participants representing national stakeholders and policy makers to discuss the research findings and propose recommendations would be 15-20. I coordinated with an organisation called Skill Information Society Nepal (SISO-Nepal) to help me organise the workshop given the importance of inviting people from accredited organisations in Nepal. While preparations for the workshop were going on, I was also liaising with relevant government offices about potential participants. To my surprise, the National Health Education, Information and Communication Committee (NHEICC), in the Ministry of Health, offered to invite participants on my behalf to the workshop. They formally invited participants by letter, emphasising the purpose of the workshop, and my role as the researcher, since my name would be recognised by the invitees from my prior work in Nepal, resulting in 38 people participating in the workshop.

Invitees were sent the workshop invitation (*Appendix A.6.1*) and a detailed workshop guideline (*Appendix A.6.2*) prepared. The main workshop proceedings covered the following:

a) overview of ASRH program in Nepal;

b) overview of research and findings from phase 1 and 2; and

c) discussion of case studies drawn from the research findings.

Given that my research and involvement with the workshop had already influenced the response to the invitation, I was aware that my presence at the workshop could influence the deliberations. Therefore, I deliberately took a backseat position in the workshop proceedings. After my initial presentation of my research findings I simply observed what was happening, and responded to any questions from participants. National adolescent health experts working in ASRH program in Nepal took up moderating roles in four discussion groups which were asked to

analyse the case studies in the light of existing ASRH policy and program. For each identified issue, participants were asked to recommend a possible solution that was appropriate, effective, efficient, sustainable and feasible at policy, strategy, program and execution levels. One person in each group was assigned to take notes of their discussion. The groups were then asked to present their recommendations to all workshop participants in a plenary session. I had appointed two note takers to help me to keep track of the proceedings of the plenary session. The final group presentations and discussion of the workshop were recorded for accuracy of report writing. The workshop, lasting 4.5 hours, was conducted in both Nepali and English. Following are few figures (4.5 and 4.6) from the workshop.

Workshop processes

Figure 4. 5 Presentation of research findings at the workshop, printed with participants' consent

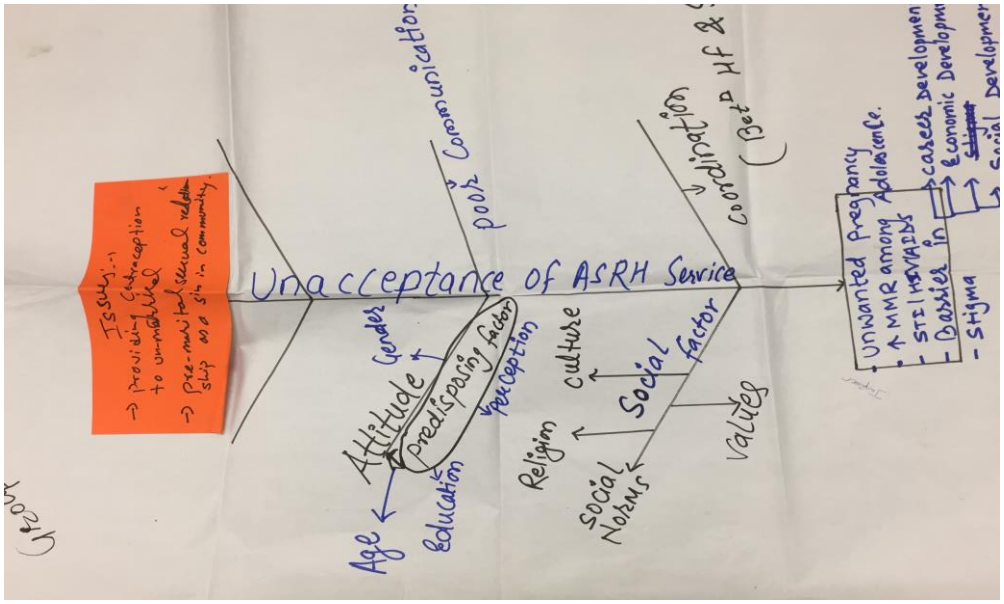


Figure 4. 6 Fishbone analysis from the workshop of issues around SRH service utilisation by adolescents

4.11 Data management and analysis

4.11.1 First phase of the research (health service utilisation data and health facility observation)

The health service utilisation data obtained from the HMIS were entered on Excel, and descriptive analysis performed. The service utilisation proportion of adolescents visiting health facilities drew on estimated adolescent populations for each health facility. The analysis focused on determining whether there was any change in the pattern of SRH service utilisation by adolescents following the introduction of the adolescent-friendly program in the health facility.

The health facility observation data were also entered into a spreadsheet, and simple descriptive analysis was made. Health facility observations utilised 20 variables *(Appendix A. 2*) carrying one point each. As per secured points against variables, the health facilities were categorised into three categories: ≥70% (≥ 14 points) compliance = Good or performing well; 40-69% (>8-<14 points) = Medium or needs some improvement and ≤39% (<8 points) = Poor or needs considerable improvement. Similarly, adolescents' general visits (all reasons) and health service utilisation data were cumulated, and an average percentage calculated for the two fiscal years (2014/2015 and 2015/2016). Based on the service utilisation data, the health facilities were again categorised by: ≥70% compliance = Good or performing well; 40-69% = Medium or needs some improvement and ≤39% = Poor or needs considerable improvement. The outcome - average percentage of both observation and service utilisation was considered to further designate the health facility as good, medium or poor. Two health facilities from each of these three categories were then selected for the second phase of the study.

4.11.2 Second phase of the research (qualitative phase)

The dataset comprised of interview transcripts and summary sheets, FGD transcripts and field notes. Data analysis began with the very first interview. I transcribed my first interview and compiled on a summary sheet my experience of the interview, my observations of the participants' facial expressions, gestures, the surroundings and any key ideas and concepts the interview generated pertaining to the research question(s). Areas that suggested further exploration in subsequent interviews were also identified. Being a novice at this kind of qualitative in-depth interviewing, I noted areas for improvement such as where I had not clarified or probed adequately, where I asked closed questions when open-ended questions would have been better, and so on. I then shared the transcript and my summary sheet with my supervisor, Dr Husna Razee. Together we reflected on the interview process, identified where

my Nepalese and professional background was perhaps influencing the interview process, either negatively or positively, and noted actions to be taken for improving the interviews. For example, in my first interview I had asked many close-ended questions which did not prompt participants to provide more in-depth answers and may have led to the participant giving me the kind of responses they thought I wanted to hear. In another instance, I had asked two question at once. These problems with my interviewing skills were noted by my supervisor when we discussed the interview together with the transcript at our regular meeting. Having my supervisor review the initial transcripts helped me to develop into a more skilful interviewer. We continued this process for the first four interviews, after which time my supervisor was satisfied with my ability to conduct qualitative interviews. However, for all interviews I continued making summary sheets and reflections and made notes for further exploration in the next interview.

When we were analysing and writing up the data, my supervisors questioned the time I had spent on SRH in the schools in my data collection process, pointing out that this data was not related to utilisation of SRH services from AFHS. I then realised that my own involvement in the ongoing discussions about school-based SRH education had resulted in too much focus during the interview on this area.

The process of making summaries for each interview is the first step in data analysis and aligns with qualitative research principles; summary making is also advocated in grounded theory approaches. I followed this principle of grounded theory, initiating data analysis at the outset of collection and continuing it throughout, all the while identifying further areas to explore in subsequent data collection, to enable comprehensive answering of the research questions (Charmaz, 2008). Therefore, data analysis was conducted throughout the data collection processes, and following the main analysis undertaken after its completion.

I applied thematic analysis to in-depth interview and FGD data from the second phase of my research. Braun and Clarke (2006, p. 79) define thematic analysis as a method for organising and describing the data by identifying, analysing and reporting the patterns (themes) within data. I followed the seven steps outlined by Braun and Clarke (2013) to conduct a thematic analysis of the data for this phase of the research. The steps included transcription of interviews and FGDs; reading and familiarising myself with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes and writing-finalising analysis (Braun & Clarke, 2013).

Step 1: Transcription of interviews and FGDs

All the interviews and focus group discussions were conducted in Nepali except for one interview with a key informant which was conducted in English. All the interviews and FGDs were transcribed verbatim using a written question-and-answer format, beginning immediately after my first interview. Transcriptions took an average of 3.5 hours with the longest taking five hours and the shortest 1.25 hours. I reviewed each transcript while listening to the audiotapes to verify accuracy. For the first three transcripts, I translated the Nepali transcripts into English and gave my English transcripts to a friend who spoke both Nepali and English fluently. My friend back-translated the English transcript into Nepali. Then I compared this Nepali translation with my original Nepali transcript to check for any differences in or problems with the translation. This process was followed for three transcripts. Once it was clear that my translations were satisfactory, I then directly transcribed, in English, the remaining interviews and FGDs recordings, which saved considerable time.

Step 2: Reading and familiarising with the data

Following transcription of interviews and FGDs, I familiarised myself with the data through repeated readings to understand and make sense of the data: it was during this phase that I began the summary sheets as I described earlier. I looked for meanings and patterns in the data for possible codes. I tried to understand the patterns in the transcripts, marking the hard copies for potential coding. I also started taking notes of my initial ideas about the data. I re-read my transcripts and discussed my initial thoughts with my supervisors.

Step 3: Generating initial codes

Using an inductive approach to the data analysis (Patton, 1990), I started to develop codes that linked to the data themselves. Braun and Clarke (2006, p. 83) state that in the inductive approach,

> …if the data have been collected specifically for the research (e.g., via interview or focus group), the themes identified may bear little relation to the specific questions that were asked of the participants and they would also not be driven by the researcher's theoretical interest in the area or topic.

This process would then facilitate data coding without using an existing theoretical or coding framework, or referring to my own presumptions about what the analysis would show. I began with the hard copies of the transcripts of my first five interviews, chosen on the following bases: 1) the interview and FGD I considered the most typical of all, 2) the transcript that seemed to be the most different from all others, 3) that which represented diversity (e.g. male and females,

socio-economic status, and so on). I used "open coding" (Bryant & Charmaz, 2007), and wrote initial codes by hand in the right margin of each transcript. As I read each of the transcripts, I underlined parts that were *interesting* in relation to the research questions. Then I questioned these data chunks by asking *what is interesting about this? Why is this interesting?* This is a process suggested by Lynn Kemp, as noted in Bazeley and Jackson (2013, p. 72). Reflecting on the answers to these questions, I labelled (coded) the underlined data chunks. I then made a list of, and defined these codes. A few transcripts were also coded in a similar process by my supervisor, after which we compared and discussed our codes, to arrive at a consensus. This coding book was then used for further coding, keeping in mind that newer codes would be generated. Once the initial five transcripts were manually coded, I uploaded all transcripts onto NVivo 11 software and coded all transcripts. Throughout this process I revised the initial coding book, mindful that my coding process stayed close to the data.

Step 4: Searching for themes

After the initial codes were generated, I then started to re-read all the codes and categories I had developed. I started to remove the duplications in the coding and then looked through the codes to recognise any patterns and used this to generate themes. I made a mind-map/thematic map (figure 4.7) with these various themes and started to look at linkages and relationships. I had several consultations with my supervisors at this stage to discuss and clarify my themes and possible sub-themes within the data that were relevant to answering my research questions. Following this joint review, I created new themes and re-assigned some codes to the relevant themes. Throughout this process, I compared my interview excerpts from all participant groups – adolescents, health service providers, and key informants – looking for commonalities and differences within and across the data.

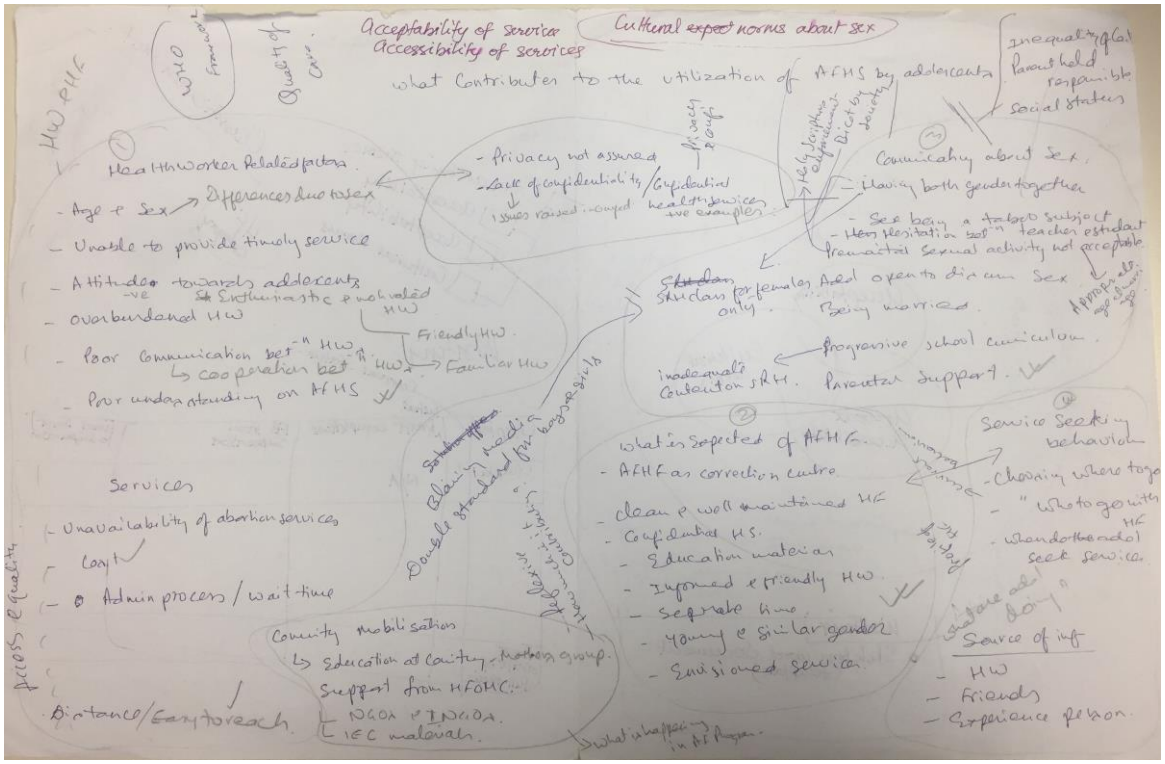


Figure 4. 7 Data analysis mind map

Step 5: Reviewing themes

In this step, I reviewed and refined my themes by looking over and over at the data extracts against the themes to ensure that the data formed a coherent pattern. I also rearranged some of the themes and collapsed a few together. My thematic map was revised until I was satisfied that the themes were now relevant to address my research questions.

In reviewing the themes, I became aware that, again, my professional interest in SRH education in schools had also influenced the analytic process. I had generated a key theme called *School Education*. Most of the content reflected in this theme was not, however, relevant to my research questions. Thus, findings for School Education were subsequently dropped from my themes except as they applied to expressly relevant areas, such as communication about sex.

Step 6: Defining and naming themes

After the final themes were generated, I analysed each, and defined them, using labels that would be relevant to my findings presentation, as well as making sense to the reader.

Step 7: Writing – finalising the analysis

Once I completed the analysis using NVivo 11, I then started writing up my findings. I discussed my initial draft with my supervisors and, on their advice, begin to link the writing to relevant

themes, first making a map of how various topics related to others. For example, under the findings for *Barriers to accessing SRH services*, I had separate headings for topics like accessibility and health facility factors. Accessibility seemed, however, more directly related to health facility factors; hence, I combined elements of accessibility with health facility factors. The process itself helped me to clarify my thinking, refine themes, and streamline my writing.

4.12 Rigour of the research

Liamputtong (2013) explains rigour as ensuring the quality of qualitative research. There are several ways that the rigour of qualitative research can be recognised. Lincoln and Guba (1985) considered trustworthiness to be the hallmark of rigour in qualitative research. Since then, rigour has become accepted as trustworthiness by many qualitative researchers (Cypress, 2017; Padgett, 2017). Lincoln and Guba (1985) proposed four criteria for this quality, namely, credibility, transferability, dependability and confirmability.

The credibility of my research was ensured by my prolonged engagement in the field, triangulation of data, and member checking. I collected my data over a six-month period. During this time, I lived in the local communities, which helped to build trust between my participants and me. Mays and Pope (2000) suggest that data triangulation could be achieved by interviewing a range of interest groups to develop an overall interpretation of the data. In my research, the different groups of participants – adolescents from different backgrounds, key informants and health workers – broadened my understanding of the issues surrounding young people's seeking SRH care. Similarly, methodological triangulation was achieved by in-depth interviews and focus group discussions with adolescents. I applied member checking to clarify participants' responses by asking for their validation of my summaries of what they told me.

By listening carefully to the interview audios and verifying the data during transcribing and translating processes, I ensured my study's dependability. In particular, translating interview from Nepali into English (as described in section 4.11.2) deepened the dependability of the data generated. I kept an audit trail (Lincoln & Guba, 1985) of all the steps and decisions I made during the research process, maintaining this journal throughout. Communications with my supervisors

during data collection and analysis were recorded there, and all decisions and changes I made during data coding and analysis were noted in memos of NVivo.

To ensure confirmability, my supervisors, who are well-experienced in qualitative research methods, reviewed the coding of my interview and FGD transcripts (section 4.11.2). I also asked some of my colleagues to review three transcripts for feedback on my coding.

In addition to these methods to ensure rigour, I enlisted the help of a male interviewer for data collection for the occasions when male participants were not comfortable talking to me about SRH, twice during FGDs with male adolescents, and also for an in-depth interview with a religious leader who was a key informant. While this could have affected the quality of data produced, the detailed question guide was used, and I sat away from the group/interview and would ask probing questions only if responses were unclear to minimise interviewer influence. The audio recordings also allowed me to check the quality of the data collected.

4.13 Ethical considerations

There are two main ethical considerations in qualitative research (Guest, Namey, & Mitchell, 2013): the first, obtaining mandatory ethics approval from the institution and research country, is a procedural issue. For this study, ethical approvals from the University of New South Wales (UNSW) Human Research Ethics Committee (HREC) and Nepal Health Research Council (NHRC), Government of Nepal were sought (***see table 4.6***). All correspondence pertaining to ethical approval is contained in *Appendix A.7****.***

Table 4. 6 Ethical approvals received for the study

Ethics Committee	Description	Date approved	Approval no
Human Research Ethics Committee (HREC), UNSW	Exploring factors impacting on the utilisation of adolescent health services in Nepal – all phases of data collection	04/07/2016	HC16427
Nepal Health Research Council (NHRC)	Exploring factors impacting on the utilisation of adolescent health services in Nepal – all phases of data collection	05/09/2016	199/2016
Human Research Ethics Committee (HREC), UNSW	Modification request for the project no. HC 16427	29/11/2016	HC16427

The second aspect of ethical consideration pertains to principles of preventing harm to research participants caused by the research and/or research process (Liamputtong, 2013), thus the importance of obtaining the informed consent, assuring the confidentiality and anonymity of all research participants, and protecting them from risk and harm.

4.13.1 Obtaining informed consent

Informed consent is an ongoing and negotiated process during qualitative research that involves face-to-face engagement (Padgett, 2012). Written and verbal consent was obtained from all research participants before conducting and recording interviews. I used a participant information and consent form (*Appendix A.9*) which was translated into the Nepali language for each group of participants to read and seek clarification from me of any aspect they did not understand. I also explained to participants the key components of the information and consent form, including the study's purpose and process, expected benefits, data storage, their rights to withdraw from the study at any time, and the confidentiality of the data they were providing as well as the meaning of providing consent. Written consent often poses difficulties in Nepal. For those who were not comfortable in providing written consent, verbal consent was accepted. I explained this to both the UNSW Ethics Committee and NHRC Ethics Committee and obtained approval to leave the decision of written or verbal consent to the participants. All of the health workers and most of the key informants gave written consent, and most of the adolescents chose to give verbal consent; all were individually obtained. Only verbal consent was obtained from the adolescents in FGDs, which was recorded. Consent was also obtained and recorded for photographs to be taken of the FGDs and to use them in my thesis and in journal articles. Pictures were also taken during the workshop (the third phase of the research, section 4.11.3). Again, the verbal consent of workshop participants to photographs being taken for future publication was obtained and recorded.

4.13.2 Maintaining confidentiality and anonymity

To ensure confidentiality, I did not record the true identity of any of the research participants and used pseudonyms in the interview transcripts and in my field notes. Throughout my fieldwork and during my thesis writing I ensured that the field notes, audio recordings of participants' interviews, and transcripts were stored in a password-protected computer. I also kept all the printed forms of data including consent forms, participants' group worksheets and drawings in a locked cabinet. All materials that will be available to the general public in future, such as my thesis and publications based on it will be clear of information that might lead to the identification of my participants. The printed and electronic versions of my research data will be

stored at UNSW for seven years, after which it will be permanently destroyed, as per University policy.

4.13.3 Protecting the participants from risk and harm

Another aspect of the ethics of research is that researchers must ensure the physical, emotional and social well-being of their study participants (Liamputtong, 2013). In my research, I considered that some of the adolescents might find it upsetting to talk about their experiences of sexual and reproductive health care which may have been negative. Hence, I acknowledged the risk of psychological effects during the interviews with adolescents. Since I have a background in nursing education, I felt able to provide any immediate medical or psychological support participants may have needed. I also followed the procedures listed below to minimise the risk of any unwanted outcomes.

1. I explained issues and concerns regarding confidentiality to all participants and their right to stop the conversation at any point, if they did not want to continue.
2. If any point during the interview or FGD a participant showed signs of distress or being upset, I stopped the interview/FGD and gave immediate support to the participant/s to deal with their feelings.
3. If further support was needed for the participants, I discussed with them consulting the Medical Officer in Dhading District Hospital. With the participant's consent, they would be referred to the Medical Officer and if they permitted, I would accompany them.
4. Followed up any participants who became distressed during the interview within two days, and again a week after the interview.
5. Provided all participants with information about counselling services available at Dhading District Hospital if they wanted to seek support.

During the interview, two female adolescents were upset and cried during the interview. One of the participants had forgotten to go for her follow up post-natal consultation at the health facility and was scolded by the HCP who said that, "one day you will forget your baby too." As she spoke of this experience with the HCP, she became emotional and started crying. I counseled her on that day, and the interview was stopped until she said she was okay to continue. As she did not want any further help from the hospital, I did not do any referral for more professional services. Another participant was upset and cried when she talked about how her father didn't care about her and wanted her to get married as early as possible because she was a girl. I provided support, and with her consent, I referred her to the medical officer in Dhading district

for further counselling. Both these participants were followed up within two days, and a week later to ensure they were okay.

I was also conscious of the need to protect my participants from any harm or distress that might have resulted from community opprobrium because they were talking about the taboo (in Nepalese society) topic of SRH (Pradhan & Strachan, 2003). To that end, all the interviews were conducted in participants' preferred places, where they could be sure of privacy and comfort.

4.14 Summary and conclusion

In this chapter, I have discussed the research approach I employed to understand adolescents' utilisation of SRH services. Methodological processes such as study site selection; recruitment and description of research participants; data collection, management and analysis; and issues related to ethics and research rigour have been presented in detail. The next three chapters present the findings from my research.

CHAPTER 5: HEALTH FACILITY AUDIT RESULTS

In this chapter, I present the results of a health facility audit of 26 adolescent-friendly health services in Dhading district. The chapter addresses the following two research questions:

- What is the current utilisation of sexual and reproductive health services by adolescents in adolescent-friendly health services?
- To what extent do AFHS in Nepal comply with national standards?

As discussed in chapter 4, health service utilisation data were collected from the health management information system (HMIS) for the fiscal years 2014/15 and 2015/16, and the health facilities were assessed using an observation checklist adapted from Nepal National Standards for Adolescent-Friendly Health Services *(Appendix A.1)*.

The findings in this chapter are presented in two sections. The first section presents the results of the health facility observations against the checklist and health service utilisation data. The second section presents a case study analysis of three adolescent-friendly health services. This case study analysis is informed by data that was collected during observations, interviews with health care providers (HCP) at the facilities, and from the review of health facility service utilisation data. Information relating to the context and implementation process for the adolescent sexual and reproductive health (ASRH) program in Dhading district was collected at both the district and national levels in consultation with the adolescent health program focal persons at each level. Policies and guidelines for ASRH and published and unpublished reports from the district were also reviewed.

5.1 Findings of health service observations and service utilisation

5.1.1 Features of adolescent-friendly health services

Dhading district has a total of 52 health facilities, of which 26 provide AFHS. Of these, only two are Primary Health Care Centres (PHCC), and 24 are Health Posts (HP). The standard human resources structure of the HP is five paramedics whereas the PHCC has one medical doctor, one staff nurse, and ten paramedics available for 24/7 care. The paramedics include health assistants, auxiliary health workers and auxiliary nurse midwives. On the days that I visited, only two health facilities had their full staff present. The absent staff numbers ranged from one to five per facility, due to various reasons like deputation to training, transfer or vacant positions. ***(Table 5.1***).

The National Adolescent Sexual Reproductive Health Program Implementation Guideline 2011 suggested that AFHS be introduced and implemented in health facilities in proximity to the nearest secondary school (MoHN, 2011b). In this study, one of the variables assessed AFHS proximity to the secondary school. The findings show that 17 health facilities were within 10 minutes' walking distance from the school, eight were 20 minutes' walk away, and one was over 20 minutes' away by foot. Also, more than half of the health facilities (14) were hard to reach because of difficult road conditions, and poor transport availability.

In April 2015, Nepal experienced a 7.8-Richter-scale earthquake that affected 31 districts. Dhading was severely affected, with four of the 26 AFHFs completely destroyed, and 14 partially damaged. The remainder were undamaged.

Table 5. 1 Background information for AFHS (n=26)

Variable	**Number**
Type of health facilities	
PHCC	**2**
HP	**24**
Human resources available on the day of the visit to health facilities	
Filled in health facilities	**2**
Not filled in health facilities	**24**
Location of health facilities (by distance time)	
Within 10 minutes from school	**17**
Within 20 minutes from school	**8**
More than 20 minutes from school	**1**
Accessibility (from the community)	
Easy to reach	**6**
Moderately hard to reach	**6**
Hard to reach	**14**
Status of health facilities building after April 2015 earthquake	
No damage	**8**
Partially damage but functional	**14**
Completely damaged and operating from temporary structures	**4**

5.1.2 Status of health facilities against AFHS national standards

5.1.2.1 Compliance of the HF with national standards

Compliance of each health facility was measured based on the quality standards defined by the Ministry of Health (MOH), Nepal for AFHS. As detailed in chapter 4, section 4.5, the health facilities were then categorised as good, medium or poor. Only three were classified in the top tier (Table 5.2).

Table 5. 2 Compliance of health facilities (n=26) based on AFHS national standards

Categories	**Number *(n = 26)***
Health facilities with >= 14 scores *(Good)*	3
Health facilities with > 8 - < 14 scores *(Medium)*	12
Health facilities with < 8 scores (Poor)	11

5.1.2.2 Availability of basic amenities and equipment

Among the health facilities observed, more than three-quarters (22) had clean drinking water available. Only half had seating in the waiting area for the clients, and fewer (11) had a separate room for counselling or an area separated by a curtain for privacy and confidentiality. Only eight had functional height and weight scales (Table 5.3).

Table 5. 3 Availability of basic amenities and equipment in the HFs (n=26)

Amenities	**Number of HF**
Clean Drinking Water	22
Seating available in the waiting area	13
Weight and Height Scale	8
Visual and Auditory Privacy[8]	11

5.1.2.3 Informing the community about adolescent-friendly health services

The national standards for AFHS emphasise adolescents and the community being informed about the availability of SRH services for adolescents in the health facility (MoHN, 2011b). One of the standard operating procedures of AFHS is to display the AFHS signboard with the logo and

[8] A private room or screened-off space in the general outpatient service area at a sufficient distance from other clients so that a normal conversation can be had without the client being seen or heard by others.

opening times (MoHN, 2011b). Less than a quarter (four) of the health facilities were found to comply on this and had displayed a day and time allocated for adolescents which were within normal working hours of 10 am to 5 pm. Only six sites had any kind of SRH information education and communication (IEC) materials available for adolescents (Table 5.4).

Table 5. 4 Information about AFHS available in HFs (n=26)

Variable	Number
AFHS logo displayed	
Displayed	4
Not displayed	22
Opening times displayed (mentioned and visible)	
Displayed	4
Not displayed	22
IEC materials in waiting area	
Available	6
Not available	20

5.1.3 SRH Service utilisation by adolescents from AFHS

5.1.3.1 Adolescents' general health service utilisation in two years

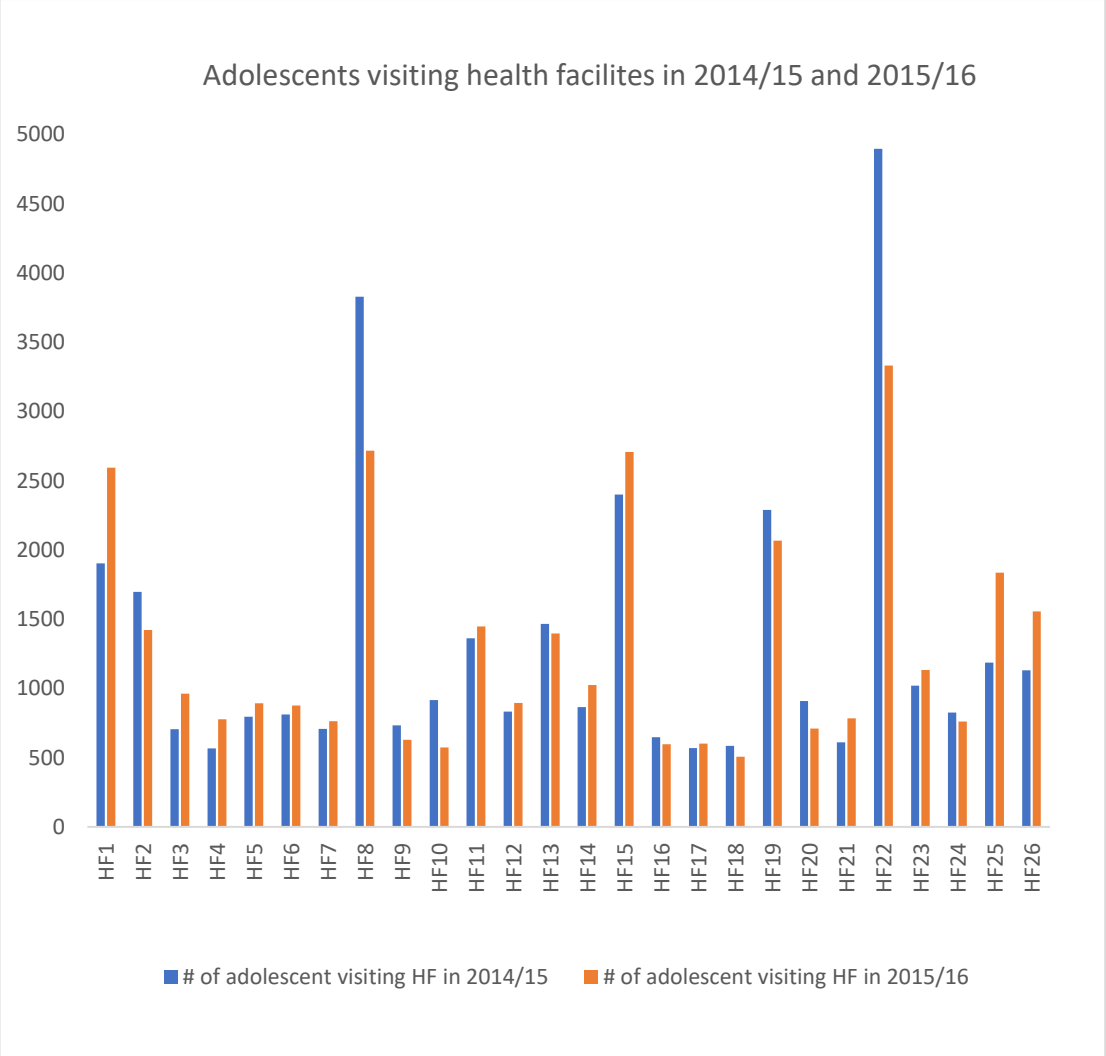
General health service utilisation refers to number of visits by adolescents to the health facility for any kind of service, for example, injuries, general illnesses (fever, diarrhea, headache etc.) and sexual and reproductive health care. The data show that the total number of visits by adolescents to the 26 health facilities in the catchment area in fiscal year 2014/2015 was 34,256, of an estimated total adolescent population of 42,783. Of those visits, the number of adolescents attending for SRH services was only 1,326 (3.9%). Similarly, in fiscal year 2015/2016, of a total of 33,557 adolescents who visited health facilities (from an estimated 44,715 total adolescent population) only 1,329 (4.0%) were seeking SRH care. These figures indicate that while high numbers of adolescents were visiting the facilities designated as AFHS, very few were attending for SRH services. The low rate of adolescent SRH visits could, in part, be explained by inadequate reporting procedures for SRH information, education and communication (IEC) services.

A comparison of the numbers of male and female adolescents (10-19 years) visiting the health services showed the number of females' visits had slightly increased from 19,268 in 2014/15 to 19,428 in 2015/16, whereas visits by males in this age group had decreased from 14,988 in

2014/15 to 14,129 in 2015/16. Overall, the information shows that over 70% of the estimated adolescent population of the study's catchment visited its health facilities in both fiscal years. This figure could be attributed to multiple visits by individuals for different reasons or for follow-up visits. The out-patients department register in Nepal records all visits – either new, repeat, or follow-up – as single visits, potentially resulting in over-reporting of the number of individuals seeking health care.

The data further show that in almost half of the health facilities (11), the number of visits by adolescents decreased in fiscal year 2015/16 compared to 2014/2015. In two health facilities (referral facilites), the number of adolescent visits to the health facility was more than the estimated target population ***(****Appendix 4****)*** for the catchment area of the health facility in both fiscal years. The probable reason is that adolescents were visiting from a neighbouring village.

Figure 5. 1 Utilisation of health services by adolescents in 2015-16



5.1.3.2 Contraceptive service utilisation by adolescents

Adolescents' awareness and utilisation of contraceptive awareness and utilisation are pertinent to maintaining their health and well-being. All types of modern contraceptive methods including oral contraceptive pills (OCP), injectable contraceptives, implants and intrauterine contraceptive devices (IUCD) are available for free in all public health facilities including AFHS in Nepal. Figures 5.2 and 5.3 show adolescents' contraceptive service utilisation by method in two consecutive years 2014/15 and 2015/16 in 26 AFHS in Dhading district. In 2014/15, the total number of new acceptors[9] of contraceptive methods 15-19-year-old female adolescents was 480. Among all methods, injectable contraceptives recorded the highest take-up (300), followed by OCP (147), implants (22), and the lowest was for IUCD (11 users). The following year 2015/16 showed similar uptake by new female acceptors (462) aged 15-19 years. Contraceptives most frequently utilised were injectable contraceptives (324), followed by OCP (118), implants (19), and IUCD (one user).

Overall, OCP and injectable contraceptives were the most common method of contraception among adolescents, and implants and IUCDs were utilised by fewer adolescents. This could be because implants and IUCDs are available only at limited public health facilities where trained health care providers are available. Overall utilisation of all contraceptive methods was minimal.

[9] Number of people who accept for the first time in their lives any modern contraceptive method during a 12-month period.

Figure 5. 2 New adolescent acceptors' choice of contraceptive methods in Nepal, 2014-15

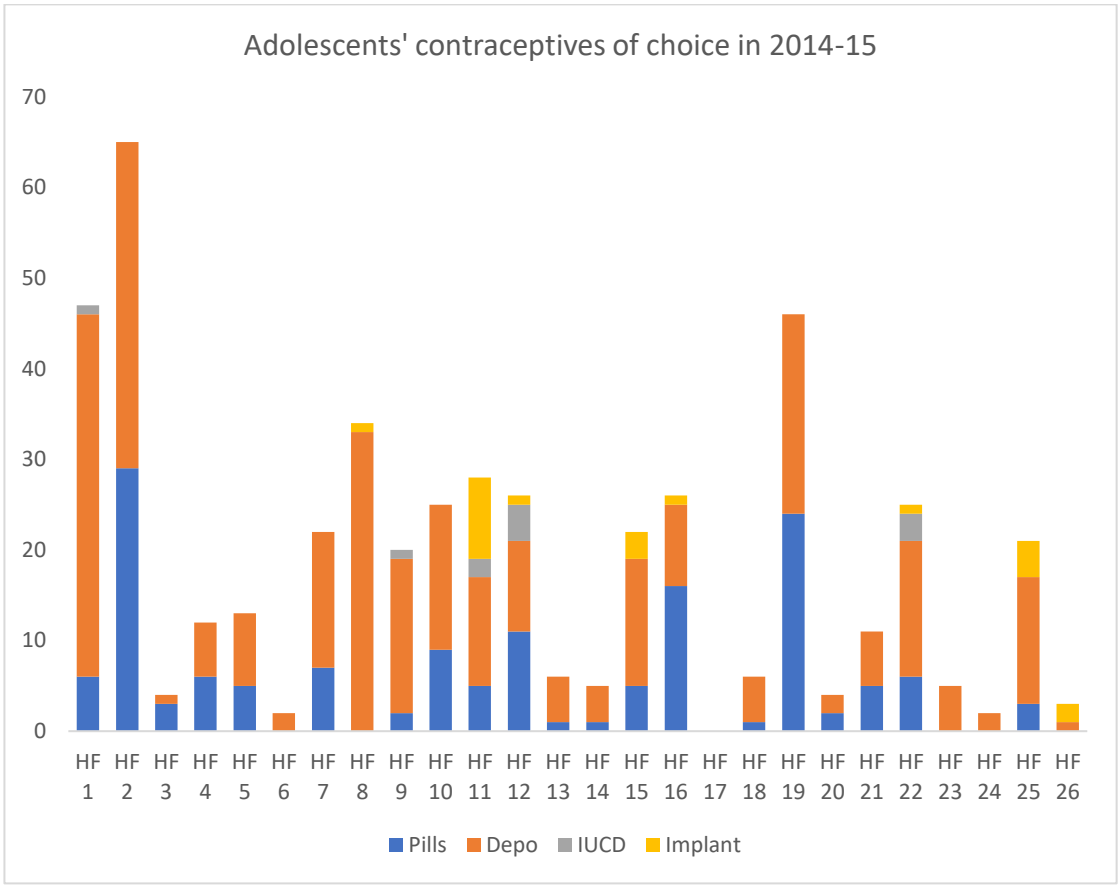
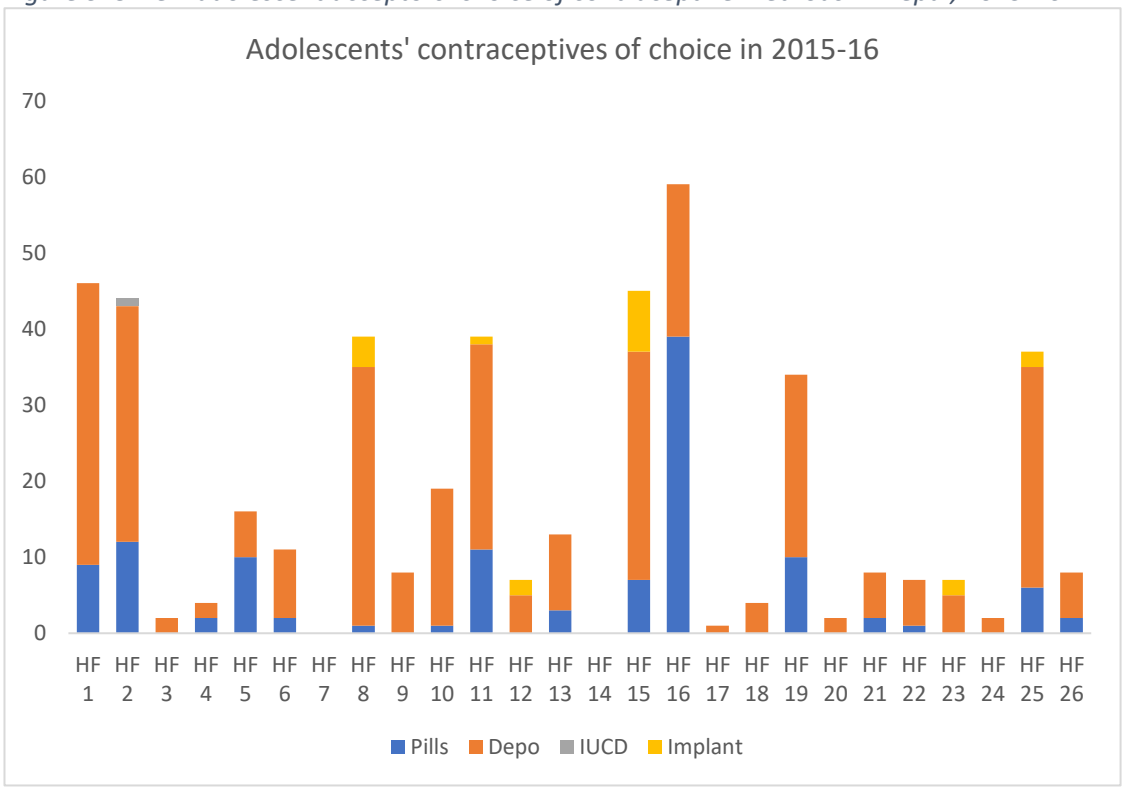


Figure 5. 3 New adolescent acceptors' choice of contraceptive methods in Nepal, 2015-16



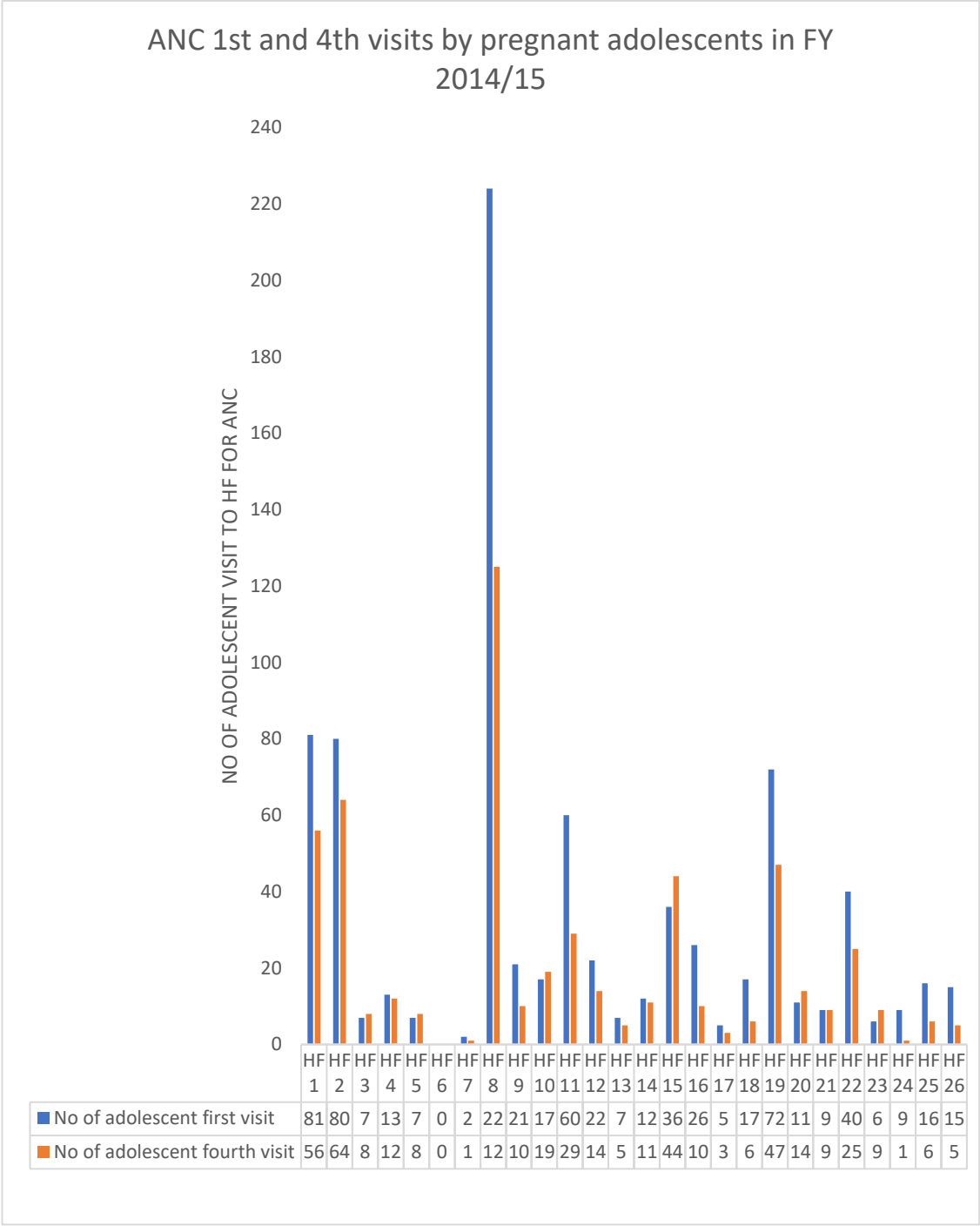
5.1.3.3 Adolescents' maternal health care utilisation

The WHO recommends that pregnant women have eight antenatal care (ANC) visits (against the four-visit model) to decrease the risk of foetal mortality and increase women's comfort during pregnancy (WHO, 2016b). Contrariwise, Nepal follows the four-visit (at the 4th, 6th, 8th and 9th months) model for all pregnancies, including adolescent (MoHN, 2017, p. 72). During these visits women receive general health check-ups for: monitoring of blood pressure, weight, and foetal heart rate; information and education about pregnancy and childbirth; infant care and post-partum family planning; danger signs during pregnancy, childbirth and after; early detection, management, and timely specialist referral in case of complications; and tetanus toxoid and Diphtheria (Td) immunisation (MoHN, 2017).

This study found that of a total of 3,254 ANC first visit clients in 2014/2015, 25% (815) were pregnant adolescents. Of those 815 adolescents, only 541 (66.4%) attended the fourth ANC visit. There was some improvement in the following year when, out of 3,280 ANC first visit clients, 22% (720) were adolescents and of those, 537 (74.6%) attended their fourth ANC health check. By health facility, *HF 8* had the highest number of adolescents attending for both their first and fourth visits in both years. *HF 6*, on the other hand, had the lowest number of adolescents attending both first and fourth ANC visits. Figures 5.4 and 5.5 show pregnant adolescents' attendance at first and fourth ANC visits for all 26 study sites.

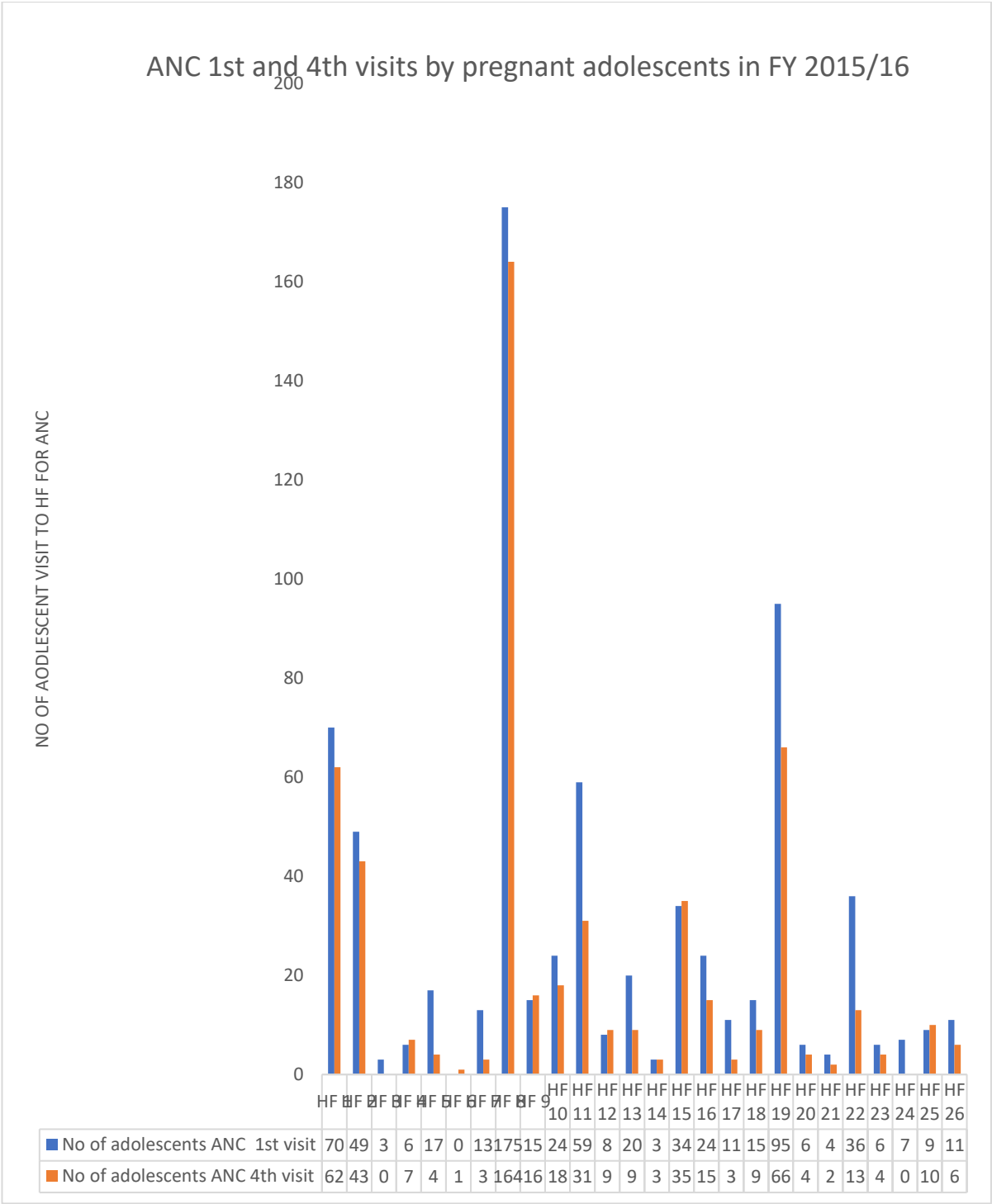
A comparison of the numbers of adolescent females' first HF visit for contraceptives (480 in 2014/15, and 462 in 2015/16) with the numbers of pregnant adolescents attending for antenatal care in the same years (815 and 720, respectively) suggests there may be a high unmet need for contraceptive advice and utilisation among this group.

Figure 5. 4 Antenatal Care service utilisation (1st vs 4th visit) by adolescents, 2015/16



	HF 1	HF 2	HF 3	HF 4	HF 5	HF 6	HF 7	HF 8	HF 9	HF 10	HF 11	HF 12	HF 13	HF 14	HF 15	HF 16	HF 17	HF 18	HF 19	HF 20	HF 21	HF 22	HF 23	HF 24	HF 25	HF 26
No of adolescent first visit	81	80	7	13	7	0	2	22	21	17	60	22	7	12	36	26	5	17	72	11	9	40	6	9	16	15
No of adolescent fourth visit	56	64	8	12	8	0	1	12	10	19	29	14	5	11	44	10	3	6	47	14	9	25	9	1	6	5

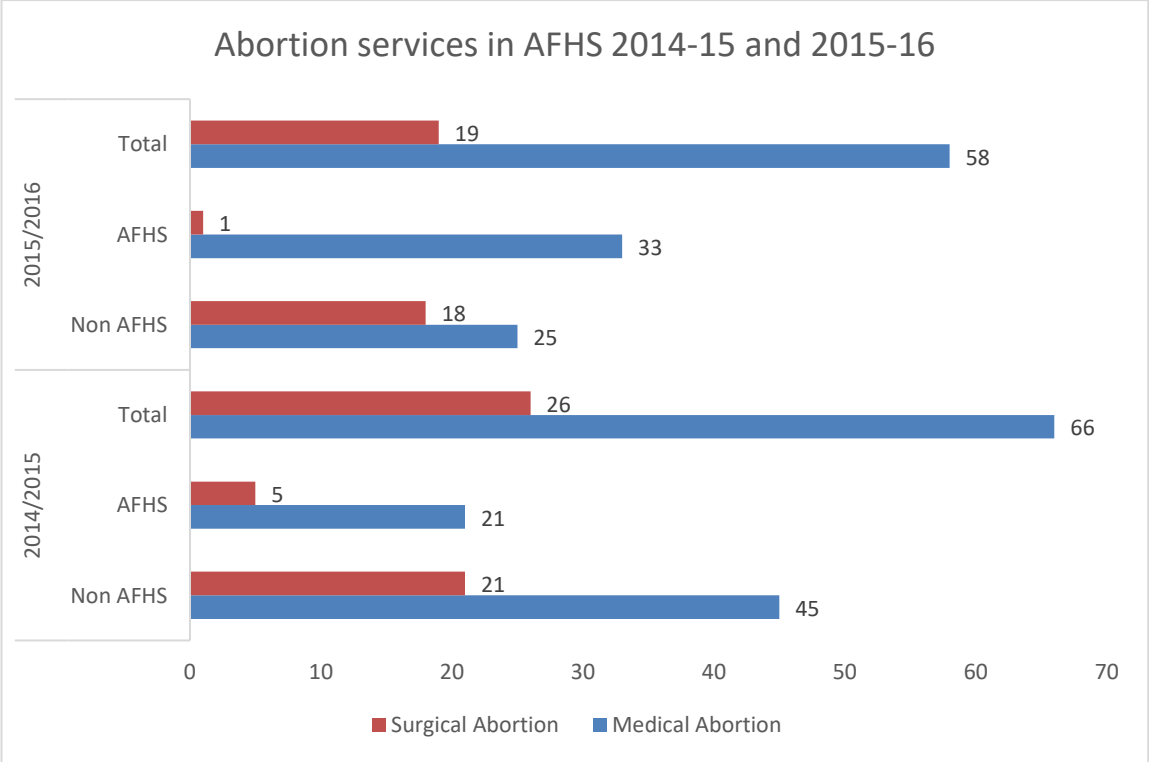
Figure 5. 5 Antenatal Care service utilisation (1st vs 4th visit) by adolescents, 2015/16



5.1.3.4 Adolescents obtaining safe abortions in Dhading

Figure 5.6 shows that there was a slight increase in the number of adolescents (26) seeking abortion care services from AFHS across all 26 study sites in 2015/16 over the previous year. Conversely, health facilities not hosting an AFHS showed a decrease in the number of abortions they performed over the same two consecutive years. The choice of medical abortion was more popular than surgical abortion among adolescents in Dhading district over the two consecutive years.

Figure 5. 6 : All safe abortion services accessed by adolescents from AFHS and non-AFHS in Dhading



5.1.4 Outcomes of health facility service utilisation and observation

Adolescents' general service utilisation percentage (% of adolescent visits[10]/total number of adolescent populations in 2014/15 and 2015/16), and health facility observation scores against the national standards for AFHS were analysed, and are presented in Table 5.5. For adolescents' general service utilisation, eight health facilities were placed in the good category (≥70% utilisation), 15 health facility were categorised as medium (40-69% utilisation), and three health facilities as poor (≤39% utilisation).

The health facility observation checklist had 20 standard points. Of 26 health facilities observed, the performance of four was found to be good (≥ 70% compliance), 13 were medium performing (40-69% compliance), and seven were poor performing (≤ 39 % compliance).

Of the six-health facilities selected as case studies I am presenting three – one each from the good, medium, and poor categories of service utilisation – in detail in section 5.2 of this chapter.

[10] Percentage of adolescent visit in this thesis refers to both unique individual visits and occasion of services. There was no recording mechanism in the health facilities for repeated client visit.

Table 5. 5 Service utilisation and observation score table

Health facility #	General service utilisation (%)		Observation score against national AFHS standards	Features considered in selection
HF1	69.59		8	
HF2	68.77		15	
HF3	92.93		12	
HF4	47.37		8	
HF5	64.40		11	
HF6	94.51		10	
HF7	66.23		9	
HF8	144.17		9	Good service utilisation, but medium observation score, easily accessible location
HF9	48.25		5	
HF10	38.53		16	Remote health facility, good compliance with national standards, but poor service utilisation
HF11	77.52		3	
HF12	51.57		12	
HF13	58.43		5	
HF14	66.78		8	
HF15	117.19		18	
HF16	69.00		11	
HF17	35.11		14	Good compliance with national standards, but poor service utilisation, HCP popular in-service delivery
HF18	30.03		10	
HF19	67.68		13	Popular AFHS in the district for good ASRH services, both medium compliance with national standards and service utilisation
HF20	82.71		8	
HF21	58.36		7	
HF22	220.53		10	Remote and accessible location, good service utilisation, but medium compliance with national standards
HF23	69.85		6	
HF24	65.40		7	
HF25	67.84		9	All HCP and staff were women, both medium compliance to national standards and service utilisation
HF26	156.89		6	

Note:

General health service utilisation (%): > = 70% as Good, > = 40% - <70% as Medium and <40% as poor

HF Observation score: >=14 (>=70% compliance) as Good, 8-13 (40-69%) as Medium and <= 7 (<=39%) as Poor

Green - Good, Yellow - Medium, Red - Poor

General health service utilisation: % of adolescent visits by total number of adolescent populations of FY 2014/15 and FY 2015/16

5.2 In-depth case study analysis

In this section, I present three case studies of adolescent-friendly health services (AFHS) in the Dhading district in Nepal. The major purpose of presenting these case studies is to provide an overview and portrayal of AFHS.

Three AFHS sites were purposefully selected for in-depth review from the 26 AFHS located within the Dhading district. Based on the results of the health service utilisation data, I selected one health facility from each of the rating categories good, medium, and poor. This process of selecting the health facilities for in-depth study aligns with the principle of purposive sampling for case studies, which offers the flexibility and opportunity to explore the phenomenon of interest (Yin, 2014). The following table presents the health facility observation scores for the three health facilities and adolescents' health service utilisation over two consecutive years, 2014/15 and 2015/16. The health service utilisation percentage was calculated based on the projected adolescent population for those two fiscal years. These health facilities are designated HF A, HF B and HF C to secure their identities.

Table 5. 6 Health facility case study observations of service utilisation

HF	Health service utilisation (% of the projected adolescent population for two fiscal years 14/15 and 15/16)	Category of service utilisation	Observation score (out of 20)
HF A	144%	Good	9
HF B	67.68 %	Medium	13
HF C	35 %	Poor	14

5.2.1 Health Facility A (Performance: good)

Background

HF A was one of the facilities most visited by adolescents, according to the health management information system (HMIS). This facility recorded 144% visits by adolescents during 2014/15 and 2015/16, which is higher than the total estimated adolescent population of the catchment area which is called Village Development committee (VDC) (the administrative area covering nine wards). This may be due to the location of the health facility, a semi-urban town only two and half hours from the capital city, Kathmandu, via the national highway which runs through its

centre. Due to the population density of the area, the location is easily accessible to adolescents in neighbouring areas. In addition, this facility met 9 out of 20 national standards of adolescent-friendly health services. Some of the key areas of compliance not met by this health facility were the availability of IEC materials, ASRH flip chart, and ASRH job aid[11] (WHO, 2010) in the waiting area and consultation room, monthly progress not reported to the district health office (DHO), AFHS logo, and opening times not displayed.

Physical setting/environment

Located in the middle of the densely populated market area of the village, this health facility was accessible to all communities in the village, being connected by road network to all wards. However, the commute time to the health facility could vary depending on the kind of transport used (e.g. ambulance, public vehicle, or rented vehicle), which, in turn, would depend on affordability. Walking time to HFA could range from a few minutes to three hours, subject to the starting point of the journey. It is a three-minute walk from where a secondary school is located. Thus, school children and adolescents pass by the facility every day on their way to and from school.

This village is a business hub for many adjoining municipalities, hence people from neighbouring villages have migrated to this place for business purposes. The majority ethnic groups in the catchment area of the health facility are Tamang and Brahmin/Chhetri; smaller populations include Chepang, Newar, Magar, and other underprivileged castes such as Dalits. These ethnic groups each have their own local language, are also fluent in the national language, Nepali, and are mostly literate. The village has electricity and a telecommunications installation.

The health facility is a compound containing two buildings with small shaded waiting areas with benches outside, and also staff accommodation for those from other districts working in the facility. Inside the facility there is a reception area where an HCP registers clients, and a waiting area with several plastic chairs and a weighing scale. This area leads to a room with a board. The board indicates that this is an adolescent-friendly facility and displays the clinic hours for adolescents. There are three other rooms in the building; two are regular consultation rooms and the other serves as a dressing room. When privacy is needed for sensitive conversations or counselling, HCP bring adolescent clients into the assigned room, which has two consultation areas separated by a curtain, and an examination table. The curtain gives visual privacy, but the

[11] Adolescent job aid is a handy desk reference for HCP to be used while providing ASRH services. Adolescent job aid was designed by WHO in 2010 and was translated in Nepali language.

conversation during consultation can be heard by other people in proximity of that room, which is used for both adolescent and antenatal care consultations. There is no dedicated space for adolescents to have physical privacy.

The second building in the health facility is a two-and-a-half storey building housing an office for the head of the health facility, beds for inpatients, and a delivery room and a post-natal room on the ground floor, and on the first and second floors, a meeting room and staff quarters. The health facility was clean in all areas; the toilet block is a separate construction within the compound and male and female facilities are separate, with running water inside and a basin for hand washing. During my visit, I observed support staff cleaning the toilets at least twice daily.

Staff characteristics and competencies

The total of sanctioned staff in the health facility consisted in one medical doctor, one health assistant, one staff nurse, three auxiliary health workers (AHW) and three auxiliary nurse midwives (ANM), one lab assistant, one immunisation worker and two support personnel. At the time of my visit, the health facility was fully staffed as per the recommendations for staffing numbers. Also, I found four additional medical doctors assigned temporarily from the MoH to accommodate the higher caseload in the facility. There was, however, a discrepancy in the actual presence of health workers in the facility during my visit. I was not able to find any doctor in the compound. Over the duration of all three of my visits to the health facility, neither of the AFHS-trained HCP was ever present. The health workers were either on leave or attending training at other sites. Staff who were present in the health facility were nurses in the maternity ward or office assistants. The staff nurse and the midwives are mostly assigned to provide services to patients admitted for treatment in the health facility as well as comprehensive obstetric care services.

For AFHS, one male and one female HCP had received training on the program implementation in the health facility, at a two-day orientation at the DHO in 2011. After one year of ASRH program practice, the female HCP was transferred to another facility, and the DHO then oriented a second female staff member. Both the male and female trained health workers were currently available in the health facility. The female health worker had received other relevant SRH training, in menstrual hygiene management, and both medical and comprehensive abortion training. The male health worker had been trained in family planning, a most relevant area of SRH.

Primary health care services available

HF A offered both inpatient admission services and treatment and outpatient consultations. It is a referral facility for other, remote villages and resident trained medical doctors provide 24-hour comprehensive emergency obstetric care every day. Outpatient service are provided by medical doctors daily from 10 am-1 pm. The facility provides primary health care services for reproductive health; safe motherhood, family planning, essential child health services, treatment of communicable diseases, emergency services, treatment for minor injuries, and specialist referrals, as well as running primary health care outreach and immunisation clinics in remote wards of the village.

Resources for AFHS

a. Financial resources

The health facility received Nepalese rupees (NPR) 10,000 as a start-up budget for AFHS, to buy, at their discretion, materials essential to establish AFHS in the facility. These were weight and height scales, and chairs and benches to create a separate room for adolescents.

b. Information, education and communication support

ASRH program implementation guidelines and health facility operation and management committee orientation guidelines were provided to HCP. The health facility received 25 sets of adolescent health booklets to be distributed in schools and throughout the community to provide information on sexual and reproductive health for adolescents.

HCP motivation towards AFHS

There were two HCP responsible for the ASRH program; Ram is a male AHW who has worked in this facility, HFA, for the past 15 years, and Sara is a female ANM who has worked here for five years. Both Ram and Sara had received ASRH, and related training in family planning counselling and emergency obstetric care, and were highly motivated to provide services to adolescents, believing it to be important, and their responsibility to help adolescents with their SRH. Sara commented: *"They [adolescents] are like raw mud, and they have behaviours which might keep them on risk and hence we need to give them information on SRH.*" Sara's comment suggests she considers adolescence a vulnerable age for sexual and reproductive health risks and it is her professional responsibility is to minimise these risks by providing SRH information. Ram said that he felt like he has "*provided service to the family, as this [SRH] is somehow linked to the status*

of the family." In Nepalese society, an unmarried adolescent becoming pregnant can mean the entire family losing social status. Ram's words suggest that by providing SRH services to unmarried adolescents, he is serving the whole family by preventing pregnancy out of wedlock.

HCP in this health facility felt that it lacked features of AFHS. Ram's expression, "*our adolescent health program collapsed*" seemed an indication of the frustration he had with the program. Sara, on the other hand, thought that the health facility was still adolescent-friendly, the only problem being the lack of a separate counselling room when adolescents needed privacy for confidential service:

> I would say it is [HF] somewhat adolescent-friendly but also not. Because, when adolescent come to the health facility, we provide them with the help they need. However, otherwise we do not have a separate room allocated for adolescents, so it is difficult to provide services confidentially. (Sara, 30, female, HCP)

When I asked Sara about the room with the adolescent-friendly sign she said it was a multi-purpose room, which was why she did not consider it as a separate, adolescents-only room.

Strategies for publicising AFHS

The HCPs from this facility regularly participated in the school health education programs at the higher secondary school near the facility and other schools in the village as noted by Ram.

> In our district every year we get funding to run a school education program. We conducted ten sessions this year in schools. We could have chosen any topic for the session, but as our health facility is running an adolescent health program and provides services to adolescents, we did three-to-four classes on adolescent health and informed them about services. (Ram, 38, male, HCP)

During the school talks, the HCP would talk about the adolescent health program and provide information on the SRH services available in the health facility. But it was not physically possible to take the health education program to all the schools in its VDC. They had, however, sent the SRH IEC booklet to all the schools in their VDC

There were no other supporting agencies working on adolescent health in this village.

Figure 5. 7 Logo for adolescent sexual reproductive health services in Nepal

Monitoring and supervision of the health facility

The WHO (2012) has recommended developing regular monitoring[12] and supervision[13] tools for tracking the implementation and progress of AFHS programs. In Nepal, such a tool has been designed by the Family Health division of the MOHN and included in the AFHS program guidelines for use by district health managers. I observed that the visitors' logbook showed regular visits from the authorities at both district and central levels. In discussions with HCP, I found out that these monitoring and supervision visits were just a formality as the health facility's location was easily accessible to both district and central authorities travelling to and from district headquarters in Dhading and other central region districts. Health workers Ram and Sara claimed that on these visits there was no monitoring or supervision of the adolescent health program; furthermore, they had not been given any feedback on how the program was being implemented.

SRH service utilisation of the health facility

As discussed earlier, HF A recorded more visits from adolescents than their age group's estimated population in the village. However, the proportion of adolescents seeking SRH services was low. In 2014/15 no adolescent girls had been prescribed contraceptive pills or IUCDs; 33 girls had been given injectable contraceptives, and one, an Implant. The following year showed a similar distribution: oral contraception (1), injectable contraceptives (34), and

[12] Monitoring is a systematic process of observing, tracking and recording activities for the purpose of measuring program implementation and its progress towards achieving objectives.
[13] Supervision is the process of interaction of higher-level managers in the health system with peripheral health care provider to monitor work processes, understand the cause of problems and provide possible solutions to improve the service delivery.

implants (4). During those two years, 224 and 175 adolescent girls, respectively, attended the clinic for their first antenatal visit. Adolescents made up nearly 30% of total antenatal care visits to HFA over the two years. The indication is that while many adolescents were visiting HFA – making it a "good performing" health facility, not very many were attending for SRH consultations, as suggested by few visits for contraception, but many more for pregnancy care. The data do not include numbers of male or female adolescents who might have collected condoms from the condom boxes, which are attached outside the building (clients are free to collect as many as they like) or from HCP.

5.2.2 Health Facility B (Performance: medium)

Background

HF B was one of the medium performers based on the audit of health facilities. Service utilisation data for 2014/15 and 2015/16shows that 67.68 % of the total estimated adolescent population of this VDC visited the health facility during these two years. Thirteen of the quality criteria out of 20 were met during the audit by observation. Key criteria that were not met included AFHS logo and opening times not displayed, no IEC materials in the waiting area, user statistics not displayed in the facility, and no condoms available in the condom box on the day of the visit.

Physical Setting/environment

This health facility is located on a hill, with rough terrain from the major roads crossing the village. The entire catchment area of this health facility lies uphill from its location, which can be reached by unpaved road from the main highway and is accessible by private cars, ambulances or by walking. Most of the wards of the village are connected by road but public transport is not available to all the places, and it can take adolescents up to two hours on foot to get to the health facility, which is also 20 minutes' walk from the nearest secondary school. There are several private schools in the village.

This village is around 1.5 hours' drive from the capital city Kathmandu. Most of the village residents belong to the Chhetri or Brahmin castes, followed by Newar, and Dalits. Most of the population speaks Nepali often, although many of them spoke in their local dialect, and most are literate. The village has electricity and telecommunication facilities.

The facility comprises of three small, separate one-storey buildings. In one room of a two-room building there was an old rusted steel bed which seemed to be non-functional. The other room had a delivery bed and equipment. According to a health facility staff, this was a birthing centre

run by the ANM who was hired by the VDC for one year. The other building was the main health facility. It had sustained major damage in the earthquake of 2015. On a wall was a printed banner (figure: 5.9) announcing adolescent-friendly clinic together with the names of the adolescent-friendly clinic HCP and opening times. However, the building was no longer used for consultations but for storage and offices, despite safety warnings to avoid it.

Figure 5. 8 Adolescent-friendly clinic flex in HF 2

The third building is a newly constructed prefabricated building of five rooms, a waiting area with benches at the front and a lobby with table and chair for registering patients. Entering the lobby, there is an area surrounded by a green screen and on a nearby wall, “Adolescent-Friendly Health Services Clinic” was written on an A4-sized paper. On the other side of the screen there was a table with a register, adolescent flip chart and an open box with few IEC materials kept neatly inside, a chair, and a small open bookrack, labelled "adolescent-friendly services clinic (10-19) years", with brochures of different kinds. When I asked, the HCP said that this was a place where adolescents could come and read the IEC materials.

Staff characteristics and competencies

The total sanctioned positions for the health facility were one health assistant, two auxiliary health workers, three auxiliary nurse midwives, and one support staff, which at the time of my visit, all the sanctioned positions were all filled. Also, there were two extra staff members, one auxiliary health worker, and one ANM working as a volunteer. However, during my visit not all staff were available on the premises. I was not able to meet the health facility in-charge at either of my visits. On my second visit, there was a family planning permanent sterilisation camp going on; I met some of the medical doctors who had come from the capital city to run the camp.

One male and one female HCP had been oriented for implementation of AFHS in which they had both been providing at HF B since 2011. They had been given IEC materials and ASRH program implementation guidelines by the DHO. Like the HCP in HF A, both workers were trained in the SRH areas of family planning, medical abortion and safe motherhood.

Primary health care services available

HF B offered outpatient services as well as a birthing centre providing 24-hour service. The facility provided primary health care services including for reproductive, family planning and maternal health, essential child health, emergency treatment of communicable diseases, minor injuries treatment, and referral services. This facility also ran primary health care outreach and immunisation clinics in remote wards of the village.

Resources for AFHS

a. Financial resources

HF B had also received NPR10,000 for essential AFHS equipment. They invested in a weight scale, chairs, a water filter, and a few registers for recording the activities conducted for adolescents. In addition, funding from the government under "the population management program" had been given to the facility for peer education training and programs in some of the village's schools.

b. Information, education and communication support

HCP were provided with AFHS orientation guidelines and 25 sets of adolescent health booklets to distribute in the schools by the peer educators that were trained under the population management program.

External support

There were some NGOs working on the adolescent health program in VDC 2. Local organisations also visited schools to inform adolescents about SRH. The HCP collaborate with them to organise ASRH community mobilisation activities such as street drama, school debating programs etc.

HCPs motivation towards AFHS

Shyam was a 37-year-old male AHW who had worked in HF B for ten years; Nanda, aged 32, was a female ANM who had worked there for the past seven years. Both of them were highly motivated to provide SRH services to adolescents and talked about their daily engagement with adolescents in the clinic. Shyam believed that SRH education should be provided to adolescents from *"at an early age"* so that *"they can choose the SRH services they need on time and shape their future".* Shyam believed SRH education benefited not only the adolescents, but also helped to *"decrease the need for government to invest so much in managing complication on SRH problems*".

Similarly, Nanda felt that adolescents were curious to learn about their bodies and she was happy to provide SRH information to them. She also noted that parents often had little knowledge about growing up and puberty, and they looked to HCP for information. Hence, she had an important role as an SRH educator to both adolescents and parents. The lack of parental SRH knowledge is reflected in Nanda's comment on a situation she had recently encountered:

> A few days back a mother brought her 13-year-old daughter to me and said her daughter is developing wound in the chest and it was painful. I talked to both mother and daughter about the puberty signs including the development of breast and asked them not to worry. It is so important for me to provide this information so that the parents and adolescents do not panic about SRH issues. (Nanda, 32, female, HCP)

My communications with Shyam and Nanda suggested that they were both interested and enthusiastic about delivering the AFHS program, which they did regularly, assigning responsibility between each other to serve adolescent clients. They had organised their roster so that one of them would always be on hand, their concern for good coordination showed they took responsibility for the adolescent health program. This was the only health facility among the case studies that maintained an adolescent-friendly register and recorded the details of adolescents' visits. Despite having to share the same outpatient department (OPD) for all patients, including adolescents, after the earthquake, they had organised a separate waiting area organised with benches and chairs outside. I observed that Shyam and Nanda called the patients in turn and took them into the consultation room separately.

Both HCP stated that their health facility did not meet all the program qualities of an AFHS. For example, they had not been able to allocate a separate room for counselling since the earthquake. However, they tried to maintain confidentiality by closing the door and taking only one patient at a time. Both were keen to get feedback from me about their AFHS program, which showed their openness to suggestions for improvement.

Strategies for publicising AFHS

HCP in HF B invited health facility operation and management committee (HFOMC) members and two school student representatives to help improve the ASRH program. They established a separate area within the health facility and called it the "adolescent-friendly clinic". They developed an IEC corner in the room and displayed reading materials for adolescents, mentioned the need to display an AFHS board with their names and contact numbers outside the clinic, and established opening times for the adolescent-friendly clinic in consultation with the school students. The health facility team was enthusiastic, and organised school activities to let adolescents know that ASRH services were available in their facility.

Further, the HCP trained 16 adolescents in ASRH to be peer educators who would provide basic information to their peers and if they query about SRH, refer them to the health facility for consultation. They established good coordination with school teachers, as Nilu, a female school teacher at the local school, described:

> HCPs come to our school and take the classes on SRH. This is how I know about ASRH service provision. I do send my students who have a problem with menstruation to the health facility. (Nilu, 42, female, KI)

Monitoring and supervision

HF B was a model for the adolescent-friendly program in the district, and therefore, it had regular district-level monitoring and supervision. Visitors from the national level also came regularly to this facility to observe and learn from the experience of the HCP. Its health workers were also invited to the district-level meetings to share their experience of providing counselling to adolescents via phone, and recording and reporting to other health workers. In my work in Nepal during 2010-2014, I witnessed several meetings where the telephone consultation provided by the health workers of HF B were praised as exemplary by the DHO.

SRH service utilisation of the health facility

AT HF B in 2014/15, 24 adolescent girls received oral contraceptive pills, and 22 Depo injectables; none received implants or IUCDs. In the following year 2015/2016, the figures were oral contraceptives (10), contraceptive injections (24), and no implant/IUCDs. Adolescent girls attending their first antenatal care visit numbered 72 in 2014/2015, and 95 in 2015/16 respectively. In total, adolescents made up close to 24.9% of antenatal care visits to HFB over the two years.

5.2.3 Health Facility C (Performance: poor)

Background

HF C was a poorly performing facility based on ratings from the health facility audit. Service utilisation data for the two consecutive fiscal years studied show that 35% of the total estimated adolescent population of this VDC visited the health facility over this period, a comparatively low rate of utilisation. However, it met 14 adolescent-friendly criteria out of the possible 20 adolescent-friendly criteria during observation of the health facility. Observation showed some of the key areas lacking were no display of the AFHS logo and opening times, no ASRH flip chart, and user statistics not displayed in the health facility.

Physical setting/environment

Located in the mountains, HFC is not accessible to the whole of the facility's catchment population, which is widely dispersed with some communities living two to three hours' walk away. Although a road runs close to the facility, it is usable only during dry seasons; it is muddy when it rains, and public transport does not run. A secondary school is located 25 minutes' walking along the road, there being no public transport between residences and the facility, or between the school and the facility's location. Although they may pass the facility on their way to and from school, adolescents wanting to visit the AFHS might walk up to three hours along steep unpaved roads from either their homes or school. There is a bus service from one village to another, used by people to go to the district market, which makes the district hospital, with its better facilities, more accessible than the AFHS. A trip to the district hospital by bus took 45 minutes, but for some villages a trip to the AFHS would take longer on foot. Thus, as I observed, more young people went to the district hospital than to the AFHS.

The population of HFC's catchment area are Newar, Brahmin, Chhetri, Tamang, Kumal, and other ethnic groups. All speak and understand Nepali, and most are literate. The village has electricity and telecommunications, but for higher secondary education, many adolescents go to the district headquarters.

Following severe damage caused by the 2015 earthquake, HF C received support from one of the development organisations to construct a prefabricated building which was a single-storey seven-roomed facility plus staff quarters within. Entering, there is a reception area with a desk and chairs for the waiting clients, and within this area there are two consultation room, one dressing room, one autoclave room and a store. There was no AFHS logo or any other sign indicating that this was an AFHS. On inquiring, the HCP said that adolescents are seen in the same place as other clients, but that privacy was provided by placing a screen around the consultation area. However, at my visit, I did not see any screen or curtain in the consultation room. The health facility was appealing in terms of cleanliness, waiting area, and reading materials for adolescents.

Figure 5. 9 A small connecting road to reach HF C

Figure 5. 10 Photograph of HF C taken from the road

Staff characteristics and competencies

The total number of sanctioned positions in the health facility were one health assistant, two auxiliary health workers, three auxiliary nurse midwives and one support staff. At the time of my visit, the positions of health assistant and one auxiliary health worker were vacant, and on the day, there were only one AHW and one ANM present in the facility.

One male and one female HCP were trained in ASRH for this health facility. However, the female HCP was transferred to another health facility after the first year of the program and since then, no other staff had been trained in adolescent-friendly service. HCP Krishna, a local of the district, had been working in HF C for 16 years. He had participated in several district-based SRH training programs including family planning and safe motherhood.

Primary health care services available

The health facility had outpatient consultations services and also a birthing centre for 24-hour care. The facility's primary health care includes reproductive health and maternity services, family planning, essential child health services, treatment of communicable diseases emergency service, minor injury treatment, and referrals. The health facility runs primary health care outreach clinics and immunisation clinics in remote wards of the village.

Resources for AFHS

a. Financial resources

This health facility had previously received NPR 10,000 to buy essential equipment to start AFHS. This health facility bought a weighing scale, water filter, some chairs and a carpet with the available funds.

b. Information, education and communication support

The HCP had been equipped with AFHS orientation guidelines and 25 sets of adolescent health booklets to distribute in schools and through local NGOs. Krishna told me that he had sent IEC booklets to the local school and also gave them to adolescents visiting HFC.

HCPs motivation towards AFHS

Krishna, a 44-year-old senior AHW was the only AFHS-trained staff member. While he expressed his motivation to provide the adolescents in his village with SRH services, I learned from interviews with Krishna, and with local adolescents and KIs, that he was renowned throughout

the VDC as a strong political identity who was often busy attending district-level meetings. During my informal talk with Krishna, he told me about his political activities, and how he had maintained his powerful position and taken up an advocacy role for HCP in the district, which, in fact, meant that he had limited time to offer at the health facility. Nonetheless, HF C had achieved significant awards for extra-curricular activities such as its safe motherhood and sanitation programs.

Krishna was a role model for many of the other health workers as he was an active person and often came up with different ideas to mobilise the female community health volunteers (FCHV) in his area. This was revealed in my interviews with health workers of other health facilities who mentioned his name as one of the influential health workers in the district. Similarly, during an interview with Nirmaya, an FCHV and key informant in the VDC, she told me about the different awards that HF C had obtained due to Krishna who was an active health worker and the environment he had created for adolescents to come and share their issues with facility health workers. However, Nirmaya also spoke about HF C workers being too busy to give time to adolescents, and that discouraged them from seeking help there. She explained:

> This VDC has fulfilled many criteria like it is announced open defecation-free (ODF) VDC, fully immunised VDC, household smoke-free VDC etc. However, it is not enough to have all these only in this VDC. That service is good, but adolescents are suffocated within themselves. (Nirmaya, 54, female, KI)

Although during his interview Krishna mentioned that it is important that adolescents receive SRH information and services because they do not get adequate information at school, my interactions with him and Nirmaya suggested that his several other activities and busy schedule took his time and focus away from HF C's ASRH program. Asked if the health facility was "adolescent-friendly", Krishna indicated that his facility is somewhat adolescent-friendly – he had all the IEC materials on display, and HFC was the cleanest of all the facilities. The only thing missing was a separate counselling room for adolescents.

Strategies for publicising AFHS

The HF C health workers conducted an adolescent health program orientation for the HFOMC members of their VDC, and requested HFOMC members to disseminate information about the program to the community. They also informed FCHV about the availability of SRH services for adolescents. Further, they coordinated with some NGOs working locally to conduct community mobilisation activities. These included street dramas which sent messages about the disadvantages of early marriage and early pregnancy, and attended mothers' group meetings

regularly, talking to mothers about delaying their daughters marrying until they were at least 20 years-old, and about managing menstrual problems. The HCP also suggested making one of the village secondary schools an "adolescent-friendly school". Krishna spoke of training school teachers in adolescent health and how they might coordinate with the health facility to provide adolescent SRH services:

> We have created one of the higher secondary school out of three in the VDC as an adolescent-friendly school. We have trained a few teachers of that school on adolescent health. The teachers coordinate with the health facility in case there is an issue on adolescent's SRH. Similarly, teachers are teaching their students about sexual and reproductive health from their learning in training. We have provided them with information materials like flex prints, posters and pamphlets to use during their class. It has supported to improve the health status of adolescents. (Krishna, 44, male, HCP)

Monitoring and supervision of the health facility

Because this HF C health worker was so politically active, any new program in the district was implemented in the health facility. Visitors from the district level and donors came to the health facility to observe the different programs. There was, however, no record of any monitoring and supervision visits for the adolescent health program.

SRH service utilisation of the health facility

According to the service utilisation statistics for the two years covered by this study, among the total number of adolescents visiting this facility, none of them had come to seek family planning services, except for one who received a Depo-injectable in 2015/16. Five adolescent girls visited for their first antenatal care consultation in 2014/15, and 11 the following year. Over the two years, of all the pregnant women who came for first antenatal visit, 16.3% were adolescents. The number of adolescents visiting HFC did not change significantly after the implementation of ASRH program. During my two-day visit to the health facility, I did not observe any adolescents visiting the facility during the six hours I spent there each day.

5.3 Reflection and summary

This chapter has presented statistics for the levels of utilisation of AFHS by adolescents and the results for compliance of with Nepal's national standards for 26 adolescent-friendly health services in the Dhading district. On the basis of this audit, health facilities were categorised as good, medium, or poor performers, and one AFHS from each category was selected for more detailed examination, of whether adolescents' utilisation had changed as a result of differences in performance following the implementation of the ASRH program. Health workers in the three

selected health facilities were found to have similar training in adolescent-friendly health provision following the roll-out of the national program; and in two of the three facilities, the level of monitoring and supervision had no significant impact on adolescents' utilisation.

Despite SRH services for adolescents being available in these health facilities, presence of AFHS trained HCP, and geographical access could be important factors that determine adolescents' utilisation of the SRH services. The next chapter will discuss the barriers adolescents face in accessing SRH services from these AFHSs in detail.

CHAPTER 6: BARRIERS TO ACCESSING SEXUAL AND REPRODUCTIVE HEALTH SERVICES FROM ADOLESCENT-FRIENDLY HEALTH SERVICES FOR ADOLESCENTS

This chapter addresses the following research questions:

1. What are the perceptions, attitudes and experiences of health care providers regarding the provision of sexual and reproductive health (SRH) services to adolescents?
2. What are adolescents' perceptions and experiences of the SRH services they received?
3. What are adolescents' experiences and challenges in accessing SRH services from adolescent-friendly health services (AFHS)?
4. What are the perceptions of community members (decision makers/gate keepers) of AFHS? Do they accept and support the adolescent-friendly health program?

Participant responses relevant to these research questions reflected a number of barriers and challenges that adolescents faced in utilising AFHS in the Dhading district. These barriers and challenges extracted from the transcripts of interviews with adolescents, key informants and health service providers are presented here according to the following major themes: socio-cultural norms, health facility factors, privacy and confidentiality, fear of disclosure, health worker-related factors, and stigmatisation of AFHSs.

6.1 Overview of participants

A total of 16 adolescents (aged 15-19 years), nine health care providers (HCPs) currently working at the six selected adolescent-friendly health service sites, and 13 key informants were interviewed. Six focus group discussions with male and female adolescents were conducted separately.

Ten of the adolescents were female, three of whom were married, and six were male; six of the 16 (four girls and two boys) had discontinued school education at grades ranging from elementary to high school. All were Hindus, except for one identifying as a Buddhist (Table 6.1).

Of a total nine health care providers, whose ages ranged from 30-52 years, four were male auxiliary health workers (AHW), and the remaining five were female auxiliary nurse midwives (ANM). All of these HCPs had had 24 months of training in health care provision. Eight identified as Hindu, and one as Buddhist (Table 6.2).

The key informants had various occupations which included: three school teachers (two male, one female), two female community health volunteers (FCHV), two health facility operation and management committee (HFOMC) members, two key stakeholders/policy makers (one male, one female) representing national-level organisations, one mother of an adolescent, one male leader of a marginalised group, one male religious leader, and one male ASRH focal person from the District Health Office. The educational levels of KIs ranged from only basic literacy, to master's degree. The age range of the KI group was 25-68 years. All KIs and HCPs were married at the time of interview. A total of 12 key informants nominated Hinduism as their religion and one, Christian; caste and economic status varied across all participants (Table 6.3).

Focus group discussions (FGD) were held separately for male and female adolescents (n=49) with participants selected to ensure homogeneity of educational status ethnicity/caste and sex (Table 6.4).

Table 6. 1 Demographic characteristics of interviewees (exit interview and in-depth interview) (adolescents)

Demographic	Value	Total
Gender	Male	6
	Female	10
Age	15 years	3
	16 years	3
	17 years	2
	18 years	2
	19 years	6
Marital Status	Married	3
	Unmarried	13
Education	Secondary school	7
	High School	3
	Out of School	6
Religion	Hindu	15
	Buddhist	1
Caste/Ethnicity	Brahmin	3
	Chhetri	3
	Newar	4
	Magar	1
	Tamang	1
	Dalit	3
	Indigenous	1

Table 6. 2 Demographic characteristics of in-depth interviewees (HCPs)

Demographics	Value	Total
Gender	Male	4
	Female	5
Age	30-35	3
	35-40	4
	41-45	2
Training	Auxiliary Health Worker	5
	Auxiliary Nurse Midwife	4
Religion	Hindu	8
	Buddhist	1

Table 6. 3 Demographic characteristics of in-depth interviewees (KI)

Demographic	Value	total
Gender	Male	8
	Female	5
Age	20-30	1
	31-40	3
	41-50	5
	51-60	3
	61-70	1
Occupation	Teacher	3
	Female Community Health Volunteer	2
	Health facility operation and management committee member	2
	Religious leader	1
	Marginalised group leader	1
	Parent	1
	District government official	1
	National level stakeholder	2
Religion	Hindu	12
	Christian	1

Table 6. 4 Demographic characteristics of FGD participants

FGD	Demographic status	Age group	No. of participants
1	Secondary school females	15-19 years	9
2	Chepang females (at school or not)	15-19 years	6
3	Tamang community females (at school or not)	15-19 years	9
	Sub-total of females in FGD		***24***
4	Secondary school male students (mix of ethnic groups but no Chepang)	15-19 years	12
5	High School males (grade 11- 12) (mix of ethnic groups but no Chepang)	17-19 years	7
6	Chepang community males (not at school)	15-19 years	6
	Sub-total of males in FGD		***25***
	Total participants all FGD		**49**

6.2 Theme 1: Socio-cultural norms around adolescent sexual reproductive health

Participants' responses clearly suggest that socio-cultural norms existing in Nepalese society around sex and sexual issues of adolescents contributed to how they access and use SRH information and services. The social expectations around adolescent sexuality and sexual behaviour often prevented adolescents from learning about sex and sexual health which in turn affected the extent to which they utilised SRH services.

6.2.1 Talking about sex and sexual health

In Nepal, talking about sex and sexuality is taboo (Pradhan & Strachan, 2003; Puri et al., 2010). As all participants noted, sex is rarely if ever, a matter of discussion in the family or community, making it difficult for young people to learn about sex either at home or through places of education. With very few exceptions, most of the participants gave reasons of their culture and tradition for not talking about sex. KI Tek, aged 35, a school teacher, stated:

> Our culture, religion, and tradition do not allow talking openly about sex and sexual matters. In other countries, this is taken as a normal thing. (Tek, 35, male, KI)

Krishna, an HCP aged 44, emphasised that "*families are not habitual in talking about such matter [sex].*" He also observed the lack of communication about sexual health issues within the community, noting that *"the practice of sharing or talking about reproductive health in front of family or father or brother is absent in our society.*" Going further than community members and

HCPs, adolescents highlighted that talking about sex brought shame. For instance, 19-year-old Muna thought talking about sex and related issues was shameful to herself as well as to her family, and even with health care providers. Feeling shame is likely to result in adolescents hesitating to seek information about matters of sexual health.

School-based sex education is a significant medium for disseminating information to help prevent adolescent pregnancies (Bennett & Assefi, 2005; DiCenso, Guyatt, Willan, & Griffith, 2002). In the school curriculum for students in grades 8-10 (aged 14-16 years), chapters on sexual and reproductive health have been incorporated (MoEN, 2013, 2015). Teachers, however, often find it challenging to talk about sex and feel uncomfortable or unconfident teaching sex education, as Tek's words reflect:

> When I was young, I never heard my parents, elder brothers or sisters talking about these issues. Neither has anyone in the society or neighbours talked about these issues with us. That is why if we talk about these issues, we fear that society will take it negatively. This is the reason that we teachers hesitate to talk about sexual health issues even when we know that it is an important topic to discuss with students. I know that is our weakness. (Tek, 35, male, KI)

Tek clearly portrays how social and cultural norms inhibit discussing SRH topics. Thus, it is not surprising "*adolescents learn very little about SRH from schools*," as reported below. Not only inadequate information, but also teachers' reluctance likely lead to misconceptions around SRH issues.

> They [adolescents] learn very little about it [SRH] from school. What I mean to say is, the teacher should explain and teach without hesitation when they are teaching about health. However, in some places, I have found that whenever teachers had to teach about health or bodily changes, they ask students to study themselves and they themselves would go out of the [class] room. (Nirmaya, 54, female, KI)

Teaching SRH, the feeling of embarrassment would often cause teachers to rush through the topic and provide little opportunity for discussion. KI Tirtha, aged 44, district focal person for ASRH program confirmed that, "*they [teachers] just read out the contents. There would be no discussion in the class and no checks on either the students understood the topic or not*." Further, Tek explained:

> While communicating sex and sex education, the teacher would not draw pictures of reproductive organs on the blackboard and neither would he/she describe the function of these organs. They teach such matter very lightly and, in a rush, but in other subjects' matter, they can talk for a whole day. Even being a teacher and knowing the matter in detail, we are not able to explain either to students nor are we able to talk in the family, which is a reality. (Tek, 35, male, KI)

In small communities, it is likely that "*one of the teacher's daughter, son or sister will be in the same class*," making subject even more challenging for teachers, and uncomfortable for both teachers and students. Students would be shy during the class and barely mention sex. It was comparatively easier for teachers who did not live locally, and were considered outsiders.

Health care providers also experienced the challenges of teaching SRH to a class of girls and boys. Krishna, a 44-year-old HCP who frequently took lessons on SRH in school, spoke about his experience as:

> I have experienced that when male reproductive organ or system are discussed female students do not participate in the class or if the female reproductive system is discussed male students do not participate. (Krishna, 44, male, HCP)

In their single-sex focus groups, male and female adolescents both talked about the challenges of "speaking openly" or having open discussions about SRH topics when "there are both male and female students in class." A male focus group discussed how embarrassed they were to speak openly when both sexes were present in class.

> There are both male and female students in the class. So, boys are embarrassed in the presence of girls and girls are embarrassed in the presence of boys. It is not possible to openly talk in front of everybody. (Male, FGD participant)

Nabita, a 17-year-old adolescent girl spoke of her experiences of talking about SRH topics in a mixed class.

> It was very odd when both boys are girls are taught in the same class. Sir [male teacher] would tell about the growth of breast and hair in body parts. He tells about the sexual relationship and use of a condom. We could not have two-way interaction with him in such topics. (Nabita, 17, female)

Nabita's statement, "*We could not have two -way interaction with him in such topics*" begs the question of adolescents' possible misconceptions about SRH when they are too uncomfortable to express their curiosity or clarify any confusions they may have.

Interestingly, while both male and female adolescents expressed their difficulty discussing SRH topics in a mixed class, HCP Krishna noted that when students did ask a question, it was usually only boys who did so: "*Girls are often shy and ask few questions*." It is likely that Krishna's experience of girls being too shy to speak was down to gender, given that KI Nilu, a female school teacher, experienced the converse. She found that girls were often comfortable discussing their SRH issues with her in school. Asked whether boys were similarly comfortable, she replied that

because only female adolescents approached her, she was not aware of boys' comfort or otherwise. She explained:

> I often tell adolescents in my school that I am your mother or sister in your school. You could openly talk to me. I am able to create this environment here, due to which adolescent girls come and share their issues with me. (Nilu, 42, female, KI)

Nilu's ability to "*create an environment*" suggests that by working to build rapport with her students they would feel safe, comfortable and empowered to seek support from her. Since sexual and reproductive health is not a topic for discussion with either family members or elders (Acharya et al., 2018), Nilu's strategy of letting her students know that a teacher or health professional can be regarded as "*a mother or sister*" is a social practice in Nepal to make the young person feel at ease and safe in talking about any issues or concerns.

Tek, a male teacher at a different school, also described, in his interview, how a female colleague used to provide SRH information to female students: "*We have a female teacher who is teaching population studies. She often collects female students time to time especially from grade 9 and 10 and shares about reproductive health and shares her experiences*." The teachers' feeling that SRH issues are more easily shared between female teacher and female adolescents suggests the importance of teaching and discussing SRH topics schools in single-sex situations only.

In interviews, some teachers, while acknowledging that teaching SRH was their responsibility, it suggested that this might be better done by HCPs who are working in adolescent-friendly health facilities, based on the assumption that SRH is a more comfortable topic for them. Key informant, Bir, a community leader in the Chepang community, also thought that HCPs were suitable persons to communicate SRH matters to the adolescents within their community, saying:

> It is very important to tell our [Chepang] adolescents about these matters [SRH]. We do not have people within our community who would talk to them about these issues. Our forefathers used to have 10-12 children, but it is not good to get pregnant or have children at an early age. So, HCP from these facilities [AFHS] needs to talk to them [adolescents] on these subjects. (Bir, 37, male, KI)

In their interviews, HCPs did not explicitly give responses indicating that they were comfortable talking about sex with adolescents. Recalling the social and cultural taboos pertaining to sex, it is likely that health care providers would also feel the same discomfort as teachers. However, HCP Ram words, "*I want to conduct intensive community and school level awareness program on ASRH*," suggest at least some willingness to more openly discuss SRH in school and community contexts.

While for most teachers, the difficulty of talking about sex with adolescents remained a challenge, most of the HCPs in this study noted that contemporary adolescents were more accepting of talking about their sexual health issues. Ram, for example, spoke of his experience of teaching SRH in school this way:

> When we demonstrate condom use, young people do not turn their faces rather enthusiastic to learn what we are teaching. It is a kind of change in the society. (Ram, 38, male, HCP)

HCP Krishna shared his similar experience of talking about SRH in a school:

> Regarding the adolescent, it is written more openly now. The contents cover all the topics on adolescence period and what should be done and what should not. Previously female students did not use to attend a class run by a male teacher, and male students did not attend a class run by female teachers if the topic was on sex and sex-related issues. However, the context is different now, and adolescents are more excited to learn and listen about sex, sexual health and reproduction and talks more openly. (Krishna, 44, male, HCP)

Both HCPs indicated that adolescents are now more open to learning about sex and sexual health issues in schools. It is part of the HCP job description to contribute to teaching health topics in schools (MoHN, 2017b). Therefore, HCPs such as Sara, who was 30 years-old, old taught such topics as menstruation, family planning, and HIV and STI in the school. This is an indication of some current effort on the part of HCPs to give adolescents SRH education. However, with only two-three teaching sessions per year allocated for HCPs from each facility to deliver these lessons – which can be on any health topic in any school – this apportioned time is inadequate for thorough-going coverage of SRH issues, despite any willingness and opportunity. There remains, therefore, a substantial gap in the sexual health information that adolescents can receive from this source. HCP Shiva spoke about the inadequacies of HCP involvement in sexual health education:

> We need to run classes in schools, but it is not confined to RH only. We need to take classes on nutrition, preventive diseases, sanitation etc. depending upon the need. There are 13 schools in this village and every school has adolescence aged children. However, there are only 1-2 schools that are focused on the adolescent health program. (Shiva, 39, male, HCP)

Study participants' responses clearly pointed to the *culture of silence* about sex that made it difficult for young people to be well-informed about their sexual health. Thus, the inhibitions around talking about sex were found to be contributory to adolescents' low rates of utilisation of AFHS.

6.2.2 Adolescents' sexual behaviour and morality

Sexual activity among unmarried adolescents in Nepal is considered as *Kharab Bani*, literally, "bad behaviour". The stigma and labelling associated with young people's sex-related behaviours was shown to affect adolescents' decisions to visit health facilities for SRH services. As HCP Krishna explained, "*Bad behaviours mean opposite-sex attraction. Since [adolescence] is the age of attraction or the condition, they may involve in unsafe sexual activities".* He was suggesting, firstly, that being sexually active outside of marriage in Nepal is not acceptable and, secondly, these societal norms themselves may lead to adolescents engaging in risky sexual behaviours. His explanation also suggests, moreover, that young people are not seeking SRH services because unsanctioned sexual behaviour is unacceptable in the society.

Furthermore, the research findings underline that the morality around unacceptable sexual behaviour is more harshly applied to female adolescents. Falling in love, for example, was often considered *BIKRITI* – or "bad influence". When participants mentioned this, they were mostly referring to the behaviour of young women, as though they were the initiators of such bad behaviour which then spread throughout the community. Not once did any participant give an example of a young man falling in love or being responsible for any other behaviours deemed socially unacceptable. This notion was articulated by Lalit, a KI from from VDC 5, who was also an HFOMC member:

> I mean it will be bad if their character is wrong. For instance, if a girl involves in a sexual relationship and gets pregnant and could not get the baby aborted, her future will be ruined. Even if she tells about it to the boy whom she had a relation, he might not accept her, or it could be that she had a relationship with several boys. (Lalit, 68, male, KI)

School teacher Tek, shared a similar view:

> With such behaviours, there might be BIKRITI. Let's say if they [boy and girl] are in love and get married at the age of 15 years or in case they do not get married and boy would elope after making the girl pregnant. The girl might risk her life in pregnancy. (Tek, 35, male, KI)

Both responses suggest that the implications of pregnancy are far worse for the girl than the boy. While both have unacceptably engaged in premarital sex, it is the girl who must face the consequences, her "*future being ruined*" because of her *BIKRITI*. These words also highlight the gendered attitudes of Nepalese society, especially the implication that *"it could be that she had a relationship with several boys,"* which clearly places the blame for *bad behaviour* on the girl in question. Then there is the honour of the family that girls must uphold, by staying virgins and maintaining chastity until marriage. Yuval-Davis (1997), in her book *Gender and Nation* that for

much of the past, and in many societies, women have had to bear the honour of their family and community, while at the same time the character of boys, and any consequences of their sexual behaviour is often ignored. This remains true of Nepal's male-dominated society which tends not to accord any blame to males for sexual misdemeanours. With pregnancy, a woman's sexual activity becomes public knowledge; the stigma for young, unmarried women is such that should a girl miss her period due to a medical or other physiological cause, she frequently faces the suspicion that she could be pregnant. Krishna described this stigmatisation:

> Sometimes if menstruation stops after menarche, there are rumours that the young girl is pregnant. In some cases, the adolescent girl might not have their periods after menarche for few months and start after few months. Young girls might not know that this kind of problem is due to hormones. (Krishna, 44, male, HCP)

Responses from some of the adolescents and KIs suggest that religious strictures and cultural obligations surrounding women's sexuality are the responsibility of women. In a FGD at the district headquarters, some of the male adolescents mentioned that women who have sex before marriage are considered *Naitik hisab le patit mahila* which literally translates as "morally degenerated females". KI Nath, a religious leader, stated that everyone, including adolescents, should be guided by the moral compass of religion.

> Religion has made instructions for everyone including adolescents as well as for us. It is the same instruction; there are no separate ones for adolescents. There are instructions on what to do and what not to do. (Nath, 61, male, KI)

Upon probing the religious musts and must-nots for adolescents, Nath said that premarital sexual activity for females will accrue "sin" and punishment in the after-life. Further musts include *"girls should be married off as virgins which are termed as "*Kanyadan*" which means Gift of a Maiden." Kanya* means virgin girl and *Daan* means giving away. In Hindu culture, the ritual of *Kanyadan* has deep religious symbolism. In this ritual a virgin daughter (bride) is offered to the groom in the wedding ceremony as a gift; parents of the bride are then released of all their earthly sins and from the cycle of birth, death and rebirth (Kapoor, Nagpal, & Maggu, 2017). Many scholars have argued this ritual is a symbol of patriarchal society which objectifies the body of women (Salam, 2011). To me, this is also echoed in the prescriptions for how females should behave in society and why they bear the responsibility familial and social honour.

Virginity has high value in Nepalese society, where Hinduism is the dominant religion. When such rigid teachings underpin the cultural and social expectations, premarital sexual activity is bound to have psychological consequences for adolescents.. The responsibility for honour falling on women may possibly be explained as a form of suppression of female sexuality (Baumeister

& Twenge, 2002; Bay-Cheng & Lewis, 2006; Tolman, 1994). According to some KIs, the responsibility of parents and the community is to ensure female adolescents keep to the moral code for sexual activity. KI Tek noted that "if *we are unable to give such [moral] education, there might be such results [as BIKRITI]*. Lalit, a 68-year-old male KI, reiterated the role of the family with his words, *"in case of developing an appropriate character; it is something to be learnt from the family*," suggesting that a female's sexual behaviour requires moral teaching, because the family's honour is at stake. The onus on adolescent girls to protect their families from the shame and blame that any sexual activity invites is highly likely to discourage them from discussing matters of SRH and/or from seeking support from local health care facilities.

It was clear from some HCP responses that the pressure on adolescent girls, brought about by social expectations and the threat of stigma should they seek SRH services, is a barrier to their accessing AFHS. As Krishna's example, below, reflects, not only will the girl herself suffer, but she will bring disgrace to her family:

> Our society is not very open yet and does not often accept everything. For example, if a girl is seen taking the condom with her from the health facility, she will have hard times. If anyone in the community knows that she is the daughter of so and so and had taken a condom, they will start backbiting, and it will be difficult for her. (Krishna, 44, male, HCP)

6.3 Theme 2: Health facility factors

Adolescents' utilisation of SRH services did not solely depend on the renaming of public health facilities to incorporate the "adolescent-friendly" modifier. This study identified several factors associated with health facility utilisation such as distance to the health facility, costs associated with health services, staff shortages and HCP workloads.

6.3.1 Distance to the health facility

Data collected from observations of the study sites, and from interviews and focus group discussions with adolescents, health care providers and key informants clearly revealed that the location of, and physical distance to health facilities is a major barrier to adolescents accessing SRH. Most of the sites were not centrally located to all wards of their respective catchment areas.

The study found that seven out of the 26 facilities were located up to three hours' walk for people from some VDC communities. Twenty of 26 AFHS were located in hilly areas accessed via

unpaved muddy roads from district headquarters through difficult terrain which, during rainy seasons was impassable.

Figure 6. 1 Road to VDC 6 travelled by motorbike

Figure 6. 2 Road to HF from one ward in VDC 3

Figures 6.1 and 6.2 show the tracks that people typically had to walk to reach the AFHS. During the wet season footpaths would be damaged; even during the dry season there was no motorised transport. Government and NGO personnel using four-wheel drive vehicles to deliver essential medical supplies and services, and ambulances carrying sick or injured people, were the only ones travelling to some of the VDCs. While public transportation was available in some wards it was not regular, with only one-three buses running per day. During fieldwork, I was unable to travel to more remote VDCs in the rainy season because of the poor road conditions.

Almost all of the study's adolescent participants indicated that walking, the normal way of getting to the health facility was tiring, exhausting and time-consuming. One adolescent boy mentioned an alternative to accessing the adolescent-friendly health facility:

> It takes one hour for me to reach my health facility from my village. There is a private pharmacy near my home, so I go there. (Male, FGD participant)

In his interview, Shiva, an HCP at the VDC 6 health facility, which is an AFHS, described the situation for some adolescents in the VDC 6 catchment:

> This health facility is accessible to only wards 1, 2, 3 and 4. We cannot reach adolescents of other wards from this HF. Most of them from other wards go to VDC 2 health facility. Those who have resources go to Kathmandu. (Shiva, 39, male, HCP)

On the day I visited AFHS in VDC 6 to interview Shiva, I met a pregnant adolescent who had come for her ANC check-up. She told me she had made the trip by truck from another ward as there was no public transport from her ward, two hours away. The challenge of getting to the health facility was the same for all age groups in these VDC.

While distance from home was a key barrier to most of the adolescents, conversely, some mentioned accessing SRH services from their local facility because it was close to their home or school. For example, Muna, a 19-year-old girl, and Sam, a 15-year-old boy, both from VDC 1, said they would visit the health facility because of its proximity. VDC 1's facility was located near the highway and public transport was available throughout the year. The location of adolescent-friendly health services within easy physical distance is, then, a likely factor in adolescents' utilisation of the services.

6.3.2 Cost of health services

This study found that cost was never an issue adolescent health service access, since all primary health care services for Nepal's population are free of cost, irrespective of age, sex, caste, ethnicity, or geographic region (MoHN, 2014b). SRH services, as part of primary health care, include health check consultations, essential drug list medicines, and temporary contraceptives such as condoms, contraceptive pills and injections (MoHN, 2014b). Although there is no cost, both HCP and adolescents indicated that government supplies would last only a few months, and for the rest of the year SRH supplies and medicines were limited. When facilities ran out of these supplies, adolescents would have to purchase them from private pharmacies. HCP Mita noted the supply problem:

> Whenever we have supply, we give it to them [adolescents], but when we do not have supply, we must ask them to buy, and some students do not have money, and that will be a problem for them. Also, those which are on the list [essential medicine list] they do not need to buy but those which are not on the list they need to buy. (Mita, 32, female, HCP)

Muna, a 19-year-old female confirmed that, *"at the moment [February] …they do not give us any other medicine except for the fever. We need to buy all other medicines outside".* Although Mita and Muna were both referring to essential drugs, and not necessarily SRH supplies such as contraceptives, the supply shortages have implications for SRH services. Reliable availablity of essential medicines would encourage young people to access health facilities and in doing so, also seek SRH services. According to Nepal's DoHS (2016), 14% of contraceptives and 34% of essential drugs remain out-of-stock in health facilities throughout the country, a situation that may discourage adolescents from visiting health facilities.

6.3.3 Staff shortages and overburdened health care providers

Only two of 26 AFHS were found to have a full complement health care staff on the days of my visits. Moreover, there was no provision for dedicated adolescent HCPs. Available staff who were auxiliary health workers and nurse midwives had been trained in ASRH, which they were expected to deliver along with numerous other health facility tasks. Many HCPs stated they were overtaxed with responsibilities, including administrative work and consequently, they had little time for adolescent consultations. When I asked HCPs why it was difficult to provide services to adolescents, one responded:

> We have a huge workload here at VDC 1 PHC. Even if I want to give services to adolescent, I cannot do that. Several training comes up, and we need to participate in that as well. There are clients coming for medical abortion who needs to be taken care of; many come for [contraceptive] implant insertion which needs to be done. Similarly, clients come for IUCD and family planning counselling, so I have to do all these. There are also clients coming for ANC check-up and delivery. So, there is a huge workload and [I] cannot provide services for adolescents only. (Sara, 30, female, HCP)

In a health facility in VDC 1 which was almost fully staffed, new doctors were assigned to the outpatient department, and ASRH-trained HCPs were allocated other responsibilities. Ram, an HCP in that facility outlined the human resources problems there:

> We have doctors, but they are not trained on adolescent-friendly services. They are more focused on curative services but do not have enough knowledge of preventive and promotive programs. So, although they are there, they need to have the training. We are two people trained on adolescent-friendly services, but these days we are conducting community programs and outreach clinics. That is why I mean to say that there is need of training [on adolescent health] for the human resources we have in our health facility. (Ram, 38, male, HCP)

Ram was clearly frustrated when he described the AFSH staffing situation. His frustration was due to facility's arrangements whereby untrained HCPs provided consultation services to patients, including adolescents. Ram's and Sara's narrations clearly suggest that service provision would benefit if ASRH-trained HCPs would provide services to adolescents. Some adolescents also indicated that busy HCPs and their (necessarily, from the HCP point-of-view) hurried service they received did not encourage them to go to the AFHS.

> They are available every time I go there. However, they are normally very busy and do not have time to talk to us unless we are ill. (Mira, 15, female)

In Nepal, the upgrading of *sub-health posts* to *health posts* has been in place since 2011. Health posts have a greater burden of health care responsibilities than *sub-health posts*. However, the deputation of staff to upgraded facilities has not proceeded along with it (DoHS, 2016), with the

result that HCPs in formerly sub-health posts are overburdened with the range of duties now required.

6.4 Theme 3: Lack of privacy and confidentiality

Similarly, with the upgrading of health facilities, the infrastructure of most of them did not change to accommodate the increased responsibilities of the sub-health posts. According to the responses across all study participant groups, the experience of inadequate privacy and confidentiality at health facilities was one of the most important reasons for adolescents' reluctance to seek SRH services from AFHS. Adolescents expressed that the lack of amenity in the built environment of the facility gave them no privacy. They cited the cramped facilities and no separate consultation room, which left them exposed to other patients and people from their local community when they went to seek SRH services, as two adolescents describe:

> There is only one check-up room. Sometimes males enter into the room when we are talking to the HCP. Or male may be present when a female's check-up is taking place or female may enter when male check-up is happening. This makes very uneasy to share the problem. (Mira, 15, female)

> The health facility is open from everywhere. If there are some issues with private body parts [external reproductive body parts], we feel shame to show to HCP because other people around might see them. (Male, FGD participant)

Above, both adolescents clearly express their feelings about the uncomfortable lack of privacy they experienced when visiting the facility. Then there is the fear that similar-age members of the opposite sex will be present when they attend. This was especially a concern for adolescent girls; for example, Nita, aged 16, said, "*I was concerned that there might be the presence of boys or male colleagues of my school in the health facility who would later tease me or talk about me*." The fear of being seen and overheard at the SRH facility, in a social context where female sexual activity is stigmatised and labelled, as described earlier, was found to strongly influence adolescent girls' decisions about going there.

The adolescents' assessments of the effect of the inadequate infrastructure in the health facilities, which meant that all patients were necessarily seen in the same room, was confirmed by HCPs at almost all of the study sites. In VDC 3, for example:

> We have only four rooms and we have to manage with whatever we have. We have to make other patients wait for some time and take them to another room and provide services. Whenever they [adolescents] come we have to send other clients and then either see them here or take them to that [pointing to antenatal care room] room to maintain privacy. (Kiran, 37, female, HCP)

From my observation of VDC 3, I saw that the consultation area was in the main lobby, which

was also a waiting area. Although Kiran attempted to improvise the space available, for example, by asking adults if they would go outside until she had finished her consultation with an adolescent, or use the store room if the antenatal room was busy, this did not provide adequate visual or auditory privacy for the adolescents.

Perceived lack of confidentiality compounded the lack of privacy in the health facility, posing an additional barrier to adolescents accessing SRH services. Some of the adolescents had experienced HCPs breaking their confidentiality. Nabita had visited the VDC 1 health facility because she was experiencing genital itching. She later discovered, to her embarrassment, that some people in her community knew the purpose of her visit, as she shared:

> "If only my mom and I come and tell the issue to the doctor, how did that go outside? We didn't tell it to anyone outside. Nobody will tell these issues themselves due to fear of losing prestige." (Nabita, 17, female)

Nabita's words indicate that her confidentiality was broken by the HCP who provided the service at the facility. Her sense of "losing prestige" means a subsequent fall in social status when a person, especially a woman, is known to have a medical complaint that could, even remotely, be linked to a sexual or reproductive health problem. Such is the stigma that this "news" about the young woman could spoil the reputation of her whole family. Nabita's symptoms would be commonly assumed to be the result of sexual intercourse. It is unsurprising that after Nabita's confidentiality was breached in this way, she decided it was "*not possible to come and freely seek the SRH services*."

Confidentiality was also equally concerning for male adolescents. Indra, a 19-year-old male adolescent said of seeking help from the AFHS that "*It is a matter of shyness in public and parents get embarrassed. Moreover, in total, all society knows this information and makes gossip*."

Other adolescents like 16-year-old Nita, had witnessed an HCP breaking another patient's confidentiality in the VDC 6 facility.

> I heard when the private [SRH] issues was shared outside. My aunt is a best friend of the one of the HCP. I heard this HCP talking to my aunt who is not a HCP. Even if they have some close friends, they should not be sharing the private matter of another person in the health facility. Such type of subject matter usually spread fast in the community from one to another. (Nita, 16, female)

The implications – personal embarrassment and family shame – of having their information disseminated by the HCP that they consult at the AFHS are severe for adolescents, and certainly represent a barrier to their seeking further access. Confidentiality is, however, not only a

concern for adolescents, but also for married adult women who may wish to have procedures which are not acceptable to the community, such as abortion. Sita is a 19-year-old married adolescent who recounted the following experience she had at the health facility:

> I was in the HF one day and a lady of my community came to do pregnancy test. The HCP did the urine test and said loudly in front of everybody [other patients] "you have got baby in your stomach." She was a woman who already had five children and was looking to having an abortion. This lady was sad and went out of the HF without speaking. She came back to nurse and said something privately. The nurse started screaming at her saying, "Why should you abort the baby, you should deliver." She was saying all this in front of everybody and this lady was sad and ashamed. (Sita, 19, married female)

The experiences of Nabita, Nita, and Sita clearly show that these young people do not trust that their information will be kept confidential by health care providers. This was acknowledged by some HCPs themselves. Kiran, a female HCP thought that lack of trust might stop adolescents from coming for SRH care, *"because they are not confident and might have doubt that when they come here for services, their issues are not kept confidential."* Other HCPs, such as Shyam, in VDC 2, was quite innovative in ensuring confidentiality. He encouraged adolescents to call him, even after working hours, for any SRH services on SRH, and he would not ask for any identifying information. He further stated:

> I provide information and counselling services through cell phone at any time, for instance once I got a phone call at midnight. The adolescent wanted to learn about implication for unsafe sex. While providing services I do not ask adolescents name rather only their problem and age. (Shyam, 37, male, HCP)

Shyam felt it was important to keep the identity of the adolescent anonymous out of respect for their privacy. However, this was a rare recognition among HCPs that adolescents feared that their visit to the AFHS would become known to others. In Nepal, the right to privacy and confidentiality are stated among other essential human rights pertaining to sexual and reproductive health; their importance is also addressed during ASRH training (NHTC, 2015). Nevertheless, along with the lack of privacy and breaches of confidentiality at the health facility, the fear of disclosure is one of the major barriers for adolescents to confidently seek SRH services.

6.5 Theme 4: Fear of disclosure

The staff members at most of the health facilities live in the local community and, therefore, they often have close connections, either socially or through kinship, to the adolescents in the community. These social relationships are beneficial in several ways – for social harmony,

cohesion, support and welfare. However, for adolescents wanting access SRH services these relationships represent barriers. Adolescents such as Indra, in VDC 5, explained the trouble that a visit to the AFHS might bring:

> Most HCPs are socially known person in the community, and they know about our home and family. Moreover, we are afraid that they might share with our parents and our parents will scold us if they know we go to the health facilities. (Indra, 19, male)

Indra's words indicate he was aware of the implications if knowledge of the reason for his visit reached his parents from the HCP. His fear of disclosure was understandable; it was a common theme in the responses of almost all the adolescents in interviews and focus group discussions. Health care providers and key informants, too, acknowledged that adolescents' fear of their parents finding out, and also that this could be a barrier to utilising the local health facility.

> Because I am a local dweller of this community and have been living here for many years, they [adolescents] might be worried about their confidentiality. That is why they might always look for new places to go for health services. If it would have been an unknown health care provider, they might share their issues. (Ram, 38, male, HCP)

Ram also mentioned that adolescents would often go to other villages or to Kathmandu for SRH services rather than risk visiting a nearby health facility. Mita, who works in another VDC, echoed Ram's words, noting that barely any adolescents came to the health facility where she worked because, she suggested, she belonged to that same community. Often, adolescents went far from home for SRH care. Raj, a 19-year-old male adolescent from the same VDC confirmed that *"it is comfortable seeking services from Kathmandu [which is 2.5 hours from his residence] as nobody knows him there*." Raj was fortunate in that he could go to the capital city for ASRH, but this is not the case for many economically disadvantaged adolescents who live in remote areas with no transportation and few opportunities.

A key informant, Tek clearly suggests that adolescents' fear of disclosure was warranted.

> He [HCP] will start talking about the adolescent saying that this person's son or daughter is not yet married but is already asking for contraceptives. For instance, on my visit the HF, they [HCPs] started telling me that the girl or the boy of your school comes to visit me for so and so services. Meaning, the HCP is not yet able to take the practices [SRH services to adolescents] as normal. Being a service provider his/her responsibility is to provide service, rather he/she is disclosing information that affects adolescents negatively. (Tek, 35, male, KI)

Tek also raises another important issue – the quality and/or adequacy of the training that health care workers receive; perhaps orientation should place more emphasis on their responsibility to

provide health care services without such negative effects as disclosure of confidential information.

Nita, aged 16, took the issue of disclosure further still. She suggested that even if the details of adolescents' visits weren't disclosed to parents or the community, the reasons for seeking SRH services *"need to be kept a secret between the health care providers"* themselves. Nita was of the opinion that it was a common practice of the health workers to *"normally discuss"* adolescents' consultations among themselves, and wished that they *"would not do that and keep [these] issues confidential."*

6.6 Theme 5: Health care provider-related factors

6.6.1 Age and gender issues

The study found that the age and gender of the HCP is often a barrier SRH facility utilisation for adolescents. Adolescents preferred that the health worker is younger or closer to their age and felt that HCPs were much older than they were who would treat them like children. Adolescents held the view that HCPs of older age do not understand their SRH issues.

> Health workers are of the age of the mother. We do not know a lot of things [SRH]. They should understand the issues and give proper advice, but they start to give a lecture. (Male, FGD participant)

Adolescents are perhaps more comfortable with younger HCPs, who may better understand ASRH, and also be less judgmental of their problems, having been through similar experiences more recently than older health workers, as suggested by 19-year-old Indra:

> I have one of my friends who has completed a course on health. And he belongs to my age and is working in the health facility. So, I ask him if I have any query. He can understand the issue of my age. He knows it all, so it is comfortable seeking advice from him. It is easy to talk to people of your age. (Indra, 19, male)

It is likely that Indra's being friends with the HCP played a role. Nonetheless, his words "*it is easy to talk to people of your age*" clearly suggests that the narrower age gap between the practitioner and adolescent client was beneficial.

Interestingly, older HCPs perceived that adolescents were not comfortable with them, and that, often, they were regarded as moral guardians by adolescents, who would therefore hesitate to share their SRH issues, as Krishna suggested:

> They [adolescents] sees HCP [of more than 30 years age difference] as guardian to them, so they cannot share their problems openly. (Krishna, 44, male, HCP)

In HCP MIta's recounting, she apparently saw herself as a guardian, rather than as a supportive professional:

> The unmarried adolescent came to the abortion service. Although I gave her the service and sent her back, I scolded her a lot; I scolded her as a guardian as we are also guardian for these young people. (Mita, 32, female, HCP)

In addition to age, the gender of the HCP causes both male and female adolescents their apprehension about being treated by a health worker of the opposite sex, as adolescents Sam and Mira expressed:

> It is uncomfortable for male adolescents to share a problem with female staffs and female adolescents with male staffs. (Mira, 15, female)

> It will be difficult to show [genitals] when there is the presence of nurses [female staff]. The male HCP should be present there. (Sam, 15, male)

In the experience of HCPs that also indicated the reluctance of adolescents to consult with health care provider of the opposite sex, even to talk about other, non-SRH issues. Female HCP Kiran said that although she made no distinction between boys or girls as clients who needed services, she noted that adolescent boys do not come to seek SRH services in her health facility, perhaps because they were not confident that she could help them:

> There is no difference in how I provide services to males. I have similar behaviour for both male and female. But male adolescents hesitate, and maybe they wonder how they could tell their SRH issues to me. (Kiran, 37, female, HCP)

Similarly, Mita, a female HCP of VDC 5 shared that it was only female adolescents who would seek services from her. She stated:

> Boys mostly stay away from us [female HCP], but many girls come for services. Even if boys come, we need to give services because they are adolescents, we cannot stay back thinking only male AHW will provide them with the services, so we give services when they come. However, it is very easy for girls, to share if they have any problems at schools or like problems they face at school. (Mita, 32, female, HCP)

Often, Ram explained, adolescent girls will only seek services from female staff, even for simple, or non-SRH issues, he described his way of dealing with this dilemma:

> If female adolescents have any issue, they often don't tell me when I am in clinic. They would tell it to my wife and then my wife would ask me what to do. I would then give the advice accordingly. (Ram, 38, male, HCP)

Ram perceived that their discomfort reflected a communication barrier that required a "mediator", whom he found in his wife, a lay-assistant at a local private pharmacy. However, while Nepali adolescents' discomfort with HCPs of the opposite sex is likely due to their socialisation along strict gender lines, which may influence how they felt about sharing their SRH concerns, the preference for consulting health care practitioners of the same sex is not confined to adolescents. Literature from various cultural settings shows that males and females in other age groups also prefer to see same-gender medical practitioners, particularly SRH-related issues (Ghimire, Smith, & van Teijlingen, 2011; Onyemocho et al., 2014; Umar, Mandalazi, Jere, & Muula, 2013; Yanikkerem, Özdemir, Bingol, Tatar, & Karadeniz, 2009). However, only a few of these studies focus on male patients' gender preference in health care provision.

These findings from this study suggest that the age and gender of health care providers available at the local facility determined, to a large extent, whether adolescents sought health care from adolescent-friendly health facilities.

6.6.2 Attitude towards adolescents

Adolescent participants in this research mentioned that the attitude of the HCP was an important factor in their decisions to access SRH services from AFHS. Previously in the literature unprofessional HCP attitudes have been identified as a significant characteristic affecting adolescents' SRH service utilisation (Kennedy et al., 2013; Tilahun, Mengistie, Egata, & Reda, 2012). This research found that some adolescents had experienced providers responding with rudeness or anger when they came for health care. For example, Sam, 15-year-old male adolescent noted:

> When someone [young person] comes to meet the patient admitted here [health facility] they shout and get angry. They would tell that "You do not have any work, so you are roaming around the health facility". (Sam, 15, male)

Sam expressed his dissatisfaction with this unprofessional attitude, which did not meet his expectation that "*they [HCP] should have asked if we have come here to visit our patients or have come with some other problems".* There was heated discussion in the male adolescents' focus group when boys shared similar experiences. Asked about how they were treated when they visited the health facility, the adolescents raised their voices and spoke of the "condescending attitudes" of the HCPs which had often discouraged them from going to the AFHS. Speaking of his experiences, Indra, 19, from VDC 5, stated:

> HF do not provide us with contraceptives such as condom when we are in need. Instead, they [HCP] show attitude, anger and speak to us harshly when we request condoms which makes it difficult for us to access SRH services. (Indra, 19, male)

Indra also recounted his friend's experience:

> One of my friends who had returned after two years of his employment abroad visited HF frequently for few days to seek condom; he experiences that HCP was irritated and one day gave the entire box of the condom and asked not to come every day. (Indra, 19, male)

Sam's and Indra's words suggest that the health workers are often rude and lack sensitivity to adolescents' SRH needs, which caused these boys embarrassment and shame and to feel unwelcome at the health facility. These attitudes did not encourage them to seek help from the AFHS.

Unmarried adolescent girls complained of barely adequate family planning services. Mira, aged 16, reported that "*HCPs would say family planning is of no use to unmarried adolescents and they should not use it before marriage"*. This attitude on the part of the HCP is another instance of that prevalent in Nepalese society that sexual activity before marriage is something that should not happen. Negative attitudes towards unmarried adolescents seeking contraception, for example, were expressed by both male and female HCPs. Ram explained that he made a clear distinction between how he treated married versus unmarried adolescents. Although he did not "know why" he felt that adolescents "should not use family planning before marriage", he offers that hormonal methods might have "side effects" for unmarried young people:

> There is some difference on how I deal with married and unmarried adolescents. If married adolescents come, I could easily provide counselling services and tell about family planning services. But if unmarried adolescent comes, I would myself feel like why this adolescent has come here, and I wish this person would not use hormonal contraceptives as it might have side effects. I do not know why but I feel they should not use family planning before marriage. (Ram, 38, male, HCP)

Similarly, Sara offered that unmarried adolescents were ignorant of the possible implications of engaging in sexual activity:

> Unmarried adolescents do not understand. They are young and have no idea of what could happen when they do this or that. They do so many things in hidden from the parents. (Sara, 30, female, HCP)

Her conviction that they "do not understand," the way she spoke, and her facial expression all indicated her disapproval of premarital sex, but also that adolescents could not be trusted, concealing "so many things from the parents".

A few HCP, such as Krishna, recognised that it is normal for adolescents to experience sexually attraction to others as a result of the hormonal changes of puberty. This acknowledgement, however, was overridden by his belief that it was inappropriate for adolescents to have premarital sex. Krishna further believed that providing SRH information and education to adolescents could encourage young people to abstain from sexual activity until they married. Many of the HCP agreed with this view, and that it reinforced the need to give adolescents SRH information – provided that the messages sent by the information were in line with revailing social attitudes. Mita, for example, did not want the "wrong message" that that sex before marriage was acceptable to be conveyed:

> Although we deliver SRH services, we need to be conscious not to give wrong message to adolescents. Sex can be safe by using condom. While sharing this information, I tell adolescents that practicing safe sex does not mean to start having sex at an early age. (Mita, 32, female, HCP)

In summary, these findings for how HCP attitudes might influence adolescents using AFHS indicated that their beliefs about appropriate sexual behaviour for adolescents often resulted in judgemental, condescending, and even angry reactions to adolescents seeking health care. Moral judgements and personal beliefs reflecting social norms were found to affect the professional responsibility of HCPs to provide services that would, in fact, protect and support adolescents' sexual and reproductive well-being. These attitudes largely demotivated adolescents from seeking SRH services.

6.6.3 Health care providers' misunderstandings about AFHS

It appeared from the data obtained that the HCPs did not adequately understand the operation of adolescent-friendly health services. In interviews and focus groups they revealed their lack of awareness about the procedures and requirements of providing health services to adolescents. Yet, all of the HCPs interviewed had attended ASRH training provided by Nepal's Ministry of Health and, therefore, it could be expected that they had been given specific ASRH knowledge.

Out of 26 AFHS, only four had the AFS logo board with opening times displayed. It was observed that in a few, the AFS board was stored, and others didn't have one in the facility. VDC 1 was among those whose AFS board on display. When questioned about this, Sara, a female HW in that facility said:

> We do not have one [AFS board]. I do not have any idea if someone will give us the AFS board or we should make one. I have no information about it. (Sara, 30, female, HCP)

Some HCPs did not know whether the AFHS program was an ongoing or a one-time program, or if it was an NGO-supported program. Sarala, a health worker in VDC 5 mentioned that she had not made any report to the DHO in during the last three years because she was confused about the program's ownership by either the government or an NGO:

> This program is lost for almost three years in our health facility. I do not know if it is a Government of Nepal program or it was supported by some NGO/INGO [temporary program]. Or if that particular NGO/INGO phased out. We are neither asked for any report nor are we providing it to the district. (Sarala, 45, female, HCP)

That HCPs were not clear about the continuity of the adolescent health program, following their initial orientation to ASRH three years before, suggests it was likely that their poor understanding was due to an absence of any regular follow-up training or reporting since then.

Misconceptions about the program could be also a result of frequent, but not unusual, health facility staff transfers either to facilities in the same district or elsewhere in the country (Ghimire, Kumal, Mahato, & Gupta, 2013). As previously described, no usual formal handover practice exists, which can result in confusion over responsibility for adolescent-friendly health services at the new place of appointment. For example, Shiva, already working in an AFHS, was transferred to another AFHS facility Despite his awareness of the ASRH role, because there was no formal handover, Shiva stated that he did not know if he should be accountable for AFHS in his new position. Interestingly, this situation seems to be peculiar to Nepal, where HCPs apparently feel that they need to be re-trained for each new place of employment, even when they are already relevantly trained. The result in Shiva's case was that unsure of his responsibility for AFHS. Such circumstances can affect how HCPs understand their roles and responsibilities in AFHS which, in turn, may influence their treatment of adolescents who come to seek SRH services.

The findings from interviews with HCPs suggest that the ASRH program orientation as it stands is inadequate to ensuring continuity of the AFS operation in all health facilities. In addition, regular monitoring and supervision by district level authorities might help to ensure the program's smooth running and decrease the apparent unpreparedness of health workers following transfers. This could diminish the negative impacts on adolescent-friendly service provision, and thus, this barrier to service utilisation.

6.7 Theme 6: The stigmatisation of adolescent-friendly health services

Some of the HCP acknowledged that they were seeing fewer adolescents in their health facilities compared to the number that accessed the AFHS following the program's initiation. Ram, in VDC 1, noted:

> When we started adolescent health program, initially there were some adolescents coming. All the services were provided from one point, and nobody would know and care about them. But when we established a separate room, there is a negligible number of adolescents visiting us. (Ram, 38, male, HCP)

Ram's words suggested that the number of adolescent visits had decreased since the health facility began providing ASRH services from a room specifically allocated to adolescents. Nepal's ASRH program guidelines indicate a separate room or area separated by a curtain for privacy during adolescent consultations (MoHN, 2011b). Asked to elaborate, Ram explained that since they did not have a separate counselling room in the health facility, when an adolescent came for SRH services, they would be taken to a separate room. This meant that the adolescent was moved from the place of initial consultation (a shared room) and often, there would be other patients waiting. I observed the rooms where the consultation was to be continued. One was immediately inside the main consultation room and, if that was in use, the second option was the maternal and child health care room, the third room along from the main consultation room. In these circumstances, adolescents felt exposed as they were walked by the HCP from one room to another. Given the stigma associated with adolescent sexual relationships, their being exposed to view in this way may have contributed to the decrease in the number of adolescents visiting the AFHS.

The explanation offered by Sara, an HCP at the same facility affirmed that adolescents may fear their visit – regardless of its purpose – becoming public knowledge. While the purpose of the AFHS logo board was to promote the availability of the service, instead it apparently only reinforced the social stigma attached to adolescent sex:

> I feel that adolescents are scared to receive services if there is an AFS board as the board specifically highlights services for adolescents. Adolescents might fear that people will talk about them thinking that they have some issue [SRH] that is serious and thus they have come to the adolescent-friendly clinic. (Sara, 30, female, HCP)

Some of the study's key informants believed that AFHS has encouraged sexual activity among unmarried adolescents because of the promotion of its availability:

> Until some point it is good, but it [ASRH services] has also brought a lot of BIKRITI [social degradation]. For those who have mature age, it is good for them to use contraceptives and be safe, but this understanding has even freed those who have not reached mature age [adolescents]. (Shanti, 35, female, KI)

> AFHS brings BIKRITI [Social degradation]. If unmarried adolescents are sexually active, they can get contraceptive services and have pleasure which is a BIKRITI. It is BIKRITI because they start being sexually activities early in their life. It is only acceptable for married adolescents. (Nath, 61, male, KI)

Further, the words of these community members suggested that providing unmarried adolescents with access to contraceptive services that should be available only to married adolescents was not acceptable in Nepalese society.

The social unacceptability of adolescent sex and the stigma of being seen to seek ASRH service was dramatically expressed by Nabita, aged 17:

> One of my friends asked me to buy the [pregnancy] test kit for her. Going to this facility with logo is problematic for her, and also for me. So, I could not help her. Later her boyfriend got it for her from another village, it came out positive, and she had to seek abortion from out of the village. (Nabita,17, female)

The study's findings from the data collected suggest that AFHS should be provided in a way that does not stigmatise adolescents, and thus, help to remove what seems a most challenging barrier to their seeking support for their SRH well-being. One strategy suggested by KI Bishnu, a 52-year old key stakeholder at the national level, was to make pregnancy testing kits available free of cost to young women, perhaps in the same way that condoms are provided, in a box outside health facilities so they could be picked up without consultation with the health workers. Bishnu believed that providing the test kits to adolescents would also decrease the number of steps to counselling, since the request for a pregnancy test initially alerts the HCP to the occurrence of sexual activity that leaves vulnerable adolescents open to stigmatisation.

6.8 Reflection and Summary

This chapter presented the findings on the barriers faced by adolescents in accessing SRH services from AFHS. Socio-cultural norms and values, as expressed in the attitudes of health care providers and community key informants, were identified as prominent determinants of adolescents' utilisation of AFHS in the culturally conservative society of rural Nepal. The taboo on communication about sex within the family, at school, and in the community impacts adolescents' knowledge about their sexual and reproductive health. Although the efforts of Nepal's government to multiply adolescent-friendly health services throughout the country to

increase adolescents' access to SRH services are commendable, there are a range of factors at the health facility and societal levels that act as barriers to their access.

Dhading, the district in which the study was conducted, has geographical challenges to accessing health facilities for all age groups. But it was the attitudes and behaviours of health care providers towards adolescents, driven by deeply-rooted conservative social norms that produced negative experiences for adolescents seeking SRH health care, especially pertaining to patient confidentiality, and which largely explained their poor utilisation of AFHS in the district. The infrastructure of the health facilities was also found to preclude the assurance of privacy and confidentiality and contributed to adolescents' fear of seeking health care at their local health facilities. Issues of privacy around adolescents' visits to the AFHS are also characteristic of a close-knit communities in Nepal, which often ascribe less value to the private life of an individual than to the standing of the family and community.

Traditional gender roles expressed in different standards for male and female adolescents in relation to sexual behaviour were a significant factor for adolescent girls' AFHS utilisation. While premarital sexual activity was not acceptable for either sex, moral opprobrium was reserved for females. Female virginity until marriage is highly valued, as encapsulated in the patriarchal concept of "Kanyadan", which is very important to the family of the bride. It was mentioned not only by the religious elder, but also by a few male adolescents. Although this was not an issue raised by health care providers, the religious leader believed that imposing the scriptural teachings on unmarried adolescent girls would prevent their engaging in sexual activity. The boys, on the other hand, were not following their own rationale, but rather the tradition that was most convenient for them.

Inadequate knowledge about the adolescent sexual health program could be explained by insufficient training and lack of regular monitoring and follow-up. This highlighted the need for the government to invest in building the capacity of HCPs to provide SRH services more appropriately for adolescents.

CHAPTER 7: THE MEANING OF ADOLESCENT-FRIENDLY HEALTH SERVICES FOR ADOLESCENTS

In the previous chapter, the barriers for adolescents to access sexual and reproductive health (SRH) services from adolescent-friendly health services (AFHS) were presented. This chapter responds to the research question: What does an adolescent-friendly health service mean for adolescents? In this chapter, I draw on the focus group discussions with adolescents in which they were asked how they might picture an adolescent-friendly health service within their local health facility. Subsequent questions then sought to elicit what "adolescent-friendly" health services meant for them (chapter 4, section 4.10.2.3, p. 105). I also draw on the responses from adolescents in in-depth interviews when they were asked what characteristics an adolescent-friendly health service would ideally, from their perspective, have.

7.1 Overview of participants

Adolescents aged 15-19 years had been selected as the group of study participants to provide data to answer this research question, gathered through in-depth interview and FGD methods. Sixteen in-depth interviews with six male and 10 female adolescents, and six focus group discussions were conducted. The demographic characteristics of the adolescent participants are profiled in chapter 6, section 6.1, p.149-152. FGD participants were selected for diversity of age, sex, caste and education.

7.2 Findings

Seven broad themes were generated from the interviews and FGDs with adolescents are now presented. Throughout this chapter, direct quotes have been attributed to the respondents using pseudonyms to protect their anonymity and privacy.

7.2.1 Theme 1: Having privacy and confidentiality

To the adolescents who participated in this study, if the health facility were genuinely adolescent-friendly, then it was of utmost importance that other people did not know about their sexual and reproductive health concerns. Without exception, all of the adolescents noted that adolescent-friendly explicitly meant that their information, particularly regarding the purpose of their visit, would not be disclosed to anyone else. I would interpret this to mean having their rights to privacy and confidentiality upheld. Privacy and confidentiality have previously been characterised in the literature as one of the essential components of AFHS (McIntyre, 2002; WHO, 2012).

Adolescents stated that they would be comfortable sharing their personal information with health care providers only if their privacy and confidentiality at the health facility were guaranteed. This would mean that health care providers spoke in low tones so that other HCPs, or other patients, could not overhear what was being said, did not begin the consultation in the public area but rather waited until they were in a separate room, and not disclosing the visit, or details of it, to parents, or other adults in the community. These needs were clearly articulated by one female FGD participant:

> The health worker talks loud with us even while giving medicine and everybody near would learn what we are getting [contraceptives]. Their voice could even be heard outside the room. They would also not take us inside the room rather start asking the problem in the counter in front of everybody. It makes us very uncomfortable. There might be private problems [SRH], and it feels awkward to learn if other people might have heard our conversation. (Female, FGD participant)

The discomfort that adolescent participants experienced when visiting the AFHS was sometimes compounded by fear of the consequences, if their personal SRH issues became public knowledge, was expressed in terms such as “very uncomfortable,” “awkward,” “embarrassing,” and “disappointing” for them. Adolescents wanted the health care provider to close the door and windows while a physical examination was being conducted and during counselling to maintain privacy.

In their focus group discussion, male adolescents said that they not often go to the health facility to discuss their SRH issues because they feared that the health workers would share their information with their parents and others. The implications of health workers’ indiscretion were portrayed by one of participants:

> Nobody goes to this health facility with their [SRH] issues, because he or she fears that if somebody goes there, health workers will tell it to other people in the community. For example, those [unmarried adolescents] engaged in sexual activity and if they get pregnant, they do not go due to shame, if anyone learns about pregnancy before marriage, then they [sexually active adolescent] will not be allowed to enter the village. (Male, FGD participant)

Some adolescents had experienced firsthand having their information disclosed to others (chapter 6, section 6.4, p. 164). Breaches of confidentiality in the health facilities seem to occur because there is no protocol for health providers to explain to adolescents that details of their consultation will be kept confidential, which includes not discussing these details with the other health workers or sharing such information with others in what is the close-knit context of the village community (chapter 6, section 6.5, p. 166). The consequences of breaches in

confidentiality – shame, stigma, family disgrace – can be especially dire when information alluding to adolescents' sexual activity is made public, as *"they [sexually active adolescent] will not be allowed to enter the village*," from the quote above, makes explicit. Given how strongly unacceptable premarital sex is for adolescents, as noted in chapter 2, section 2.5.3, p.32, and elsewhere in this study, for the health facility to be adolescent-friendly likely means to adolescents that there is no risk that the purpose of their visit will not be revealed to others inside or outside of the facility. The issue of privacy and confidentiality also implies the trustworthiness of HCPs beyond their giving verbal assurances. Adolescents wanted health workers to explicitly promise confidentiality, and ask if they consented to having any information shared:

> The HCPs should ensure us verbally that she will not talk about our issues to anybody else. It will be kept confidential, and she should tell us not to fear to share the problems. She should also ask if we are feeling uncomfortable. (Female, FGD participant)

Many adolescents noted that most of the HCPs are residents of the same local community and/or village, not perceived to be a positive thing when it came to seeking sexual and reproductive health services. Living in close-knit communities is another dimension of the earlier-mentioned issue of confidentiality of adolescents' intimate information being breached from within the health care facility. Similarly, the familiarity between health workers and adolescents and their families meant that the confidential details of adolescents' intimate lives could not kept guaranteed with the assurance that the adolescent participants saw as a highly desirable aspect of AFHS.

In Nepal, the Public Service Commission selects HCPs through a rigorous recruitment procedure. Following selection, they are appointed by the ministry of health (MOH) facilities anywhere in the country where vacancies exist. In practice, many health workers are assigned to the health facility near to or in their hometown. Civil servants, including HCPs, are held in Nepali society to be among the most respected citizens. Hence, even non-local HCPs will soon acquire similar social status and recognition within the community as locals enjoy after a time. Of the six health facilities included in this study, four had HCPs who had always been part of the community they served. In the other two, non-original resident HCPs had settled, and been working in their community for over ten years.

While it might be assumed that an HCP from the same community or one who has lived in that community for a long time has formed close community connections that would allow would-be patients to feel comfortable approaching them for health care. For adolescents wanting to

discuss their SRH, however, SRH, these close connections are a liability that makes them feel rather more uncomfortable. Tilak, aged 18, stated in the boys' FGD that "*it is easy to seek services with HCP who is from the same community, but that is to only to get treatment for diseases except for SRH issues"*.

For the adolescents, having HCP who did not know their families perhaps gave them a sense of anonymity which then made it easier for them to talk to them about their SRH issues. Moreover, some adolescents seemed to perceive that unfamiliar HCPs would guarantee confidentiality and thus, the risk of their families having knowledge of their health care visit. From adolescent focus group discussions, it was clear that having HCPs with no knowledge of their families or their family background was a crucial aspect of an ideal AFHS, as the quote from a male adolescent, below, indicates. In the close-knit communities of the Dhading district, however, this anonymity could not be offered.

> I wish the staffs would be changed every day and the HCPs would be from outside the village. They should not know us and neither we should know them. It will easier for us to talk about our issues with them. This way they will not know who we are and whose children are we. This will prevent them from talking about us. The HCP could be in this health facility one day, another health facility in the other day. (Male, FGD participant)

For adolescents, a genuinely adolescent-friendly health service would not only give the assurance that HCPs would keep their information confidential, but also its physical layout would be arranged to provide them with absolute privacy. Without exception, adolescents emphasised the need for a separate adolescents' room in the health facility for their exclusive use. In their focus groups, adolescents were asked to brainstorm and draw pictures of the adolescent-friendly health services they would envision. Adolescents drew the conventional health facility layout, but with the additon of an adolescents' counselling room which they presented in a unique way, either at the edge of the building or in an annex to the building. This can be interpreted as their way of expressing the need for a separate and private space with no or limited public access. One of the groups, for example, placed the entrance to the counselling room at the back of the building. When they presented the drawing, they explained that locating the entrance at the rear would ensure that other people from the community visiting the facility would not see them enter. One group preferred a room allocated for adolescent counselling on the first floor of the health facility which would ensure that other patients would not overhear any details of the purpose of their visit.

Figures 7.1 and 7.2 reproduce the concept drawings of focus group participants representing their ideal AFHS. In the first drawing, the counselling room is located on the left-hand side of the first floor.

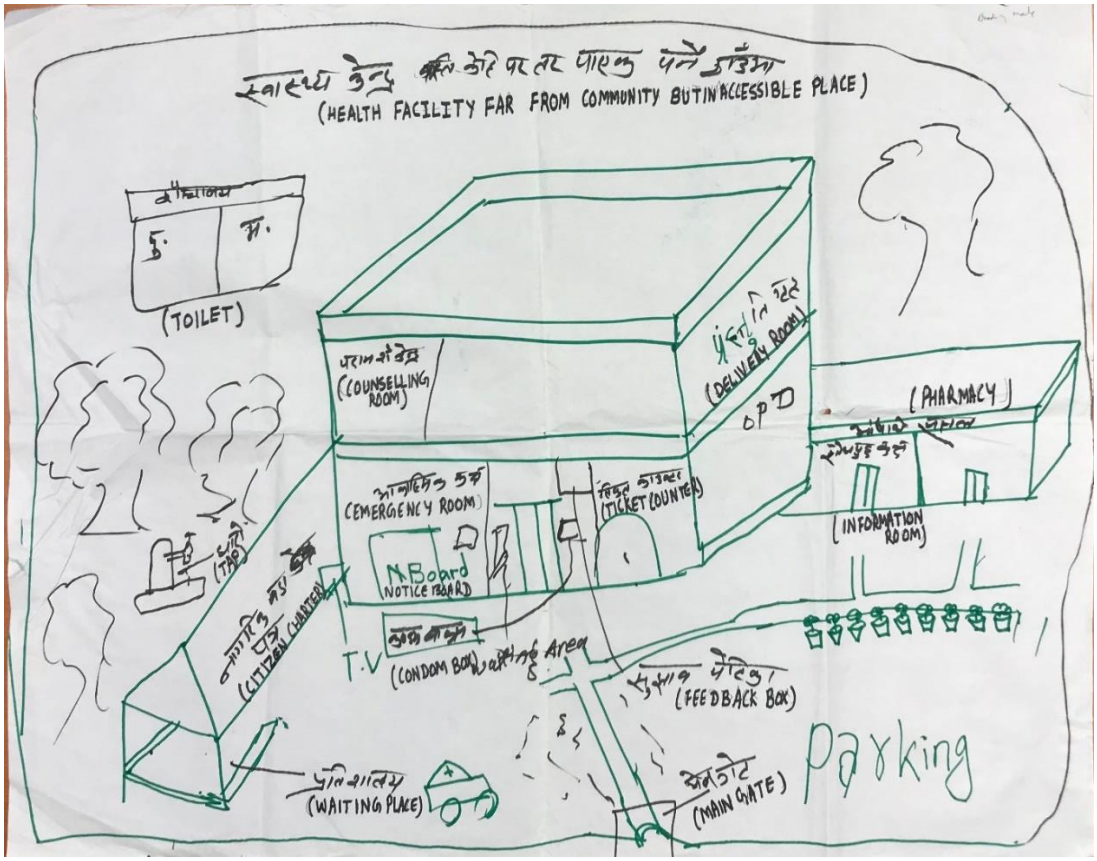


Figure 7. 1 Concept drawing of the ideal AFHS facility by male FG participants, VDC 1

Figure 7. 2 Concept drawing of an AFHS facility as desired by male FG participants, VDC 5

While adolescents' drawings expressed their need for a separate room to protect their privacy and confidentiality, they also indicated that, ideally, they would enter and exit the health facility without being seen by other people. For example, in figure 7.2 routes to the entrance and exit are drawn in two different directions. They would, therefore, not have to enter via the waiting room, usually at the front of the health facility. This way, people would not see which room they entered, nor from which room they exited, as one group of male participants noted: *"Once we enter the health facility building nobody should see us where we went and where did we get out from."*

Adolescents also highlighted that, were the health facility located in a more isolated place, away from the village or far from the market, they would feel more comfortable visiting. While, for many reasons, having the health facility centrally located in the community makes it easier for most people to access, this was not the case for adolescents because of their sensitivities about privacy and confidentiality.

As they often emphasised, adolescents were fearful of their visit to the AFHS being exposed to their families and other adults. Their concepts of how facility infrastructure could better meet their needs indicate that they require invisibility when they go enter and leave. This desire is not surprising given how vulnerable Nepalese adolescents are to the social stigma and shame

associated with premarital sexual activity. Thus, for adolescents, AFHS meant having a service housed at a location that safeguards privacy, and places confidentially at the front and centre of infrastructure arrangements of the health facility.

An additional aspect of privacy and confidentiality is anonymous access to family planning items such as condoms – of which even the health workers need not be aware. Male participant of the VDC 5 FGD suggested, for example, that:

> There should be a condom box in an accessible place which is not seen by other people. So that it is not needed to ask for a condom, rather we could just take it out. (Male, FGD participant)

Some FGD participants suggested that condoms should be available in the toilet and others thought the condom box should be at the exit (the exit that is, ideally, different from the entrance and is for adolescents' exclusive use), as included in the map drawing exercise shown in figure 7.2. In summary, for all adolescent participants, an AFHS was one whereby the location of the health facility, and how health services were provided, would guarantee absolute privacy and confidentiality.

7.2.2 Theme 2: Service provision without discrimination

Adolescents in all the FGDs and interviews indicated that in adolescent-friendly health services, HCPs would "*treat* [them] *equally*" irrespective of age, gender, physical appearance and how they dressed, caste, and nature of their health care needs. It was noted by adolescents that HCPs were often annoyed to have to talk to them, would not listen to their issues, and treated them like children who should not be asking about SRH issues. Adolescents wanted to be acknowledged as adults with valid SRH needs. A 17-year-old male FGD participant from VDC 5 recounted how he was "scolded" by the health worker and told that he should be "ashamed to come and ask for a condom" when he was "a kid":

> I went to get a condom day before yesterday; the HCP scolded saying that you are not ashamed to come and ask for condom being a kid. I returned. Then I went to the private pharmacy to get it... I felt frustrated... I am not a kid. (Male, FGD participant)

Mira, 15-year-old female adolescent had a similar experience and mentioned in her interview that when she asked for a contraceptive, an HCP said*," Why would you need it? It is of no use to you, and you should not be using it before marriage."* These experiences told by adolescents clearly indicate that such judgmental and unprofessional attitudes are definitely not adolescent-friendly and are likely to discourage them from using the facility. Instead, indicated by the quote above, they would rather go to a private pharmacy.

Equal treatment was something adolescents wanted from an AFHS as noted by a young woman from the Chepang[14] community:

> Few of the HCPs do not even touch us if we are poorly dressed or if our clothes are dirty. If they are treating us and call themselves adolescent-friendly, they should not do that and treat us equally like those who are well dressed. (Female, FGD participant, Chepang)

The experience of being poorly treated because they were not dressed well was not only shared by Chepang females; a male participant from another village explicitly stated in group discussion that *"They [HCPs] would only listen to those who are well dressed, go in good trouser, suit, and sunglasses and they do not care to listen to poor and not well-dressed clients*." A male participant from the Chepang Community shared that *"HCP behaviour depends upon how we are dressed. To those poor and badly dressed they would treat badly and even to get the treatment they have to struggle. But those who are smart and well-dressed they treat nicely*."

Further, adolescents from the Chepang community expressed during FGDs that people from their community were treated badly because of their caste. In Nepal, as discussed in chapter 2, section 2.3 p. 18-19, people are categorised by caste and ethnic identities. These social categories determine how people treat each other (Pandey, Mishra, Chemjong, Pokhrel, & Rawal, 2006). Chepang adolescents felt that they were given the attention they needed as health facility clients. They also reported that people from their caste, being mostly involved in agricultural or labouring work, were considered dirty and untidy because of their appearance and dress. Chepang adolescents also explained that people from their community are often not expressive and cannot make their needs clear to the HCPs. In Nepal, 63% of the health workforce comes from relatively advantaged castes, mostly Brahmins, Chhetris and Newar (Caffrey, Chilvers, & Martineau, 2013). Discrimination in a society where caste is expressed in social categories may be one of the reasons that the Chepang adolescents felt unable to clearly express their issues to health care providers, and why they were not treated well. A Chepang female FGD participant mentioned:

> People from our caste could not talk properly. They feel ashamed and also fear the HCP and could not even give their introduction properly. The HCP are always in a hurry and try to do their things quickly. So, they would not try to explore what had happened when any member of our community goes there. They ask what happened and if said a headache, quickly give medicine for a headache and send back. There is no cross-question. (Female, FGD participant, Chepang)

[14] Chepangs are a marginalised indigenous group in Nepal.

The words above clearly suggest that Chepang adolescents felt that their real needs and concerns were not adequately or caringly addressed. In Nepal, it is quite usual for patients to complain of a headache, or some other ache or pain when their actual medical problem may be different. It is usually up to the health care provider to further explore the reason for their visit. In the case of Chepangs, however, it is clear that they are not given the time required to take a proper history and to understand the reason for the adolescent's visit. Moreover, since Nepali is a second language for the Chepang, they may not have the Nepali words to communicate their actual health concerns. A Chepang male FGD participant shared his experience of the treatment he received:

> Once I was very sick for around a week, I was not able to get out of bed for several days. I went to the health facility thinking that I might get some relief after taking medicine from them. The HCP scolded and said "you are so dirty and your house must be dirtier." They told me things that would hurt me mentally. We go to the health facility with some expectation rather than to have fun. They could give us some suggestions if they do not have medicine. If they talk nicely, it would be more than medicine. We do not know everything on our own; they should tell us nicely on what to do and what not to. They know about many things, but we do not. If they talk to us, we will take the information. However, if they treat us badly when we are sick, we do not want to come to the health facility next time. Rather we want to go to a traditional healer to find out if we have some witch effect or something. (Male, FGD participant, Chepang)

Chepang adolescents, in the quotes above, provide evidence of the discrimination they experience because of their social status and appearance. The resort to alternative solutions, such as from the *"traditional healer"* makes explicit the unacceptability of current AFHS to Chepang adolescents. Other Chepang adolescents told of instances when they felt so fearful of how the HCP might treat them that they needed someone to go with them to the facility. A Chepang female focus group participant said, *"There is this environment of fear, feeling that they do not like us and feeling of shame. I always feel that… That is why I cannot go to the health facility alone. I need to either take my mom or friends*."

As mentioned earlier in this section, HCPs, as educated civil servants, often from advantaged, higher caste backgrounds whereas Chepang people live in poor communities in the most remote areas. Hence, the social expectation that they should look up to HCPs as respected people creates a power differential between the service provider and service seeker that likely disempowers Chepang adolescents. On top of this, when they are not treated with respect, it is natural that these adolescents feel too fearful and uncomfortable to seek further support.

For Chepang adolescents, an adolescent-friendly health service means a place where they would be accepted as equals, treated with respect, spoken to patiently and given the time and attention they need to explore and help resolve their real concerns. . The words of the Chepang participant, *"they could give us some suggestions if they do not have medicine"* suggest that although the Chepang adolescents had only minimal expectations of the health workers even those went unmet.

7.2.3 Theme 3: Being friendly, respectful and interested in adolescents' concerns

All the adolescent participants felt that if health facilities were truly adolescent-friendly, service providers would be friendly and supportive to adolescents. Some of the adolescents had expectations of calm and gentle health workers who would make them feel comfortable about expressing their health concerns, but instead became fearful when the health care provider responded with anger. In his interview, Indra, aged 19, commented, *"They [HCP] should not get angry about our issues, and they should put an adolescent at ease while providing health services".*

Almost all adolescents, including those from the Chepang community, spoke of encounters with HCPs who entered the room with unpredictable faces, without greeting them or smiling. Adolescents described their feelings of awkwardness and loss of confidence when met with such unwelcoming behaviour at the health facility, when what they needed was a smile and gentle tone of voice that would make them feel at ease to talk about their problem.

More than half of the adolescent participants also expected HCPs to try to better understand the problem or issue they presented with, by asking for more details and questioning them further. For example, Sam, a 15-year-old male adolescent said, *"I would have told everything that had happened to me. But the HCPs did not ask in detail about what, how, when, where and why it had happened*." Sam's experience raises the serious concern that adolescents may not fully disclose the nature and details of their issue, whether due to fear, shyness or lack of knowledge. This is why they want and need the HCP to probe for further information which would demonstrate to the adolescent that the HCP is interested in knowing more about them. But not only did HCPs not show interest or friendliness, they became angry:

> There are few doctors who start screaming when we go to the health facility. They are like why you come so late and blah, blah... this would often demotivate [us] to see the health care provider. They should behave like a friend and talk nicely. They should use simple language to talk to us. (Male, FGD participant)

Male adolescents also expressed that HCP were at times rude rather than welcoming and talk polite. For example:

> Health workers should be smiling and welcoming, speak politely to people from our side, talk with respect: say aunus, basnus, janus. They speak very rudely when somebody go to the health facility. They say *bas, pachi aija*. (Male, FGD participant)

The Nepali word *bas* means being told to "sit down" but in a rude derogatory way; *pachi aija* is "come later". Adolescents' expected to be spoken to with respect, with words like *aunus*, or "please come in", *basnus*, or "please sit down", and *janus*, meaning "please, you may go". What these adolescents perceive as disrespectful language could be an attribution of both age and social status hierarchies in Nepalese society. In Nepal, power relations are often reflected in the language. Fairclough (2015) views language as an indirect way of establishing the distribution of social power. Power relationships may be a function of age, education or wealth. HCPs are both older and more educated than adolescents. Health workers address young female patients, especially, as *Bahini* which means younger sister, and young males with *Bhai* to boys which means younger brother, automatically invoking a hierarchy in the provider-patient relationship. Thus, HCPs consider young people to be children and not properly empowered to make decisions for themselves. Most of the adolescents reported that the effect of these dismissive and discriminatory attitudes was that they felt powerless, and reluctant to express their problems and seek answers from HCPs who present themselves as superior by dint of their social status when they should be delivering health care without preoccupation or prejudice based on their knowledge as educated civil servants.

The findings from the focus group discussions presented above suggest that for these adolescents an essential characteristic of a properly functioning AFHS is the attitude of health care providers towards adolescents and their sexual and reproductive health needs. Adolescents stated that AFHS means that staff are friendly, show interest in and acceptance of their concerns, and show them respect.

7.2.4 Theme 4: Being able to relate to the provider

All of the adolescents participating in interviews and focus group discussions highlighted that it would be beneficial if HCPs were closer in age, and of the same gender as themselves, which would enable shared concerns, feelings and emotions. Adolescents presumed that younger HCPs could more easily relate to their experiences and to themselves, and perhaps understand at depth their need for confidentiality. This would also help to build trust between health

workers and their adolescent clients. In reality, adolescents expressed that often, the mainly older-age HCP made them uncomfortable talking about their concerns.

> We expect them to be a trustworthy person. And I assume if there is a young doctor then he/she would empathise us and would not make an issue or talk about our matters. (Female, FGD participant)

This adolescent's words suggest that younger HCPs, having been through similar experiences, would validate adolescents' concerns. Similar views were expressed by a 19-year-old female participant who expressed that *"If there had been a friend as a service provider, it would be much easier to get the sexual health services*." Adolescents' desire for younger health facility staff could be explained by relational-cultural theory (Miller, 1987), which explains that people want connections with others that give them a sense of worth through empathic responding. Adolescents in this research had the feeling that younger-age HCPs would more likely be able to empathise with their experiences, contributing to an environment of comfort, care and trust.

Many participants also described the difficulty of speaking to opposite-sex HCPs about their SRH issues. One, a 19-year-old male, shared his experience of visiting a health facility when he had a genital skin infection. A female nurse attended him, and although he felt very uncomfortable, because his pain was intolerable, he had no choice but to speak to her about his symptoms. The nurse, he further noted, was so uncomfortable that she would not look at his genitals. Such uncomfortable situations arising from the biological sex difference between client and provider were commonly mentioned by adolescents as a reason they would not go to the facility next time they had an SRH issue.

In the adolescent males' VDC 3 FGD participants agreed on the importance of having *"both female and male HCPs available for male and female [patients/clients] in the health facility*," noting, "*it is very difficult to go to the health facility for us [males] at the moment*." This was because that health facility was operated by an all-female health staff. I visited this health facility twice during my data collection, once for observation and again, to interview the health care providers. On both these occasions, I noticed that only female patients were attending the health facility. I asked why this was the case at this particular health facility and was told that since the transfer of the male HCP five years previously, they had never been allocated a male replacement and thus, only female health care providers were available.

The adolescents' desire to have an HCP of the same sex could be due to gender norms; the very specifically-defined gender norms for men and women in Nepalese society may serve to

influence the discomfort that adolescents feel when they have to share their SRH concerns with an HCP of the opposite sex.

In summary, adolescents' utilisation of health facilities are to an extent determined by the age and sex of the health facility staff, and how they provide services. For these adolescents, an AFHS should have HCPs who are closer to them in age, of the same sex, and who can relate empathically and respectfully to adolescents' SRH problems.

7.2.5 Theme 5: Clean and well-maintained health facilities

In their focus groups and in individual interviews, adolescents envisioned adolescent-friendly health services as clean and well-maintained, inside and out. To them, a well-maintained health facility meant having separate toilets for male and female clients, and in the female toilet, a container for the disposal of sanitary products, a comfortable waiting area with benches and chairs, clean drinking water, proper compound walls, an incinerator within the compound to dispose of waste, and a flower garden to make the health facility a pleasant place to be. One participant, for example, indicated how important it was for the health facility to be clean:

> If somebody is admitted to the health facility, the attendant [visitor] of the sick person will him/herself get sick due to the lack of cleanliness in the health facility. The sick person does not get better because of the dirty and smelly environment of the health facility. Rather than going there for treatment it is better to spend some money and go to Kathmandu. (Male, FGD participant)

In Nepal, when a patient is admitted for treatment, a family member or relative needs to be there to serve as an attendant. The quote above reflects that a clean and well-maintained environment is important not only for the hospitalised person's recovery but also to protect the wellbeing of the accompanying family member. Unless the facility is clean, the adolescent's words suggest, young people are not motivated to seek help there. Some participants acknowledged that there had been improvements in cleanliness, compared to what they had experienced previously. For example, FGD participant of VDC 3 mentioned:

> The health facility has built the place to throw needles [incinerator] now. It [needles] used to be all around in the ground and would hurt if we would run in the grass. (Male, FGD participant)

From my observations of all 26 AFHS study sites, I noted that 18 maintained the cleanliness of the floors, rooms and surroundings of their health facilities. However, only 13 facilities had comfortable waiting areas with seating arrangements for the patients. All but four had clean drinking water. All had toilets, but only four had separate toilets for males and females.

7.2.6 Theme 6: Information, Education and Counselling

Adolescent participants felt that the availability of information, and education material, and SRH counselling were essential components of AFHS. They said that an adolescent-friendly service would provide advice and instructions on the use contraceptive methods. Both male and female adolescents noted that they needed access to information about "which methods will prevent pregnancy," which contraceptive method to use "before marriage," and "before having sex".

Emphatically, the provision of reliable and helpful information about contraception was key to AFHS. In focus groups, when presented with the vignette (chapter 4, section 4.10.2.3, p 106) about 15-year-old Rita and 19-year-old Shyam, who were in love and wanted to have sex with each other, there was enthusiastic discussion around the kind of information and services the couple needed to prevent pregnancy.

> It is important for Rita and Shyam to get information about contraceptives first. HCPs should talk to them and provide reading materials on contraceptives so that they can decide what to do and what to use and prevent pregnancy. (Female, FGD participant)

Similar views were expressed by male adolescents in another FGD; overall, adolescents' emphasis on the need to prevent unwanted pregnancy is because sexual activity, which would be revealed by a subsequent pregnancy is, for adolescents in Nepalese society, a source of shame and disgrace.

> They [Rita and Shyam] would need information about contraceptive methods so that they would protect themselves from pregnancy before getting married because it [unmarried pregnancy] is not acceptable by family and society. (Male, FGD participant)

Adolescents further emphasised to receive not only the information on contraceptives but to learn about the consequences of not using contraceptives. FGD participants from the male group in VDC 3 noted: *"HCPs should inform us if there is a possibility of getting diseases like HIV, syphilis and other infections without using a condom"*.

These words shared by both male and female adolescents indicate the importance of SRH information about contraception so that they understand and make the right choice to prevent possible consequences. The words "*it [unmarried pregnancy] is not acceptable by family and society*" suggest adolescents are concerned about maintaining the social norm of not getting pregnant before marriage as well as having safe sex.

Adolescents also envision AFHS delivering information on SRH either through information, education and communication (IEC) materials or through the health care providers.

> There should be books in the waiting place so that we can read while waiting. There are few reading materials on contraceptives, nutrition, pregnancy, etc. The one on contraceptives describes all methods but does not tell what is useful to us [adolescents]. (Female, FGD participant)

The MoHN emphasises displaying different kinds of IEC materials, which they provide in the form of booklets and pamphlets in the waiting area of health facilities. During my observations of the 26 AFHS in Dhading district, I found that only six had any kind of SRH IEC materials displayed in their waiting areas. While I did not inquire into the reasons for this lack, it is possible that the IEC materials might have been lost or misplaced during the earthquake in April 2015. Another reason could be poor management of IEC supplies or, moreover, that the health workers do not prioritise the needs of the adolescent health program. It is also possible that the health facilities do not display the IEC materials. because school students are expected to read only course books.

In two focus groups, adolescents discussed the idea of health facilities running community health awareness programs to inform adolescent in the community as well as local communities about SRH issues of adolescents with the aim of creating a more supportive environment for adolescents to seek SRH services from AFHS. In a male participant in a FGD, thought that technology offered potential solutions for addressing adolescents' issues:

> Health facility has experienced medical persons so if there would be the provision of asking them our problems in SMS then it would be easier to ask questions even without going to the health facility. Because it is difficult for adolescents to go and ask these issues personally, it could be SMS, hotline, written questioning. And HCPs could answer in SMS or print the answers and post on the walls. (Male, FGD participant)

Adolescents indicated the importance of not only having comprehensive sexual health information available, but also a means through which any questions they had could be answered. An adolescent-friendly health service should provide information and communication channels through so that adolescents can make appropriate decisions about their sexual and reproductive lives and enable them to engage in safe sexual activity.

7.2.7 Theme 7: One-stop service with flexible hours

For most of the adolescents, an AFHS should be a one-stop health service for all their needs, including free contraceptives such as condoms and oral medications. In four of the six adolescent focus groups, participants contraception was nominated as one of the top three adolescent-friendly indicators. The other two groups placed contraceptive services in their top five. Many of them sensed that contraceptive services were already available in their local health facility. A few mentioned that emergency contraceptive pills (ECP)[15] should be available at the health facility whenever they are needed.

For most adolescents an AFHS would ideally have flexible hours that take school hours into account. Students would have to try to visit the health facility after school or during lunch break. This proved difficult because, as Sam, 15, explained, *"they [HCPs] are in a rush most of the times and keep me waiting for a longer period. It would have been easier if I could get my consultation done immediately after getting to the health facility".* Because the health facility is often crowded with adults during normal hours, adolescents often could not get an appointment and had to return to school without getting what they needed. One participant suggested evening hours might be helpful: *"Health facility is open from 10 am to 3 pm. But for us as students, we are only off at 4 pm so it should also open in the evenings so that we can get services whenever we have emergencies".* The National Adolescent SRH guidelines suggest separate days and times be allocated for adolescent visits but still only during the normal health facility operating hours from 10 am to 5 pm, hours which seem to be unfriendly to adolescents.

One FGD group expected AFHS to provide services for all kinds of disease that would reduce the burden of going to the city for treatment. Similarly, another FGD group expected ambulance services operating from the health facility so that emergency cases visiting from the village can be transported to Kathmandu.

7.3 Reflection and Summary

This chapter has presented what an adolescent-friendly health service looks like from the perspectives of the adolescent study participants. Above all else, adolescent-friendly means that privacy would be protected, and confidentiality guaranteed. This would primarily be a function of health care providers' attitudes to, and how they treat adolescents. The location and internal infrastructure of the health facility also had roles. Health care providers would, furthermore, respect the adolescent clients irrespective of their caste, educational or economic background,

[15] In Nepal morning after pills are called Emergency contraceptive pills

be interested in their issues, and spend time listening to and seeking to understand their real needs. For adolescents to feel at ease, HCPs should be closer to their own age group so they able to empathise with adolescent experiences. Same-sex practitioner-patient consultations were universally desired. SRH information and services would be freely available, particularly that relating to contraception and prevention of sexually transmitted disease. The ideal AFHS would cater for adolescents' SRH needs as a one-stop service with flexible opening hours. It would be clean, have well-maintained facilities, including separate male and female toilets, and pleasing surroundings.

CHAPTER 8: DISCUSSION AND CONCLUSION

This thesis examined the utilisation of sexual and reproductive health (SRH) services from adolescent-friendly health services (AFHS) by adolescents in Nepal. As noted in chapters 1 and 2, Nepal initiated and scaled up AFHS between 2009 and 2017. While previous research demonstrated increases in adolescents' awareness and knowledge about the availability of these services, this has not translated to increased service utilisation. Thus, as noted in Chapter 1, the main aim of this thesis was to obtain a rich understanding of what contributes to the utilisation of AFHS in Nepal. To address the aim, this study set out to specifically answer the following research questions (RQ):

1. What is the current utilisation of SRH services by adolescents in AFHS?
2. To what extent do AFHS comply with national standards?
3. What are the perceptions, attitudes and experiences of health care providers regarding the provision of SRH services to adolescents?
4. What are adolescents' perceptions and experiences of the SRH services they received?
5. What does an adolescent-friendly health service mean to adolescents?
6. What are adolescents' experiences and challenges in accessing SRH services from AFHS?
7. What are the perceptions of community members (decision makers/gatekeepers) of AFHS? Do they accept and support the adolescent-friendly health program?

This research employed a case study design to investigate the utilisation of AFHS in Nepal. This included a quantitative phase to analyse health facility data to address RQ 1, and a qualitative approach to address the rest of the research questions. In this chapter, I discuss the findings of these studies within the context of existing literature, as well as framing my discussion around the WHO-defined adolescent-friendly criteria for health services. I conclude the chapter by presenting the strengths and limitations of the study and the implications and recommendations for policy, practice and research.

8.1 Current utilisation of adolescent-friendly health services by adolescents and compliance with national standards

The audit results (chapter 5) showed that in almost half of the AFHS levels of adolescent ultilisation were not merely low, but actually declining. This result is not unique to Nepal – low uptake has also been documented in other countries. For example, a mixed method evaluation conducted in two adolescent-friendly health clinics in Puducherry, India, reported that only 15% of adolescent girls and no boys from the catchment area of the health facility had used the health services (Mahalakshmy et al., 2019). Similarly, a review conducted by Chandra-Mouli et al. (2016) noted that in Bangladesh, despite the introduction of an AFHS, there was no significant difference in health service utilisation by adolescents between intervention and comparison health facilities. One of the major reasons for poor service utilisation in Puducherry, India was noted as poor awareness of available adolescent-friendly health clinics, whereas in Bangladesh area of improvement in the AFHS was indicated to be privacy and confidentiality to increase the service utilsation (Chandra-Mouli et al. 2016; Mahalakshmy et al., 2019).

It is not surprising that this PhD study has shown a decline in the number of adolescents visiting AFHS, since only three out of 26 AFHS were found to comply with the national standard for AFHS. The other health facilities lacked basic equipment such as scales to measure weight and height, and more than half did not have basic amenities such as seating space in their waiting areas, nor the visual and auditory privacy required to provide services for adolescents. While the government of Nepal aims to scale up AFHS in all of its public health facilities (MoHN, 2018, p. 105), the poor compliance of the current facilities with the recommended national standards raises questions about the provision and sustainability of the program. James et al. (2018), in their study of 30 AFHS conducted in two provinces of South Africa, found that the average standard met by health facilities ranged from 27-49% in one province and 36-75% in the other. While the South African study did not associate the adolescent-friendly standards with the utilisation of services by adolescents, the authors discussed the importance of improving the standards to increase service utilisation by adolescents.

One of the reasons for health facilities not complying with national standards could be poor monitoring and inadequate supportive supervision of these facilities. Poor monitoring and supervision were also noted as one of the major challenges during the piloting phase of AFHS in Nepal (see section 2.7.1) (MoHN, 2010). Health facilities and health care providers' productivity has often been associated with regular monitoring and supportive supervision (Frimpong, Helleringer, Awoonor-Williams, Yeji, & Phillips, 2011; Jaskiewicz & Tulenko, 2012). This was also

somewhat relevant to my study, as discussed in chapter 5, section 5.2.3. The health facilities which had better supervision and more monitoring visits met more of national standards criteria for AFHS. This suggests that for the AFHS to provide quality services, it is necessary to have regular monitoring and supportive supervision. Apart from health facilities not meeting the national standards for AFHS, these facilities faced various challenges in their provision of AFHSs.

8.2 What determines utilisation of adolescent-friendly health services in Nepal?

In this section, the findings for RQs 2-7 are discussed. This draws on the findings presented in chapters 6 and 7. The discussion is framed around the WHO-defined adolescent-friendly criteria for health services which were discussed in chapter 3, section 3.5, p.62. The WHO criteria for adolescent-friendly services include accessibility, acceptability, and appropriate, effective and equitable health services.

8.2.1 Accessibility of health services

Health services are considered accessible if adolescents can obtain the SRH services at an affordable cost; if the service is located within an easily reachable distance; and if adolescents have information about the kind of services available (Sawyer & Patton, 2015; Tylee et al., 2007). Accessibility also means having convenient opening times for adolescents to access services, and community members understanding and being supportive of adolescents accessing services from AFHS (WHO, 2012).

Geographical access to the health facility from where adolescents are living, or studying, has been documented as a major requirement for access to SRH services in many developing countries (Bam et al., 2015; Bukenya, Mulogo, Kibira, Muhumuza, & Atuyambe, 2017; Erulkar et al., 2005). In terms of geographical accessibility, some of the pertinent issues in my study were the distance to the health facility, poor road conditions, availability of transportation and time needed to reach the health facility. The health facility audit showed that 20 out of 26 AFHS were only accessible by dirt roads or walking trails. These findings would suggest that geographical accessibility is a barrier for adolescents to access the existing AFHSs. Surprisingly, however, many of the adolescents in my study did not identify geographical access as a key issue in accessing SRH services.

The adolescents in this PhD study were more concerned about the vicinity of the facility. Geographical accessibility implies that the health facility would be centrally located in relation to where adolescents and others who would utilise the facility lived. However, as presented in chapter 7, many adolescents did not want the health facility to be located in marketplaces, for

example, where people commonly gathered. Their preference was for locations where people would not see them coming and going. This preference was related to their needs for the privacy and confidentiality of their SRH concerns, as noted later in this chapter.

The WHO also considers the cost of SRH services as a measure of accessibility. In Nepal, all government-sponsored public health facilities provide all health services, including SRH services and prescribed medicines and contraceptives free of cost to its citizens, including adolescents. Thus, it is not surprising that the issue of service or contraceptive costs was not raised by any of the adolescent participants as being a deterrant to their utilisation of AFHSs. However, cost has been identified in the literature as a barrier for young people seeking SRH services from private clinics, as noted in the study conducted by Regmi et al. (2010b). In my study, I focused on the barriers for accessing SRH services from government-funded public facilities, which may be why participants did not identify cost as a barrier.

Health services' opening hours were an important aspect of accessibility for adolescents in this research. They wanted to have SRH facilities open throughout the day and especially after school hours. This finding is similar to other studies which have shown that due to inconvenient opening and closing times, adolescents did not seek SRH services from health facilities (Alli et al., 2013; Atuyambe et al., 2015; Mokomane, Mokhele, Mathews, & Makoae, 2017). Opening times are especially important given that most of the adolescents are attending school during the normal opening hours of the health facilities. Nepal's National ASRH program guidelines advise allocating a particular day and hours for adolescent SRH visits that should be determined in discussion with them (MoHN, 2011a). As presented in chapter 5, section 5.1.2.3, p. 122, only four health facilities had a separate day and time allocated for adolescents but still within normal working hours of 10 am to 5 pm, and the remainder provided service on a drop-in basis. However, this did not seem to match with adolescents' preferences, which was for after-school hours. This finding contrasts with a study from South Africa conducted by Mokomane et al. (2017) in which young people did not prefer to have a separate day and time for SRH services since they would be denied services at other times. This indicates the importance of discussing service provision times with adolescents to ensure they are indeed accessible.

Another important aspect of SRH service accessibility for adolescents was having the support of community members including parents, teachers and gatekeepers. The WHO (2012) emphasises educating the community about the provision of SRH services and its usefulness. In this current study, more than half of the key informants (KIs) interviewed were aware of the existence of AFHS for adolescents, and while these KIs seemed to be generally comfortable with the

existence of AFHSs, prevailing social-cultural norms influenced how well parents, local teachers and HFOMC members accepted the kind of services provided by these facilities. For example, as noted in chapter 6, in general, the KIs interviewed did not accept adolescents' engaging in premarital sexual activity and, therefore, most of the KIs wanted the AFHS to provide information pertaining to abstinence from sexual activity until marriage. Many of the KIs believed that sex education and contraceptive information would serve to increase the interest of adolescents in sexual activity. Similar findings were noted in a study conducted in Ghana, where community members believed that increasing access to contraceptives would increase sexual activity among adolescents (Kyilleh, Tabong, & Konlaan, 2018). Similar to the findings of this PhD study, Acharya et al. (2018), in their qualitative study in Nepal among 78 adolescents aged 14-17 years, noted that adolescents received very little information about sex, sexual health or menstruation either at school or at home. The findings of this study (see chapters 6) clearly show that there is inadequate support from the community for AFHSs to provide SRH information, education and supplies to unmarried adolescents. This highlights a need to engage the community and gain their buy-in to make SRH services more accessible to unmarried adolescents.

8.2.2 Acceptability of health services

SRH services are considered acceptable when adolescents are willing to obtain the services available. Confidentiality and privacy, non-judgemental attitudes, and approachable and considerate HCPs have been previously identified as contributors to the acceptability of SRH services from the adolescent perspective (McIntyre, 2002; Sawyer & Patton, 2015; Tylee et al., 2007; WHO, 2012).

8.2.2.1 Privacy and Confidentiality

In this study the privacy and confidentiality theme was the most dominant generated across interviews with adolescents and HCPs. Poor privacy is explained in terms of inadequate physical space and layout that meant other people could see or hear the provider-adolescent consultations (Geary, Webb, Clarke, & Norris, 2015). Poor confidentiality is explained as inadequate protection of the information adolescents share with HCPs during their consultation leading to others in the community finding out the reason for their visit or details of their condition (Amankwaa, Abass, & Gyasi, 2018; Sychareun et al., 2018). The issues of confidentiality have been reported in several studies in Nepal as one of the major barriers for adolescent utilisation of SRH services (Kennedy et al., 2015; Regmi et al., 2010b). Both in my study and others, adolescents placed great importance on having privacy and confidentiality in an AFHS

indicated by HCPs speaking in low voices, and taking them to a separate room during consultations or to a place that ensures privacy (Atuyambe et al., 2015), closing the door and windows of the rooms during examinations (Daley et al., 2017), and not disclosing their information to other HCPs, parents or other adult community members (Coker et al., 2010; Gautam, Soomro, Sapkota, Gautam, & Kasaju, 2018; Kennedy et al., 2013; Sychareun et al., 2018).

In my study, observations of 26 AFHS revealed that less than half (11) of the facilities had physical space or infrastructure that provided visual and auditory privacy. While there were some efforts in the health facilities to maintain privacy, it was not sufficient. For example, as discussed in chapter 5, among the three case studies, health facility "A" had a separate room for adolescents counselling, health facility "B" had no separate area at the time of this study but was providing consultation services one at a time for adolescents, and health facility "C", despite claiming to maintain the privacy of adolescents, did not have a separate area or use curtains in the consultation area for visual or auditory privacy. In my study, adolescents also shared examples of HCPs breaking their confidentiality with other HCPs and people in the community. As noted in chapter 6, this caused shame and embarrassment both for adolescents and their families, which then resulted in families "losing prestige" within the community. This finding resonates with a qualitative study conducted by Sychareun et al. (2018) in rural Lao PDR which noted that unmarried adolescents were often anxious about losing their reputations and being gossiped about if others in the community found out that they had gone to seek SRH service.

A systematic review conducted by Mazur et al. (2018) nominated privacy and confidentiality as one of the most used indicators for assessing the utilisation of SRH services by all young people, including adolescents. Thus, adolescents' desire for privacy and confidentiality is a well-established component of AFHS (Erulkar et al., 2005; Wright et al., 2017). It has also been established from research that adolescents would not utilise SRH services from health facilities if they cannot be assured of the confidentiality of information they share with HCPs (Femi-Adebayo, Kuyinu, Adejumo, & Goodman, 2017; Kennedy et al., 2013). Adolescents in my study valued confidentiality to the extent that they thought that by having a new HCP in the facility every day instead of a regular provider it could be guaranteed. In the current health system of Nepal, HCPs are often placed in their hometown on practical grounds for continuity of services at the local health facilities. With the federal system now in place in Nepal, the Ministry of Health has provided for HCPs to choose a duty station close to their homes. This might further complicate SRH services for adolescents, who would prefer to have a non-local service provider. There are several benefits to having an HCP who belongs to the same community in terms of

staff retention, greater availability of HCPs in the health facility, and understanding the local setting and language. Having non-local providers may not, therefore, be practical; an alternative solution might lie in professional development for local HCPs. As noted, the need for privacy and confidentiality is so important to adolescents that they preferred the AFHS to be in an isolated setting with entrances and exits placed so as to not be easily visible to passers-by. A qualitative study in Sweden among 23 adolescents noted similar findings, with many of the FGD participants suggesting AFHS separate entrances that were not visible to other HF visitors. However, participants could not come to a consensus on this (Hällström et al., 2017). The findings of this study and the literature clearly identify privacy and confidentiality as key contributors to better adolescent utilisation of SRH services. The participants' suggestions for more isolated locations and less visible entrances and exits may be temporary, if impractical, solutions to the problem of confidentiality and privacy. A more sustainable solution would be to have greater community acceptance of premarital adolescent sexual activity.

8.2.2.2 Health care providers attitude towards adolescents

The WHO places great importance on health care providers being non-judgemental, considerate and able to relate to adolescents in a friendly way. This has to be ensured by providing appropriate training to HCPs about the importance of SRH services and encouraging them to be supportive of adolescents (Tylee et al., 2007; WHO, 2012).

The judgmental attitudes of HCPs were clearly highlighted by the experience of one FGD participant in this study, Indra, who witnessed an HCP shouting at his friend (see chapter 6, section 6.6.2, p. 170). Another reported that when he requested condoms, he was scolded by an angry HCP for visiting the health facility to obtain SRH services when he was unmarried. In some cases, adolescents were blamed for not having an adequate understanding of sexual health. The impact of such HCP attitudes is clear from Nabita's statement that she would not be returning to that health facility. While most of the HCPs had judgmental attitudes towards adolescents there were some HCPs like Shyam from case study HF B who would avail his mobile phone numbers to adolescents and provide consultations via phone if they did not want to visit the health facility and also during out of office times. As mentioned earlier in section 4.2.2.1 Shyam would maintain privacy in the health facility by serving the client one at a time in a separate room. Shyam's attitude towards adolescents might be the reason for this health facility to have 67.68% of service utilisation by adolescents despite the damage caused to the structure of this health facility by the earthquake. Judgmental attitudes of HCPs have been reported in research from other countries (de Castro et al., 2018b; Kennedy et al., 2013; Mchome et al.,

2015). de Castro et al. (2018b) conducted a qualitative study with eight simulated adolescent clients. When these simulated clients experienced being judged by the HCP for seeking contraceptives, it resulted in adolescents' diminished self-confidence. Similarly, Kennedy et al. (2013) in their qualitative study of 15-19-year olds in Vanuatu noted that HCPs denied SRH services because they disapproved of adolescents engaging in premarital sexual activity. Such negative attitudes discourage adolescents from seeking SRH services and result in poor acceptance of AFHSs (de Castro et al., 2018b; Mchome et al., 2015; Smith et al., 2018).

Literature suggests that inadequate HCP capacity building can result in negative attitudes towards adolescents' SRH (Tilahun et al., 2012; Warenius et al., 2006). Most of the SRH training in Nepal emphasises technical aspects over appropriate interpersonal communication skills. Efforts should, therefore, be made to equip health workers with the requisite competencies and skills to deliver SRH services to adolescents in a respectful, non-judgmental manner as part of regular capacity development emphasising interpersonal communication skills and privacy and confidentiality practices (Geary et al., 2014; Tylee et al., 2007).

8.2.2.3 Being able to relate to the provider

Adolescent participants in my study noted that the HCPs should be young people of similar age and the same gender who can relate to adolescents' experiences and allow them to feel comfortable sharing their issues and knowing they will be understood. As one male FGD participant explained (chapter 6, section 6.6.1, p. 167), it is difficult for adolescents to relate to older HCPs because all older people are, in Nepalese communities, considered guardians, and discussing SRH issues with people of this stature is to be disrespectful. In Nepal, mid-level health facility positions such as Auxiliary Health Worker (AHW) and Auxiliary Nurse Midwife (ANM) are the contact points for SRH service provision. Vocational training for AHW and ANM is a maximum 18 month-course after high school education i.e. grade 10. Once their training is completed these ANM and AHW are recruited to serve in the health facilities. However, by the time they are employed, many of them are already married and over 25 years of age. The findings of this current study are similar to those of others which show that age and gender similarity are important to adolescents seeking SRH services (Atuyambe et al., 2015; Erulkar et al., 2005; Regmi et al., 2010b; Smith et al., 2018). Smith et al. (2018) in their qualitative study of South African adolescents noted that participants indicated that younger providers better understand the issues and challenges faced by them. The adolescents' preference for younger and similarly-gendered HCPs would seem to be a universal one. In the context of South Asian culture, it is deeply rooted in socio-cultural, inter-generational and inter-gender relationships that respect is

shown towards people who are older, and respect includes not discussing taboo topics such as SRH (Madan-Bahel, 2008, p. 25). Furthermore, it is not commonly accepted for men and women to discuss SRH issues among themselves; men are expected to discuss such topics with other men while women discuss it with other women. This finding suggests that the AFHSs should have both male and female HCPs trained to provide SRH services to adolescents. The national ASRH program emphasises having health workers of both sexes available in AFHSs. In reality, however, shortages of healthcare providers, as discussed in chapter 5 (5.2.3), mean that HCPs are often overburdened with responsibilities and that health workers untrained in ASRH provide the services. This indicates the necessity of ASRH training for all health care providers in the AFHS facilities.

8.2.2.4 Trust between health care provider and adolescents

In a society where premarital sexual activity is not socially sanctioned, for adolescents to access and utilise SRH facilities they must be able to trust the HCPs. My study clearly demonstrates that privacy and confidentiality are currently inadequate, substantiated not only by the adolescents' experiences and what they have stated, but also by my observations of the health facilities. The lack of privacy and confidentiality experienced by Nepalese adolescents contributed to a lack of trust in HCPs. Trust is identified as an essential element in a successful provider-patient relationship (Birkhäuer et al., 2017; Gopichandran & Chetlapalli, 2013) which determines adolescents' willingness to seek care and utilise health services (Mohseni & Lindstrom, 2007; Russell & medicine, 2005). Having trust in their local HCP is crucial for unmarried adolescents in a culturally conservative society wherein their sexual behaviour is not acceptable. As discussed earlier in section 8.3.2.1, adolescents in this study feared the consequences of visiting the health facility for SRH services and having details of their consultation disclosed to their parents or other adults in their communities. The adolescents felt ashamed and fearful that their actions would bring disgrace to their families. Thus, their being able to trust HCPs to keep their visit and their information confidential, including not sharing it with other HCPs, as reported by respondents in the study, is absolutely essential if adolescents are to utilise AFHS. Lack of trust in HCPs is not a new finding; several studies have noted that adolescents do not trust HCPs to maintain the confidentiality of their accessing SRH services. For example, Kennedy et al. (2013) in their study of adolescents and key informants in Vanuatu noted that adolescents' not trusting that their information would be kept confidential was an important barrier to utilising SRH services. Conversely, their trust towards HCPs increased when detailed information and the opportunity to interact via question and answers were provided. It is not only adolescents who name trust as an important element; HCPs in India have identified that adolescents' trust in HCPs

is important to increasing utilisation of SRH care from health facilities (Mahalakshmy et al., 2019). While (Mahalakshmy et al., 2019) noted that HCPs mentioned rapport building and improving privacy at the health facility was necessary for building trust, de Castro et al., (2018b) in their research in Mexico found adolescents trusted HCPs if they properly explained the details relating to their SRH queries. While other studies have linked adolescents' trust to lack of privacy and confidentiality, what is unique in the context of this study is that for the adolescents, trust meant not sharing their information even with other HCPs, in addition to others in the community.

There is no single solution to problem of trust as perceived by adolescents because there are so many dynamics involved, including HCPs' social and communication skills, and their capacity to respect the SRH needs of adolescents (Allinson & Chaar, 2016).

8.2.2.5 Environmental issues

The physical environment of the service delivery point should be appealing and clean, according to the WHO (2012). In this study, adolescents raised concerns as about the cleanliness of the waiting areas and toilets and the availability of clean drinking water. It was also only adolescents who thought that having a clean and hygienic health facility was important not only for them but also for sick patients and none of the other group of participants raised the issue of cleanliness. The issue of cleanliness in public health facilities is not unique to Nepal. A systematic review conducted by Mazur et al. (2018) showed cleanliness, separate toilet facilities, lighting and ventilation were some of the major criteria for an adolescent-friendly environment. Another systematic review of indicators for youth-friendly health care from young people's perspectives conducted by Ambresin et al. (2013) noted that cleanliness was one of the priority indicators for low-income countries. Similarly, cleanliness was the reason that adolescents preferred going to private clinics in Puducherry, India, because they were clean compared to public health facilities (Mahalakshmy et al., 2019). Clean and hygienic health services are important for all patients irrespective of age and gender.

8.2.3 Appropriate health services

Appropriate services are those that are the right ones to fulfil the needs of adolescents and that are provided at the point of health service delivery on the day of visit or through referral services to appropriate health facilities (WHO, 2012). In this study, appropriate service provision by health facilities included promotive, preventive and curative services including providing SRH information; free counselling; contraceptive services; and treatment of any SRH related conditions. However, adolescent participants were sometimes unwilling to visit the health

facilities with these appropriate services because they had experienced poor availability of SRH supplies. In the study conducted in Ethiopia by Dagnew, Tessema, and Hiko (2015), adolescents who received drugs during their visit to the health facility were 2.7 times more satisfied than those who did not. Adolescents in this current study mentioned the need for AFHS service to be comprehensive, which included providing contraceptives, information, education and communication (IEC) materials, drug treatments for illnesses and disease, and community awareness programs on a regular basis. A national stakeholder, Bishnu, even suggested that making pregnancy testing kits available would be an appropriate AFHS feature. Since the services nominated by adolescents were not provided by AFHSs on a regular basis, their expectations were not being met, and this may have affected their utilisation of health services. This research did not explore in depth the appropriateness of the existing services as this research focused on understanding the utilisation of AFHS and survey to determine adolescents' health needs in community was not within the scope of this study. While it can be argued that appropriateness of services may be a reason for poor utilisation of AFHS, this was not elicited in the interviews or focus group discussions. It must be noted that in this current research there was no specific probing for appropriateness of the services provided. Hence, further research that would determine the needs of adolescents and its comparison with the available service at the point of delivery or through referral linkages could be helpful to understand this area more precisely.

8.2.4 Effective health services

Services that are provided in the right way and make a positive contribution to adolescents' health are effective services (WHO, 2012). This relates to HCPs' knowledge and skills pertinent to adolescent SRH, their using evidence-based protocols and guidelines to provide health services, giving adequate time to adolescents, and making sure the necessary equipment, supplies and basic service requirements are available (WHO, 2012, p. 36-37).

From the interviews with HCPs it was clear that they possessed the knowledge necessary to know what SRH services adolescents needed. They had acquired this knowledge from their training in family planning, safe motherhood and termination of pregnancy. All of these training courses have components covering counselling and treating patients respectfully and confidentially. However, as discussed earlier in section 8.2.2, HCPs lacked communication skills and had poor attitudes towards adolescents SRH needs. The National ASRH orientation guidelines for AFHS pertain only to program orientation and do not cover specific skills for adolescent counselling and treatment. Hence, a step-by-step guide and training in counselling

and treatment could be an area to strengthen if the capacity of HCPs is to be enhanced. This research could not examine the adequacy of time given to adolescent consultations, and in relation to AFHS effectiveness, because there were only two adolescents who participated in client exit interview in the three months data collection period *(refer to chapter 4, section 4.10.2.2)* and the information obtained was not adequate to draw conclusion. This could be an area for further exploration.

8.2.5 Equitable health services

Health services are equitable when all adolescents, not only selected groups, are able to obtain the health services they need. This is facilitated by policies and procedures in place that ensure health service provision to all adolescents, along with their equal treatment (WHO, 2012).

Nepal's adolescent SRH program implementation guidelines clearly state that all adolescents should be provided with SRH services irrespective of their age, sex, sexual orientation or social status, without prejudice or judgement (MoHN, 2011a, 2011b). All HCPs in the health facilities studied had been introduced to these principles during their orientation to the ASRH program. It was also observed that all of the facilities had the orientation guidelines on the premises, and all the HCPs mentioned that they knew about this policy. Moreover, during the interviews, HCPs said that they did not judge, or discriminate adolescents based on their age, sex, sexual orientation and marital status. However, from the perspective of the adolescents, not all of them were "being treated equally" by HCPS compared to other people who were older in age, adolescents who were married or belonged to higher socio-economic group. As noted in chapter 5, the experiences of the Chepang community clearly highlighted discrimination by HCPs notwithstanding that a hallmark characteristic of an AFHS is to ensure that all adolescents are provided with nonjudgmental and non-discriminatory SRH services (WHO, 2012). A qualitative study among South African adolescents (12-17 years) considered that designated adolescent-friendly health services might result in less discrimination towards young people (Smith et al., 2018). However, this does not seem to apply to AFHS in Nepal; in this current study adolescents felt that health facilities recognised as AFHSs nevertheless discriminated against them. Tylee et al. (2007) in a *Lancet* series on adolescent health noted that in a society where age and social status comes with a power differential, adolescents have limited agency to exercise their choices. Nepali society practises discrimination based on age, caste and economic and social status (Pandey et al., 2006) which possibly influences the relationship between HCPs and adolescents. Adolescents in this current study provided examples of health care providers treating them "like children" and with disrespect because of their age, and ignoring their SRH

needs. Similarly, adolescents from the (disadvantaged) Chepang community experienced rude behaviour from HCPs because of their poor social and financial circumstances. While the fact that Chepang adolescents did receive SRH services suggests equality of access, the judgemental and disrespectful attitudes ofthe HCPs raises concerns about the equality of treatment. This then raises the question of whether there is equitable service for all Nepalese adolescents. From the evidence in chapter 6, it is clear that when it comes to adolescents from the Chepang community there was no perception of equality. This also questions the legitimacy of the health facility being recognised as an AFHS. The findings relating to equitable services for Chepang adolescents is a key finding of this study, particularly in the light of Daley et al.'s (2017) meta-ethnography of adolescents' expectations of their healthcare providers, which suggested that adolescents wanted to be accepted by the HCP regardless of their race, ethnicity, age, appearance, or the nature of their health care needs.

8.3 Moral framework in sexual and reproductive health of adolescents

In the sections above, I have discussed the findings of this study within the WHO's quality of care framework. This framework does not pay adequate attention to the local socio-cultural context of AFHS, which was a dominant theme generated in my qualitative findings. Therefore, in the following section, I discuss the socio-cultural context and moral framework that underpins many of my findings.

8.3.1 Socio-cultural context

The findings from this study show that adolescents had limited access to SRH information. It is clear from the study findings and also from the literature that this is closely linked to conservative socio-cultural norms which make open discussion of sex and sexuality unacceptable. This situation is maintained by vigilant community members who act as gatekeepers. Studies from other countries have noted that community members might act as gatekeepers of adolescents' access to SRH information and services (Kennedy et al., 2013; Nash et al., 2019). Nash et al. (2019), in their qualitative research conducted in Malawi with female adolescents, parents and key informants, found that parents were the major gatekeepers of their adolescent daughters' access to SRH services and information. While research from developed countries has noted that adolescent- parent communication promotes safer sexual behaviour among adolescents (Amialchuk & Gerhardinger, 2015; Widman, Choukas-Bradley, Noar, Nesi, & Garrett, 2016), this is not the case in a culturally conservative society like Nepal, where the notion of sexual activity of unmarried adolescents is itself stigmatised. Further, as discussed in Chapter 2, section 2.5.2 and Chapter 5, section 5.1, there have been some efforts

to teach SRH education in schools. However, my research and other studies in Nepal showed that the teaching-learning process was embarrassing for both teachers and students (Acharya et al., 2018; Acharya et al., 2009; Pokharel et al., 2006). Furthermore, Acharya et al. (2018) argued that ineffective teaching and learning of SRH in schools could be due to school teachers' poor knowledge and skills for delivering SRH information. My research provides an additional perspective, that of the socialisation of teachers. A school teacher, Tek, mentioned, *he never heard his parents, brother or sisters discuss sex while growing up*. Given the typicality of this norm in Nepali society, this may affect the capacity of school teachers to deliver SRH education to adolescents. Participants in this study further shared that in the closed-network communities of Nepal, teachers and students often live in the same neighbourhood or are related to each other, which results in discomfort experienced on both sides in discussing sex-related matters. The paucity of information provided at home and in school, together with a lack of community support for adolescents accessing SRH services might pose a risk to adolescents' sexual health.

8.3.2 Moral guardian or health care provider

The findings from interviews with adolescents and HCPs clearly showed that HCPs performed a dual role, professional as well as a moral. Often, HCP attitudes towards adolescents were determined by their moral framework around sexual behaviour, especially as it pertained to unmarried adolescents. Adolescents noted that HCPs would "lecture" and "shout" if they went to seek contraceptive and abortion services. Given that it was only unmarried adolescents who noted experiencing this kind of attitude, it is likely that HCPs "lecture" or "shout" because they are guided by their moral framework. This moral framework is rooted in the prevalent social and cultural expectations of the Nepali society that views premarital sexual activity as unacceptable (Puri & Busza, 2004; Regmi et al., 2011). Foucault (1985) explains morality as a set of values or "rules of action" that people are expected to follow prescribed by various parties within a society. In this study, these parties included families, schools and religious institutions, as well as health facilities. HCPs such as Ram and Sara were clearly guided by the moral values they learnt through their socialisation. The moral framework that seems to guide HCPs shapes how they deliver SRH services. This was especially apparent for older HCPs interviewed for this study. When a significant practitioner-adolescent age gap existed, it was difficult, particularly for older HCPs, to accept adolescents being sexually active. HCP Ram's words *there is some difference in how I deal with married and unmarried adolescents* is one example of health workers' attitudes as guided by the moral framework that informs Nepali society. Thus, while Ram found it easy to

talk about contraceptives to married adolescents, he questioned why unmarried adolescents needed them.

Also, HCPs found it challenging to communicate and disseminate SRH information to unmarried adolescents, especially if they lived in the same community. As mentioned in Chapter 5, in the more rural areas of Nepal, communities are close-knit, often through kinship, and also through the role of moral guardianship assumed by older adults. In that context it was suggested that some HCPs feel entitled to judge unmarried adolescents, and this attitude was mirrored in their treatment of adolescents who came to the facility. Adolescents like Indra and Maya, as mentioned in chapter 5, related how the HCP was angry when they went to the health facility to get condoms; other adolescents experienced being "lectured at" for seeking SRH services. It could be argued that displaying this kind of attitude is a form of "moral policing", which is perceived by adolescents as unfriendliness, at least by unmarried adolescents, or married adolescents wanting to terminate a pregnancy. This is not unique to Nepal – other studies in developing countries have also highlighted similar moral attitudes towards adolescent sexual behaviour (Müller, Röhrs, Hoffman-Wanderer, & Moult, 2016).

In this current study adolescents clearly wanted adequate time to discuss their concerns and wanted to be treated with respect and to feel comfortable and valued. However, when HCP's operate within a moral framework adolescents feel they are being judged and disrespected and therefore they are unlikely to seek help from these HCPs or if they do come to the health facility they are likely to want their time with the HCP to end quickly. The tension between "moral policing" and providing SRH services may result in a narrow focus on SRH education "dictated by personal values and beliefs" (Muller et al 2016, p. 72). As discussed in this thesis, I would argue that adolescent sexual health can be considered in Nepal as a "highly morally charged terrain" (Muller et al 2016, p. 72). Thus, a moral framework is likely to lead to HCPs practicing within a narrow definition of SRH service and ignoring essential SRH services such as cervical screening, sexual coercion and sexual violence, sexual orientation and mental related to sexual health issues for fear of encouraging adolescent sexual activity and potential repercussions from parents. Such impact of a moral framework on the quality and kind of services provided has been demonstrated within the South African context (Muller et al, 2016).

8.3.3 Gendered Morality

Socially defined gender roles prescribe what are socially acceptable activities and behaviour for male and females. Although gender roles create restrictive differences between male and

females in Nepalese society, in the context of SRH, the moral framework is stricter for the sexual behaviour of females. Sexual behaviour is a gendered phenomenon, as in most South Asian societies (Abraham, 2001), and sexual intercourse is socially sanctioned for females only within the bounds of marriage (Mathur, Malhotra, & Mehta, 2001). Both males and females were subject to derogatory labels such as *Kharab Bani* or *BIKRITI;* any deviation from the moral framework, however, makes females more vulnerable to these "bad behaviour" labels even though their male counterparts are presumably equal partners in the behaviour. Connell (Connell & Messerschmidt, 2005) makes the point that premarital sex has few repercussions for men; rather, it is with a marker of men's power in a patriarchal society. Connell's statement is certainly true in the context of this study and made explicit in *BIKRITI* applying solely to female adolescents (chapter 6, section 6.2.2, p.157-159). The persistence of patriarchal attitudes in Nepalese society is evident when adolescent boys are not blamed or judged in the same manner as girls, and do not face the same consequences of engaging in premarital sex. The purpose of labelling is to suppress behaviours that deviate from the socially acceptable, as Bob Fine (Fine, 1977) has noted. This kind of gendered judgement can create confusion for male and female adolescents who share a sexual relationship with each other. These kinds of beliefs could also create a dilemma for female adolescents in discussing their issues with their partners as well as accessing SRH services from AFHS, where there is fear of being identified, and f its consequences. The dilemma is a dangerous one for adolescent girls given their vulnerability to SRH problems including unwanted pregnancy and sexually transmitted infections. Such a situation raises another question about the equitability of SRH services.

In summary, in the above sections I have presented the main findings of the study in line with relevant literature and within the WHO-defined adolescent-friendly criteria for health services. While geographical accessibility was pertinent, what was more important to adolescents was the confidentiality of AFH services. I have discussed privacy and confidentiality as an important factor that affects adolescents' acceptance of AFHS. Another aspect of AFHS acceptability discussed was the attitude of HCPs to adolescents, which had implications for the trust they had in service providers. I have discussed gender differences and the moral framework that surrounds adolescent sexual behaviour which has profound effects for adolescents' SRH service utilisation.

In the next section, recommendations and policy implications arising from the study are presented, followed by strengths and limitation of this study that could have affected the results.

8.4 Recommendations and policy implications

Based on the research findings presented, I now discuss their implications, and make recommendations for policy. As discussed in chapter 4, which detailed the methodology of the research, guided by pragmatism I focused on drawing out potential solutions to the problem of poor utilisation of SRH services by adolescents in Nepal (Creswell, 2013, p. 28). The recommendations provided here draw on findings from data collected from in-depth interviews and focus group discussions, as well as the half-day stakeholder workshop (Chapter 4, section 4.10.3).

The recommendations are presented within the following five action areas of the Ottawa Charter for Health Promotion (WHO, 1986):

a) building healthy public policy;

b) creating supporting environment;

c) strengthening community actions;

d) developing personal skills; and

e) reorienting health services

All of these areas of action are relevant to promoting the adolescents' sexual and reproductive health and the role of adolescent-friendly health services in directly contributing to it.

8.4.1 Developing a healthy public policy for promoting the SRH of adolescents

Currently, Nepal does not have a dedicated adolescent health policy; instead, the current national health policy makes reference to the need to incorporate adolescent-friendly health services in all health institutions under its policy "*to provide quality health service to every citizen in an effective way and provide basic health services free of cost*" (Government of Nepal, 2014, p. 11). While the Ministry of Education has developed a comprehensive sexuality package (MoEN, 2017), it is yet to be integrated into education curricula and policy. In light of this, Nepal could benefit from revising the Adolescent Health and Development Strategy to include more doable actions to address the following issues:

- Advocate to increase the dedicated budget for adolescent SRH to improve the quality and coverage of services.
- Expand inter-sectoral coordination and collaboration between the Ministry of Health and Ministry of Education. Adolescents could be reached by providing SRH services

through secondary schools, youth centres, and private institutions such as pharmacies and NGO-run clinics. A systematic review conducted by Denno et al. (2015) of effective strategies for delivering ASRH services noted the positive service utilisation outcome of SRH services being provided at youth centres. Nepal could also apply this type of approach to increase the number of service delivery points for adolescents through engaging local youth organisations. Nepal could also benefit from its current health sector strategy which plans to establish adolescent-friendly information corners in schools (Ministry of Health Nepal, 2017a).

- Build public-private partnerships with poly-clinics and pharmacies that are established in both rural and urban areas as part of the private health sector in Nepal (Ranjit, 2016). Building the capacity of HCPs working in the private sector would provide an opportunity to deliver SRH services.
- Increase investment in SRH research and development studies to improve program management, capacity building, quality standards, and evidence-based advocacy.
- Foster collaboration with the non-government and private organisations, religious institutions, community-based organisations, and adolescents to expand comprehensive sexual and reproductive health education.

Finally, adolescents' SRH is their concern, and should be led by adolescents themselves. Hence, strategy formulations should actively engage adolescents at all stages to ensure that their needs and expectations are appropriately addressed and fully met.

8.4.2 Creating a supportive environment

The socio-cultural norms and values attached to unmarried adolescents' SRH health have an impact on SRH service utilisation. Hence, interventions should be comprehensive, with community support being sought to address the socio-cultural issues impeding AFHS utilisation. AFHS interventions that have community support and acceptance have been shown to be effective in catering to the SRH needs of adolescents (Denno et al., 2015; Mmari & Magnani, 2003). As mentioned in Chapter 2, section 2.7.1, Nepal's Adolescent Health and Development Strategy 2000 introduced a holistic approach to adolescents' SRH that involved creating enabling environments, strengthening the capacity of health care providers, and developing demand-generation activities for adolescents (MoHN, 2000). To date, however, the activities of the program in Nepal has focused on SRH service provision and demand-generation activities only. Some of non-profit organisations like CARE Nepal, and international development agencies such as UNFPA have piloted holistic approaches to creating adolescent-friendly environments

through social mobilisation and behavioural change communication activities, with successful intervention outcomes (Taylor, 2007; The ACQUIRE Project, 2008). These studies showed that creating an enabling environment within communities improves adolescent access to SRH services and information (Taylor, 2007; The ACQUIRE Project, 2008). These initiatives were limited to catchments of only a few villages and were never scaled up, and programs ended when external funding was withdrawn. Kennedy et al. (2013) in their study of adolescents in Vanuatu emphasised the importance of community engagement to generating support for adolescents' SRH, especially among community gatekeepers such as parents and community leaders. Nepal could learn from successful interventions in local cultural settings inside and outside the country and build on such results to support its adolescent health program.

Another important aspect of creating a supportive environment for adolescents is appropriate health facility infrastructure that offers visual and auditory privacy during consultations. Given the fact that Nepal has experienced challenges to its health infrastructure, health facility operation and management committees (HFOMC)[16] could engage adolescents in discussing possible solutions space allocation or improvisation for the provision of privacy.

8.4.3 Strengthening community actions

Strengthening community action is about developing partnerships and alliances with local community organisations with the aim of their committing to supporting the SRH of their adolescent members. Community action also requires that communities are empowered to steer their own initiatives (Chandra-Mouli, Plesons, Hadi, Baig, & Lang, 2018) cite the inspiring results achieved by Pakistani organisations Aahung and Rutgers in their promotion of adolescent SRH education by strengthening community organisations such as local media, religious institutions, adolescents' influencers and schools. One of the community action areas for Nepal could be engaging HFOMC and strengthening their capacity in planning, designing, implementing and evaluating community-based adolescent health promotion activities. In addition to this, the local municipal government could provide funding for these activities so that ownership can be taken. HFOMC should also invite adolescent representatives to participate in setting the ASRH agenda.

As mentioned earlier, socio-cultural norms and values around adolescent sex and sexuality had an immense impact on adolescents' access to SRH services from AFHS. These social prescriptions

[16] HFOMC is an operation and management committee responsible for health facility governance at the community level constituted in local elected members, FCHVs, community and religious leaders, women's representatives and school teachers.

informed the community expectation that adolescent-friendly health services should promote sexual abstinence for unmarried adolescents rather than treat their SRH. Concerted community interventions that address socially-entrenched beliefs about adolescents' sexuality through behavioural change communication (BCC) are recommended to help support the rights of adolescents to unfettered access to SRH information and services. This could be achieved by developing tools and techniques, tailored information, and educational messages to suit local contexts and languages, with increased frequency in dissemination. Various support-generation activities among community gatekeepers are necessary to address the issues of adolescent access to SRH services. Media campaigns and social mobilisation activities like street drama and rallies could add value to community reach.

8.4.4 Developing personal skills

Strategies which enable adolescents to make choices that will assist their healthy transition to adulthood involve developing their personal skills and capacities in effective communication, self-expression and interaction with health care providers and other adults. Comprehensive sexuality education (CSE), an awareness program, and social mobilisation interventions are the keys to developing the personal skills of adolescents. Therefore, CSE should be made an integral part of education in schools, and informal channels for sex education should be developed for adolescents who are not in school. As discussed in chapter 2, the CSE curriculum has been designed which is yet to be implemented and evaluated. This is one of the areas for government focus, since it supports the thrust of the AFHS program. CSE would allow adolescents to be more informed and, in turn, more effectively express their SRH concerns and issues to HCPs.

Peer education is one of the strategies globally acknowledged to help to increase awareness, provide information and help fellow peers to develop personal behaviour change skills. The government could also support peer educators, along with CSE, to reach adolescents in the community with SRH information. Research has demonstrated that adolescents who have learnt about SRH through peer education are likely to utilise SRH services from health facilities (Feleke et al., 2013; Swartz et al., 2012; Thin Zaw, Liabsuetrakul, Htay, & McNeil, 2012). (Feleke et al., 2013) reports that discussing voluntary counselling and testing (VCT) within peer groups was significantly associated with VCT service utilisation.

Similarly, Swartz et al. (2012) noted that adolescents living in rural and remote areas with poor educational and economic resources benefited from peer education, showing improvements in HIV and AIDS knowledge and health seeking behaviour. The success of peer education relates to

adolescents having the opportunity to engage with information disseminated by peers of similar ages, with whom they are more open to discussion (Mason-Jones, Flisher, & Mathews, 2010; Sandhu et al., 2013). In Nepal, peer education has been implemented by several NGOs and INGOs to enhance the delivery of SRH information and services to adolescents. These efforts have, however, been only sporadic, and their outcomes have never been of interest for scaling up in the government system. Integration of peer education into the health system could be beneficial for AFHS utilisation.

Cell phones and the internet are increasingly in use in Nepal among adolescents – there are 250 new users every hour (Neupane, 2018). The success of m-health has also been documented in reaching adolescents with SRH information (Cho et al., 2018; Olsen, Plourde, Lasway, & van Praag, 2018). By tapping into this trend, Nepal could develop m-health interventions for adolescents and perhaps disseminate information via apps or SMS.

8.4.5 Re-orienting health services

Strengthening national health systems is one of the major areas identified in the literature as an important component of promoting/addressing the sexual and reproductive health of adolescents. Improving health care provider training in technical, interpersonal counselling and communication skills with add-on analytical competencies in identifying underlying attitudes, values and cultural norms are characteristically important elements of better health systems. In Nepal, HCPs have an important role, as resource persons in the community, in dispensing SRH services to adolescents. My research indicated that adolescents were reluctant to access AFHS because of HCPs' attitudes. Further, their privacy and confidentiality were compromised, and adolescents faced judgemental behaviours that were demotivating. As discussed in section 8.2.3.5, HCPs' negative attitudes may be the result of inadequate capacity (Tilahun et al., 2012; Warenius et al., 2006). Hence, capacity-building training and regular refresher training interventions for HCPs to update their knowledge and develop positive behaviour, attitude, and counselling skills are of paramount importance. Together with ongoing ASRH capacity-building interventions, the government should include ASRH competencies in basic pre-service education curricula for all primary health workers like nurses, HA, ANM, AHW and midwives to ensure whoever encounters adolescents have the skills to deal with them in a sensitive and effective way.

In addition to counselling training, Turner, Pearson, George, and Andersen (2018) note that training for HCPs needs to be experiential and immersive so that they can examine their values and do not impose their personal moral framework on their provision of adolescent SRH

services. Values clarification has previously been successfully applied to reduce HIV stigma (Kidd et al., 2003), and improve medical abortion care (Cappiello, Beal, Gallogly-Hudson, & Nursing, 2011; Mpeli, Botma, & Justice, 2015; Turner et al., 2018). Also, Nepal has adopted and translated the WHO adolescents' job aid which is a reference tool and step-by-step guide for HCPs to interact with adolescents (WHO, 2010). Techniques such as establishing rapport and clinical interaction skills that are included in the job aid need to be reinforced among HCPs.

Regular monitoring and supervision of AFHS could be another area to strengthen capacity of HCPs. Frimpong et al., (2011) in their study in Ghana established that monitoring and supportive supervision is associated with increased productivity of HCPs as they felt supported by their supervisor. Nepal has developed the monitoring and supervision tools for ASRH program which could be effectively implemented to supportive and encourage HCPs in delivering quality health service to adolescents.

8.5 Recommendations for future research

A number of areas for future research have emerged from this research. First of all, adolescents' utilisation of AFHS was explored only in Dhading district because of the time and budgetary constraints. Dhading is a semi-urban district, and it has better information access in comparison to remote rural areas where there is very limited access to media, and which have strong socio-cultural traditions which could provide a different perspective on adolescent SRH and AFHSs. Hence, further research set in other regional areas might produce interesting differences in results for ASRH service utilisation.

Since my research was focused on exploring factors contributing to the utilisation of SRH services by adolescents, the SRH health issues of adolescents were tangential to the study's aims. There is limited research in Nepal that has explored adolescents' SRH health concerns in depth, hence exploratory research is important to the development of specialised health services.

As discussed, earlier CSE is yet to be scaled up in Nepal. Future research concentrating on exploring the effectiveness of CSE on adolescent's knowledge about and attitudes towards sex, sexuality and SRH services could help to create a dialogue with policymakers to integrate CSE into the regular school curriculum.

8.6 Strengths of the study

This study has several strengths. The main strength is its use of a case study methodology to understand the utilisation of ASRH services. Maximum variation sampling (Suri, 2011) was

applied to ensure a diverse range of participants, as noted in chapter 4, which gathered diverse perspectives and added to the credibility of this study. The research included a broad range of health facilities with varying performance standards and qualities. Perspectives were obtained from a range of stakeholders to inform a holistic understanding of the utilisation of SRH services from AFHS. These included service providers as well as adolescent recipients.

Given that the literature indicates the enormous influence of socio-cultural factors on sexual and reproductive health, the perspectives of key informants from the community were also sought. These included parents, teachers, health facility operation and management committee members, religious leaders and stakeholders working in the field of ASRH in Nepal such as NGOs, INGOs and UN organisations. To collect this diverse range of perspectives from a variety of participants, different methods of data collection were used, including, in-depth interviews, focus group discussions and observations.

As mentioned in the chapter on methodology, another strength of the study was the trustworthiness of the research process, which included pre-testing the study tools in another, non-study, district through a detailed process of revision, as described in chapter 4.

This study has focused on a sensitive topic, discussion of which is, in some situations, proscribed in a country like Nepal. As noted in chapter 2, it is not culturally accepted to talk openly about sexual and reproductive health issues. As has been noted in the literature (Barter & Renold, 2000; Hughes & Huby, 2002), it is difficult to obtain rich information about culturally sensitive topics. Hence, using creative methods to explore such a sensitive topic is a key strength of this study. By using vignettes and drawings, as described in chapter 4, a safe environment was created for adolescents to share their experiences of seeking SRH services.

Finally, I was the main researcher in this study. As noted in the introductory chapter, I am a Nepalese with a well-established career in the area of SRH in Nepal, which has earned me the trust of HCPs and the Nepalese community in general. This enabled me to build rapport and trust among my research participants, which strengthens the authenticity, trustworthiness and credibility of the data collection.

8.7 Limitations of the study

This study has addressed a very important and burning public health issue in Nepal. It does have some limitations that need to be mentioned. One is the generalisability of the findings. Participant selection for the study was continued until I was satisfied that the data would be adequate to answer the research questions (Fusch & Ness, 2015). However, the findings of this

study cannot be generalised to other contexts. While it must be noted that this was not the purpose of this study, it nonetheless fulfilled its purpose of gaining an in-depth exploration of what contributes to the utilisation of AFHSs in Nepal. Moreover, the findings may be transferable (Cope, 2014) to countries with similar socio-economic conditions.

Secondly, the research had some methodological limitations. The study covered only one district of Nepal and its AFHSs. I chose six AFHSs that were in geographically accessible locations, to fit time and resource constraints. Thus, this study does not provide an understanding of the barriers faced by adolescents living in more remote locations. Their challenges are likely to be different from those of the adolescents living in the catchment areas of the six selected sites. Also, as Nepal is a highly multicultural and multi-ethnic country, the factors associated with challenges to accessing SRH services might be different in other settings. A multi-district study with a broader representation of different regions and ethnic communities would give a wider understanding of the Nepalese context.

Third, participants were selected from the ethnic groups represented in each study site, and these included Brahmins, Chhetries, Tamang, Newar and Chepangs. These groups are all Hindu castes, and this study did not include participants from Muslim or Christian minorities. The availability of those groups at the study sites might have provided additional perspectives. Similarly, the study did not include adolescent participants with different sexual orientations, including lesbian, gay, bisexual, transgender and intersex and adolescents with disability. The inclusion of these groups in future studies would help illuminate more diverse perceptions and experiences of adolescents, provide us with richer insights and a more nuanced picture of what contributes to the utilization of adolescent-friendly health services, particularly the cultural and social context in which adolescents seek these services in Nepal.

Finally, while I have noted my professional and ethnic background as a strength, it is also important to note that this background could also have influenced the way some participants responded to the interview questions. As noted in chapter 4, some HCPs and KIs may have left out some information because they expected me to know it. For instance, some of the participants would say *"you know it Didi (sister)*" and would not provide any more detail when they felt that as the researcher-expert, I already knew the answers. However, the use of probes helped to explore the answers during interviews. Nevertheless, it is also possible, that some HCPs may have given me the answers they thought I would want to hear.

The service utilisation records at the health facility were of poor quality and were difficult to make sense of. Hence, I had to collect data from the district-level compiled reports, which are secondary sources. The primary source of data would have allowed making additional analyses such as marital status and equity of access among the different ethnic group which would have enabled a conclusion on adolescent utilisation of AFHS among different groups.

Given the timing and ethical concerns, I was unable to observe the actual delivery of SRH services to adolescents. Initially, the observation was to be part of the study, but the Nepal Health Research Council did not approve the observation. Their alternative suggestion of exit interviews with adolescents did not eventuate, as described in chapter 4. I therefore needed to rely on the information provided in in-depth interviews with adolescents based on their memories of their experiences of receiving SRH services. Sometimes this experience was up to six months old, so it is possible that some details of their experience were forgotten or misremembered during the interviews.

Despite these limitations, the findings of the study are important in their highlighting the status of adolescent-friendly health services and the factors associated with adolescents' utilisation of SRH services in a developing country context.

8.8 Conclusion

Addressing the sexual and reproductive health of adolescents is an important landmark in creating a future generation of healthy adults who may be parents, teachers, health care providers and policymakers. An effective adolescent-friendly health service could address some of the SRH concerns of this group. As a person working in the field of SRH for more than a decade, I was emotionally attached to this research and passionate about the whole research process and its outcome.

In this research, I was able to present information on outcomes of the Nepali government's AFHS program for two fiscal years during which the SRH service utilisation of almost half of the health facilities assessed had declined. My observations of AFHSs also suggested that half of the health facilities had poor compliance with national standards. I then attempted to understand the perspectives of adolescents, HCPs and community stakeholders on barriers to service utilisation from AFHS. I was able to present the findings of this research with reference to the WHO's quality of care framework, which provides a clear guideline for AFHS requirements. These criteria were relevant in many areas for AFHS in Nepal. However, the WHO's framing of accessibility is insufficient in the cultural context of Nepalese society, and demanded a deeper

examination of its meaning, using a social lens. The quality of care framework does provide a guide for improving adolescent access in general terms. The larger share of issues in the context of Nepal was related to the WHO's criteria of acceptability for AFHSs. Social and cultural norms and beliefs often regulate the decisions and actions of people in society, and in the study, health care providers were seen to be part of this bigger picture in which found adolescents found their attitudes towards their SRH to be unacceptable. The hierarchal gap between adolescents and health providers resulted in adolescents having little trust that their intimate concerns would be kept confidential. These key findings on the barriers to utilisation of SRH raised the question of whether current AFHSs in Nepal are truly adolescent-friendly. Further, should the current AFHS program continue to be scaled up without any modification? These are plausible questions prompted by the findings about the meaning of AFHS for adolescents, which could be the hope of modifications to the current AFHS program. For adolescents, AFHSs are clean and pleasing environments where privacy and confidentiality are ensured, where they are treated like friends, and their needs are respected.

To conclude, in this study, I made an attempt to understand the barriers to AFHS utilisation, but a comprehensive understanding could be gained from future research with multi-religion and wider geographic coverage. Thus, new areas for research have arisen from this study. This study has added to the global knowledge of adolescent-friendly health facilities and established the fact that socio-cultural norms and values need to be addressed for wider acceptance of AFHS. The findings of this study are useful and applicable within South Asian and global contexts. I anticipate that they will trigger policy and decision makers to review the current AFHS program in Nepal and make meaningful modifications that will strengthen its acceptability to adolescents and improve their utilisation.

8.9 Next steps: dissemination of research results and advocacy

Dissemination of the research findings among relevant stakeholders and research participants is important to initiate discussion of ASRH in Nepal. Although the preliminary findings were discussed during the recommendation collection workshop, a final and detailed report of the results will be shared with policymakers and stakeholders. At the international level, some of the study's findings have been shared at two international conferences. Also, one manuscript (*included in Appendix B.1*) which has been submitted to an international journal is under review a. An additional two manuscripts based on the research findings are currently being developed for publication. The research findings will continue to be presented to national and international audiences to add to the global discussion of adolescent sexual reproductive health.

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APPENDICES

Appendix A: Field Work Materials

The Appendix A consists of documents that supported fieldwork for all three phases of the study. The following documents are presented in this appendix

Appendix A.1: National Standards (Standard Operating Procedures) for adolescent-friendly health services in Nepal

Appendix A.2: Health facility observation checklist

Appendix A.3: Participants recruitment flyers and invitation letter to central level actors for interview

Appendix A.4: Health service utilisation data collection tool

Appendix A.5: Qualitative data collection tools – Interview and focus group discussion guidelines

Appendix A.6: Recommendation collection workshop invitation letter, workshop concept and list of participants (third phase of the research)

Appendix A.7: Ethical Approval letters from Human Research Ethics Committee (HREC), UNSW and Nepal Health Research Council (NHRC)

Appendix A. 8: Participant information and consent forms for health care providers, adolescents and key informants in English

Appendix A.9: Participant information and consent forms for health care providers, adolescents and key informants in Nepali language

Appendix A.10: Home Interview Safety Protocol

Appendix A.1 National Standards (Standard Operating Procedures) for adolescent-friendly health services in Nepal

AFHS Management	Remarks
Display the AFS logo outside of the health facility	The AFHS logo is a symbol showing adolescents and the community that the health facility (HF) is now providing AFHSs. The AFS logo should be prepared by the health facility once the orientation to the HFOMCs and the service providers has taken place. The health facility can have an opening ceremony if they wish and could invite key local stakeholders from surrounding schools, youth organizations, etc.
Clearly communicate the scheduling and scope of AFHS to the community	The opening times of the AFHS should be made visible outside the health facility using the format given in the National ASRH Implementation Guide.
Include the provision of AFHS in the Citizens Charter	When updating the Citizen Charter, include the provision of AFHS and the right to adolescent sexual and reproductive health (ASRH) in the Citizens Charter.
The AFHS at your health facility is well promoted in areas where adolescents gather and in the community	Adolescents do not yet know that AFHS exist at your health facility so to create demand, the community and other institutions need to be informed about the availability of AFHS. The use of local radio or another type of media to advertise the AFHS is also possible.
Linkages are established with schools, youth clubs, child clubs and other institutions that work with or for adolescents	Linking with other organizations and institutions means sharing resources and ideas to improve ASRH at the community level. It also means you can establish referral systems to and from other types of service providers addressing young people's social and economic needs if these are available.
Health workers receive support and supervision	Health Facility Operation and Management Committees (HFOMC) need to ensure that the HFs has space for private and confidential counseling by planning for and providing the necessary infrastructure. Health workers (HW) should be supported by the HF in charge to conduct the service provision in an adolescent-friendly manner.
An adequate client record and reporting system have to be maintained	Recording and reporting are important to monitor whether the utilization of the health services provided is increased among adolescents in your catchment area. This method will also help you assess whether your health facility is successful in attracting more adolescents.

Adolescents should be included in the HFOMCs as an invitee member	Adolescents can give advice on their needs and will help the health facility become more adolescent-friendly by proving their views in the HFOMC. They can also actively use their networks to support demand creation activities. Participation of adolescents in programs that affect them is also good practice.

Delivering AFHS	**Remarks**
Ensure Clinic timing suits the needs of adolescents	Adolescents are attending school, so if possible put aside special opening hours just after school. If this is not possible, then display the general clinic opening times and add that adolescents are welcome.
Ensure the health facility is clean and comfortable for adolescents	Clean health facility is a general quality criterion for health facilities and is expressed as an important factor in adolescents.
Ensure privacy through a separate counselling room or the use of curtains	Ideally a spare room that is in use for other counseling purposes is used when providing counseling or services to adolescents. Alternatively, a curtain can be put up to avoid other people from seeing or listening to the conversation.
Appropriate and easy to understand IEC/BCC materials on ASRH are available in the waiting area	The 8 Information Education and Communication (IEC) booklets provided by National Health Education Information and Communication Centre (NHEICC) should be displayed in the waiting area and the counseling room. During the time spent waiting, adolescents, their friends, and caretakers can read these IEC booklets. You can also try and get IEC materials of local NGOs or youth organizations and display them too.

Role of service provider	Remarks
Service providers give correct ASRH counseling (using ASRH flipchart or other tools)	The ASRH flipchart will help you in providing the correct and relevant information to the adolescent presenting with a specific sexual and reproductive health (SRH) health problem.
Service providers use the Adolescent Job Aid for proper examination and case management	The Adolescent Job Aid is a useful tool that will help service providers to make the right treatment decisions when adolescents come to the health facility.
Service providers show respect to the concerns and needs of adolescents without any prejudice	Do not discriminate or judge adolescents based on their gender, marital status, age or sexual orientation when providing ASRH counselling or services related to SRH. Every adolescent has the right to appropriate and timely information on family planning, abortion, HIV, and STIs, etc. By including this non-discrimination details in the SOP and subsequently in the HCPs roles and responsibilities, it paves the way for protecting the rights of adolescents who may be unmarried, lesbian, gay, bisexual, transgender or intersex.
Service provider spent adequate time with the adolescents and listened to them	Adolescents feel shy and uncomfortable and might take some time to explain their problems
Service providers ensure the privacy and confidentiality of adolescents	No one is allowed to hear about the problems or needs of a patient that is shared confidentially with a health worker. Ideally use a spare room or a room that is divided using a curtain to avoid other people from seeing or listening to the conversation. Kindly ask other people (including the person who accompanied the adolescent) to leave the room.

Appendix A.2: Health facility observation checklist

Name of the District: Date of assessment:
Health facility ID:

S.N	Topics	Yes	No	Explain the observation
A.	**Observations of physical facilities**			
1	The AFHS logo is displayed outside the health facility			
2	The opening times of the AFHS are made visible outside the health facility			
3	Separate opening hours for adolescents at least once a week are in place			
4	The health facility is clean, comfortable and had enough waiting area			
5	There are sitting arrangement in the waiting space			
6	There is fan in the waiting place for summer season			
7	Drinking water is available in the health facility			
8	The weighing scale and height scale is available in an easily accessible place in the health facility			
9	Adolescent-specific IEC materials are displayed in the waiting area			
10	Privacy is maintained during counseling or treating young people. - Separate room for counseling available - Curtain separates room			
11	Health facility has a copy of ASRH flip chart			
12	Health facility has a copy of adolescents' job aid			
B.	**Observation of reports**			
13	AFHS has been promoted in the past six months through linking with other institutions (schools, youth clubs, child clubs, etc.) and peer educators ***(look for information materials developed)***			
14	HFMOC and the HF-in-charge had discussed about adolescent health in the meeting ***(check the agendas and decisions in HFOMC meeting register)***			

15	HFOMC minutes show that adolescents have participated in the meeting as an invited member			
16	The monthly reporting of use of services by adolescents is maintained			
17	The health facility displays user statistics at the health facility using the format provided by ASRH program implementation guideline			
C.	**Observation of commodities in the facility**			
16	Availability of contraceptives in the health facility (condom, pills, injectables)			
17	Storage of contraceptives and other drugs in the health facility			
18	Location of condom box and condom in the health facility			
20	Essential medicines as per government list			

Appendix A.3: Participants recruitment flyers in English and Nepali languages

UNSW AUSTRALIA

HREC Approval Number: HC 16427

English Version

For recruiting health facility in-charge (Phase 1)

Are you interested in making a difference in adolescent's health?

The University of New South Wales (UNSW), Australia in collaboration with Ministry of Health, Nepal are conducting a study to understand what contributes to the utilisation of sexual and reproductive health services from adolescent friendly health facilities and to what extent adolescents have used these facilities in the last two years.

Our study will involve the following:

- Collecting health service utilization data
- Observation of the health facility using a standard checklist

We would like to invite you to join our study if your health facility has implemented adolescent friendly health program for the last two years. Your views and experiences are valuable in making recommendations to the Nepal Ministry of Health that may help in improving the services provided to young people in Nepal.

If you would like to participate in this study or want to find out more information, please contact the researcher:
Pushpa Pandey at 9841490531, Email: pushpa.pandey@unsw.edu.au

Version Number: 2 Version dated: 17 November 2016

UNSW AUSTRALIA

HREC Approval Number: HC 16427

Nepali Version

For recruiting Health Facility Incharge (Phase 1)

के तपाई किशोर किशोरीहरूको स्वास्थ्यमा सकारात्मक परिवर्तन ल्याउनका लागि इच्छुक अनुहुन्छ ?

विगत दुइ वर्षमा किशोर किशोरीहरूले कति सम्म किशोर किशोरी मैत्री स्वास्थ्य सेवा प्रयोग गरेका छन र उनीहरूलाई किशोर किशोरी मैत्री स्वास्थ्य सेवा प्रयोग गर्नमा केले असर पुऱ्याउँदछ भन्ने कुरा पत्ता लगाउनका लागि नेपाल सरकार स्वास्थ्य मन्त्रालयसँगको समन्वयमा युनिभर्सिटी अफ न्यु साउथ वेल्स (University of New South Wales) सिड्नी, अस्ट्रेलिया ले यो अध्ययन गर्न लागेको छ।

हाम्रो अध्ययनमा निम्न कुराहरू समावेश हुनेछन

- **स्वास्थ्य सेवा उपयोग गरेको तथ्याङ्क सङ्कलन गर्ने**
- **स्तरिकृत चेकलिष्टको प्रयोग गरेर स्वास्थ्य संस्थको अवलोकन गर्ने**

यदि तपाइको स्वास्थ्य संस्थाले विगत दुइ वर्षमा किशोर किशोरी मैत्री स्वास्थ्य सेवा प्रदान गरि रहेको छ भने हामी तपाईलाई यो अध्ययनमा समावेश गराउन चाहान्छौं। तपाईका बहुमुल्य विचारहरू यो अध्ययन पछि बन्ने प्रतिवेदनमा नेपाल सरकार स्वास्थ्य मन्त्रालयलाई सुझाव दिनका लागि महत्त्वपूर्ण हुनेछन। यसले गर्दा नेपाल सरकारले किशोर किशोरीहरूलाई प्रदान गर्ने किशोर किशोरी मैत्री सेवालाई सुधार गर्नका लागि सहयोग पुग्नेछ।

यदि तपाइ यो अध्ययनमा सहभागि हुन चाहनुहुन्छ वा यस सम्बन्धमा अझै धेरै जानकारी चाहमानुहुन्छ भने तपाइले यो अध्ययनका अनुसन्धानकर्ता तलको ठेगानामा सम्पर्क गर्न सक्नुहुन्छ।

अनुसन्धानकर्ता, पुष्पलता पाण्डे, सम्पर्क फोन ९८४१४९०५३१, ईमेलः pushpa.pandey@unsw.edu.au

Version Number: 2 Version dated: 17 November 2016

HREC Approval Number: HC 16427

English Version

For recruiting Health Care Provider (Phase 2)

Are you interested in making a difference in adolescent's health?

The University of New South Wales (UNSW), Australia in collaboration with Ministry of Health, Nepal are conducting a study to understand what contributes to the utilisation of sexual and reproductive health services from adolescent friendly health facilities and what are the experiences and perspectives of health service providers during the delivery of sexual and reproductive health services to young people .

Our study will involve the following:

- interviews of 1-1.5 hours to find out your views regarding what enables young people to utilise adolescent friendly health services
- observe how health care providers interact with young people as they provide services

We would like to invite you to join our study if you are a health care provider who has worked for at least six months in an Adolescent Friendly Health Service. You participation will provide valuable input to the recommendations we make to Ministry of Health of Nepal. Such recommendations may help in improving reproductive and sexual health services provided to young people in Nepal.

If you would like to participate in this study or want to find out more information, please contact the researcher:
Pushpa Pandey at 9841490531,
Email: pushpa.pandey@unsw.edu.au

Version Number: 2

Version dated: 17 November 2016

HREC Approval Number: HC 16427

Nepali Version

For recruiting Health Care Provider (Phase 2)

के तपाइ किशोर किशोरीहरूको स्वास्थ्यमा सकारात्मक परिवर्तन ल्याउनका लागि इच्छुक हुनुहुन्छ ?

किशोर किशोरीहरूलाई किशोर किशोरी मैत्री स्वास्थ्य सेवा प्रयोग गर्नमा केले असर पुऱ्याउँदछ भन्ने कुरा र स्वास्थ्यकर्मीहरूलाई किशोर किशोरीहरूलाई यौन तथा प्रजनन स्वास्थ्य सेवा दिँदा के कस्तो अनुभव तथा विचारहरूछन भन्ने कुरा पत्ता लगाउनका लागि नेपाल सरकार स्वास्थ्य मन्त्रालयसँगको समन्वयमा युनिभर्सिटी अफ न्यु साउथ वेल्स (University of New South Wales) सिड्नी, अस्ट्रेलियाले यो अध्ययन गर्न लागेको छ ।

हाम्रो अध्ययनमा निम्न कुराहरू समावेश हुनेछन

- **के भएमा किशोर किशोरीहरूलाई किशोर किशोरी मैत्री स्वास्थ्य सेवा लिनका लागि सहयोग पुग्दछ भनेर तपाईको विचार थाहा पाउनका लागि करिब १ देखि डेढ घण्टा सम्म तपाई सँग अन्तरवार्ता**
- **स्वास्थ्यकर्मीहरूले किशोर किशोरीहरूलाई किशोर किशोरी मैत्री सेवा दिँदा कसरी छलफल गर्दछन भन्ने थाहा पाउनका लागि सेवा दिदै गरेको अवलोकन गर्ने ।**

यदि तपाई कम्तीमा विगत ६ महिनादेखि किशोर किशोरी मैत्री स्वास्थ्य सेवा प्रदान गरिरहनु भएको स्वास्थ्य कर्मी हुनुहुनछ भने हामी तपाईलाई यो अध्ययनमा सहभागि हुनका लागि निमन्त्रणा गर्दछौं । तपाईका बहुमुल्य विचारहरू यो अध्ययन पछि बन्ने प्रतिवेदनमा नेपाल सरकार स्वास्थ्य मन्त्रालयलाई सुझाव दिनका लागि महत्त्वपूर्ण हनेछ। यसले गर्दा नेपाल सरकारले किशोर किशोरीहरूलाई प्रदान गर्ने किशोर किशोरी मैत्री सेवालाई सुधार गर्नका लागि सहयोग पुग्नेछ ।

यदि तपाइ यो अध्ययनमा सहभागि हुन चाहनुहुन्छ वा यस सम्बन्धमा अझै धेरै जानकारी चाहमानुहुन्छ भने तपाइले यो अध्ययनका अनुसन्धानकर्ता तलको ठेगानामा सम्पर्क गर्न सक्नुहुन्छ ।

अनुसन्धानकर्ता : पुष्पलता पाण्डे , सम्पर्क फोन ९८४९४९०५३९, ईमेल : pushpa.pandey@unsw.edu.au

Version Number: 2

Version dated: 17 November 2016

HREC Approval Number: HC 16427

English Version

For recruiting adolescents (Phase 2)

Are you interested in making health facilities friendly for young people?

The University of New South Wales (UNSW), Australia in collaboration with Ministry of Health, Nepal are conducting a study to understand what contributes to the utilisation of sexual and reproductive health services from adolescent friendly health facilities. For this, we are seeking adolescent 15 – 19 years (volunteers) to find out your views and experiences about receiving sexual and reproductive health services from Adolescent Friendly Health Facilities.

Our study will involve a group discussion with adolescents and individual interviews. Each of this will take around 1 to 1.5 hours.

If you are an adolescent aged 15 – 19 years and have used an Adolescent Friendly Health Service within the last 12 months we would like to invite you to join our study. For your participation, you will be provided with light refreshment package, a mobile recharge care and a small gift to thank you for taking part in this study.

Even if you have not used an Adolescent Friendly Health Service, if you are between 15 – 19 years of age and interested in participating in this study, we invite you to join this study

If you would like to participate in this study or want to find out more information, please contact the researcher: Pushpa Pandey at 9841490531, Email: pushpa.pandey@unsw.edu.au

Version Number: 2

Version dated: 17 November 2016

HREC Approval Number: HC 16427

Nepali Version

For recruiting adolescents (Phase 2)

के तपाई स्वास्थ्य संस्थालाई किशोर किशोरीहरूका लागि मैत्रीपूर्ण बनाउन चाहनुहुन्छ ?

किशोर किशोरीहरूलाई किशोर किशोरी मैत्री स्वास्थ्य सेवाबाट यौन तथा प्रजनन स्वास्थ्य सेवा प्रयोग गर्नमा केले असर पुऱ्याउँदछ भन्ने कुरा पत्ता लगाउनका लागि नेपाल सरकार स्वास्थ्य मन्त्रालयसँगको समन्वयमा युनिभर्सिटी अफ न्यु साउथ वेल्स (University of New South Wales) सिड्नी, अस्ट्रेलियाले यो अध्ययन गर्न लागेको छ । यसका लागि हामीहरूले किशोर किशोरी मैत्री सेवाका बारेमा तपाइहरूको विचार र अनुभव थहा पाउनका लागि स्वयमसेवी रूपमा सहभागि हुन चाहाने १५ देखि १९ वर्ष उमेर समुहका किशोर किशोरीहरूसंग भेटन र छलफल गर्न चाहेका छौं ।

हाम्रो अध्ययनमा किशोर किशोरीहरू संग समुह छलफल र व्यक्तिगत अन्तरर्वार्ता हुनेछन । यसका लागि करिव एक देखि डेढ घण्टा लाग्नेछ ।

यदि तपाई १५ देखि १९ वर्ष समुहको किशोर /किशोर हुनु हुन्छ र विगत १२ महिना यता किशोर किशोरी मैत्री सेवा लिनु भएको छ भने हामी तपाईलाई यो अध्ययनमा सहभागि हुनका लागि निमन्त्रण गर्दछौं । तपार्य यस अध्ययनमा सहभागि हुन चाहानु भयो भने हामी तपाईको सहयोगका लागि हल्का खाजा, मोवाइल रि चार्ज र एउटा सानो उपहार दिनेछौं ।

यदि तपाईले किशोर किशोरी मैत्री सेवा लिनु भएको छैन तापनि यदि तपाइ १५ देखि १९ वर्ष समुहको किशोर /किशोर हुनु हुन्छ र यस अध्ययनमा सहभागि हुन चाहानुहुन्छ भने हामी तपाईलाई यो अध्ययनमा सहभागि हुनका लागि निमन्त्रण गर्दछौं ।

यदि तपाइ यो अध्ययनमा सहभागि हुन चाहानुहुन्छ वा यस सम्बन्धमा अझै धेरै जानकारी चाहमानुहुन्छ भने तपाई यो अध्ययनका अनुसन्धानकर्ता लाई तलको ठेगानामा सम्पर्क गर्न सक्नुहुन्छ ।

अनुसन्धानकर्ता : पुष्पलता पाण्डे , सम्पर्क फोन ९८४१४९०५३१, ईमेल : pushpa.pandey@unsw.edu.au

Version Number: 2

Version dated: 17 November 2016

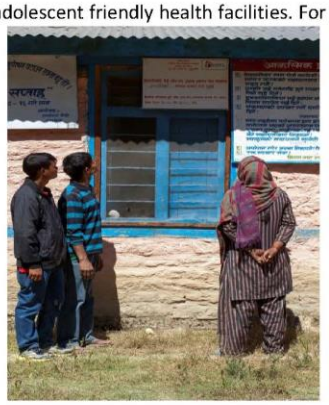
HREC Approval Number: HC 16427

English Version

For recruiting adolescents for exit interviews (Phase 2)

Are you interested in making health facilities friendly for young people?

The University of New South Wales (UNSW), Australia in collaboration with Ministry of Health, Nepal are conducting a study to understand what contributes to the utilisation of sexual and reproductive health services from adolescent friendly health facilities. For this, we are seeking adolescent 15 – 19 years (volunteers) to find out your experiences from your recent visit to Adolescent Friendly Health Facilities to receive sexual and reproductive health services.



Our study will involve an individual interviews lasting for 45 minutes to 1 hour.

If you are an adolescent aged 15 – 19 years and have used an Adolescent Friendly Health Service within the last one week we would like to invite you to join our study. For your participation, you will be provided with light refreshment package, a mobile recharge care and a small gift to thank you for taking part in this study.

If you would like to participate in this study or want to find out more information, please contact the researcher:
Pushpa Pandey at 9841490531, Email: pushpa.pandey@unsw.edu.au

Version Number: 2

Version dated: 17 November 2016

HREC Approval Number: HC 16427

Nepali Version

For recruiting adolescents for exit interviews (Phase 2)

के तपाई स्वास्थ्य संस्थालाई किशोर किशोरीहरूका लागि मैत्रीपूर्ण बनाउन चाहनुहुन्छ ?

किशोर किशोरीहरूलाई किशोर किशोरी मैत्री स्वास्थ्य सेवाबाट यौन तथा प्रजनन स्वास्थ्य सेवा प्रयोग गर्नमा केले असर पुऱ्याउँदछ भन्ने कुरा पत्ता लगाउनका लागि नेपाल सरकार स्वास्थ्य मन्त्रालयसँगको समन्वयमा युनिभर्सिटी अफ न्यु साउथ वेल्स (University of New South Wales) सिड्नी, अस्ट्रेलियाले यो अध्ययन गर्न लागेको छ । यसका लागि हामीहरूले किशोर किशोरी मैत्री स्वास्थय संस्थाबाट सेवा लिदा रहेका तपाइहरूको अनुभव थाहा पाउनका लागि स्वयमसेवी रूपमा सहभागि हुन चाहाने १५ देखि १९ वर्ष उमेर समुहका किशोर किशोरीहरूसंग भेटन र छलफल गर्न चाहेका छौं ।

हाम्रो अध्ययनमा तपाईसंग व्यक्तिगत अन्तरवार्ता हुनेछन । यसका लागि करिव ४५ मिनेट देखि एक घण्टा लाग्नेछ ।

यदि तपाई १५ देखि १९ वर्ष समुहको किशोर /किशोर हुनु हुन्छ र विगत १ हप्तामा किशोर किशोरी मैत्री सेवा लिनु भएको छ भने हामी तपाईलाई यो अध्ययनमा सहभागि हुनका लागि निमन्त्रण गर्दछौं । तपार्य यस अध्ययनमा सहभागि हुन चाहानु भयो भने हामी तपाईको सहयोगका लागि हल्का खाजा, मोवाइल रि चार्ज र एउटा सानो उपहार दिनेछौं ।

यदि तपाइ यो अध्ययनमा सहभागि हुन चाहानुहुन्छ वा यस सम्बन्धमा अझै धेरै जानकारी चाहमानुहुन्छ भने तपाई यो अध्ययनका अनुसन्धानकर्ता लाई तलको ठेगानामा सम्पर्क गर्न सक्नुहुन्छ ।

अनुसन्धानकर्ता : पुष्पलता पाण्डे , सम्पर्क फोन ९८४१४९०५३१, ईमेल : pushpa.pandey@unsw.edu.au

For recruiting Key Informants (Phase 2)

Version Number: 2

Version dated: 17 November 2016

HREC Approval Number: HC 16427

English Version

For recruiting Key Informants (Phase 2)

Are you interested in making a difference in adolescent's health?

The University of New South Wales (UNSW), Australia in collaboration with Ministry of Health, Nepal are conducting a study to understand what contributes to the utilisation of sexual and reproductive health services from adolescent friendly health facilities. For this, we are seeking volunteer members from the community to learn their perspectives about adolescent friendly health services.

Our study will involve an in-depth interview for 1.00 - 1.30 hours with you.

If you are a member of the management committee of an Adolescent Friendly Health Service, a teacher, a parent of a 15 – 19 year old, a local leader or a community health volunteers we would like to invite you to join our study.

If you would like to participate in this study or want to find out more information, please contact the researcher:

Pushpa Pandey at 9841490531, Email: pushpa.pandey@unsw.edu.au

Version Number: 2

Version dated: 17 November 2016

HREC Approval Number: HC 16427

Nepali Version

के तपाइ किशोर किशोरीहरूको स्वास्थ्यमा सकारात्मक परिवर्तन ल्याउनका लागि इच्छुक अनुहुन्छ ?

किशोर किशोरीहरूलाई किशोर किशोरी मैत्री स्वास्थ्य सेवाबाट यौन तथा प्रजनन स्वास्थ्य सेवा प्रयोग गर्नमा केले असर पुऱ्याउँदछ भन्ने कुरा पत्ता लगाउनका लागि नेपाल सरकार स्वास्थ्य मन्त्रालयसँगको समन्वयमा युनिभर्सिटी अफ न्यु साउथ वेल्स (University of New South Wales) सिड्नी, अस्ट्रेलियाले यो अध्ययन गर्न लागेको छ। यसका लागि हामीहरूले किशोर किशोरी मैत्री सेवाका बारेमा यस समुदायका स्वयमसेवी सदस्यहरूको विचार र अनुभव थाहा पाउनका लागि भेटन र छलफल गर्न चाहेका छौं।

हाम्रो अध्ययनमा तपाईसंग गहिरो अन्तरवार्ता पनि समावेश छ। यसका लागि करिव एक देखि डेढ घण्टा जति समय लाग्न सक्ने छ।

यदि तपाई किशोर किशोरी मैत्री सेवा दिने स्वास्थ्य संस्थाको स्वास्थ्य संस्था सञ्चालन तथा व्यावस्थापन समितिका सदस्य वा शिक्षक वा १५ देखि १९ वर्ष समुहको किशोर/किशोरका अविभावक वा स्थानीय नेता वा समुदाय स्वास्थ्य स्वयम सेवक हुनुहुन्छ भने हामी तपाईलाई यो अध्ययनमा सहभागि हुनका लागि निमन्त्रणा गर्दछौं।

यदि तपाइ यो अध्ययनमा सहभागि हुन चाहानुहुन्छ वा यस सम्वन्धमा अझै धेरै जानकारी चाहमानुहुन्छ भने तपाई यो अध्ययनका अनुसन्धानकर्ता लाई तलको ठेगानामा सम्पर्क गर्न सक्नुहुन्छ।

अनुसन्धानकर्ता : पुष्पलता पाण्डे, सम्पर्क फोन ९८४९४९०५३१,
ईमेल : pushpa.pandey@unsw.edu.au

Version Number: 2

Version dated: 17 November 2016

(The email invitation will be in English language only)

Date:

Mr/Mrs.....
(Name and address of the organization)

Dear Mr/Mrs.....

Re: Request to participate in the research study titled "Utilisation of adolescent friendly sexual and reproductive health services in Nepal".

The research mentioned in the subject line is being conducted by University of New South Wales (UNSW) Australia in collaboration with Ministry of Health, Nepal. We invite you to participate in this research which is aimed at understanding the utilization of Adolescent Friendly Sexual and Reproductive Health Services in Nepal.

Adolescent Friendly Health Services aim to provide sexual and reproductive health services to young people in Nepal. Ministry of Health has added a component of adolescent friendly health services to its existing public health facilities in more than 1000 health facilities in 56 districts during 2008-2014. We are interested in exploring your views about these services and what contributes to young people using these services.

Your views about Adolescent Friendly Health Services in Nepal are important to us and understanding your views, we believe, will help in improving the services for young people in Nepal. As a [*insert the area of expertise of participant*] you are in an ideal position to help us better understand the current situation of adolescent friendly health services in Nepal.

If you decide to take part in the research study, we would like to interview you. The interview will last for 1-1.5 hours. The interview will be conducted by Pushpa Pandey in either Nepalese or English, depending on your preference. Your responses will be kept confidential and only be used for the purpose of the research.

There is no compensation for participating in this study. However your participation will be a valuable addition to our research, and the findings of this study will be used to provide a recommendation to Nepal Ministry of Health to help tailor the sexual and reproductive health services so that they are better utilised by adolescents.

If you are willing to participate, please email or Pushpa Pandey with your suggestions for a day, time and venue for the interview. If you would like more information, please contact her as follows:

Email: pushpa.pandey@unsw.edu.au
Phone: 9841 490532 (Nepal number)

Thanking you,

Dr Husna Razee
Principal Investigator

HREC Approval Number: **Version dated**: 27 June 2016

Participant group: Key informants at central level

Appendix A.4: Health service utilisation data collection tool

Name of the District: Date of data collection:

Health Facility ID:

Level of Health Facility (Health Post/Primary Health Care Center)

Duration of data collection:

Total number of Adolescent (10-19 years) in the catchment area of HF (*Refer target population given for HF in that Fiscal Year)*:

1. No. of Adolescent (10-19 years) who have visited the HF (for all kind of services) in last two year

Sex	Age group	2014				2015												2016								
		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Remarks
Male	**10-14**																									
	15-19																									
	Total number of clients including above																									
Female	**10-14**																									
	15-19																									
	Total number of clients including above																									

***Refer to HMIS-1 (Main register)**

7.2 Health Service utilization *(separate sheet for each year)*

	Service type	Sep		Oct		Nov		Dec		Jan		Feb		March		April		May		June		July		Aug		Total
		< 20	> 20	< 20	> 20	< 20	> 20	< 20	> 20	< 20	> 20	< 20	> 20	< 20	> 20	< 20	> 20	< 20	> 20	< 20	> 20	< 20	> 20	< 20	> 20	
Family Planning	Pills (Current users)																									
	Depo Injection (Current users)																									
	Implant (Current users)																									
	Emergency Contraception																									
Ante-natal services	2 and/or 2 + dose of TT																									
	First time ANC visit																									
	Four-time ANC visit																									
Delivery services	Institutional Delivery																									
	Delivery by SBA																									
	Abortion services																									

***Refer to Family Planning, ANC register Delivery, Delivery register, TT register, Abortion services register, Maternal Health service register**

Observations/Remarks:

- **Explain your observations about the HMIS report (Completeness, accuracy, Underreporting/Over reporting):**
- **Explain the reasons if data is not available:**

Appendix A.5: Qualitative data collection tools- Interview and focus group discussion guidelines

A.5.1 In-depth Interview Guideline for Health Service Providers

Pre-interview preparation

- Keep the participant information sheet and consent forms ready
- Pre-test audio recording equipment(s)
- Keep pen and paper ready to take notes

Introduction

Namaste and thank you so much for your interest to participate in this research study. My name is Pushpa Pandey. This interview is part of a study undertaken by The University of New South Wales, Sydney, Australia and Ministry of Health, Nepal. The main purpose of the study is to understand what factors impact on the utilisation of health services by young people in Nepal. We are interested in finding out your views and experiences relating to adolescent-friendly health services. You have been invited to participate in this study because you are a government health service provider working in the adolescent-friendly health facility for the last six months. The duration of the interview will be one to one and a half hours. I would like to record this interview as that will help me to accurately translate your response from Nepalese to English and ensure that I am reporting what you have said accurately. However, if you are not comfortable in having this interview recorded, I will just take notes. Is it ok to record the conversation?

[*If the participant agrees for the audio recording, switch on the recorder*]

Thank you for agreeing to record the discussion.

I will also take notes to help me remember our discussion. All the information you will be providing me today will be kept confidential and no name or identification will be revealed in any documentation and report unless there is an issue of safety to you. If such a matter is revealed, I will discuss this with you before sharing the information with anyone else. The information gathered from this interview will be only available to the research team or if required by law. You are free to withdraw from the research at any time. You do not have to answer any questions if you do not want to. Let me know in that case. We hope that the findings from this study will help improve health services for young people in Nepal.

Do you agree to participate in this interview?

[*Once the written consent has been provided by the participant and verbal consent has been recorded, start interview*]

Do you have any questions before we start the interview? *[Clarify if there is any question or proceed with the discussion]*

1. What do you think about sexual and reproductive health (SRH) services for adolescents? Probe:
   - What value does it add to the community?
   - What value does it add to young people's health?
2. In your opinion what does an adolescent-friendly health facility involve? Probe:

- How can a health facility be made adolescent-friendly?
- What makes [*name of AFHS*] adolescent-friendly? Why and why not?

3. How do you feel about providing SRH services to adolescents? Probe:
   - Why do you feel that way?
4. How has the service provided in this facility changed since it became established as an Adolescent-Friendly Service? Probe:
   - Has there been a change in a number of adolescents visiting this health facility?
   - How has it changed?
   - How do feel about this change? Why do you feel that way?
5. Tell me something about your experience in delivering SRH services to young people. Probe:
   - What was most satisfying and enjoyable for you in providing the service?
   - What was the least satisfying and enjoyable for you in providing the service? What contributed to this dissatisfaction?
   - What challenges have you faced in providing services to young people? Why was it a challenge? How did you deal with it?
6. How do you provide services to male and female adolescents? Probe:
   - What are the differences?
   - Why?
7. How do you deal with unmarried adolescents? Is this different to how you deal with married adolescents? Probe: Why or why not?
8. Have you changed your approach to providing SRH services to young people in last two years? Probe:
   - What brought this change?
9. How would you like to provide SRH services to young people? What will help you in achieving this?

Closing

Thank you for participating in this research. In this interview, we have covered [*Provide a summary of main ideas*]. Is there anything more you would like to add?

I will prepare a summary report for this study in 4-6 months. I plan to conduct a workshop with you and other participants to share the findings with the study participants. Will you be interested in participating in that workshop? [*Note participant interest and how she/he can be contacted for the workshop invitation*] I will also be happy to send you a copy of the summary report at that time for your feedback if you are interested.

I would like to reassure you once again of the confidentiality of the information you have shared with me today. Any information that can identify you or this facility will be removed.

Thank you

A. 5.2: Client exit interview guideline for young people who have used sexual and reproductive health service from adolescent-friendly health facility

Pre-interview preparation

- Keep the participant information sheet and consent forms ready
- Pre-test audio recording equipment(s)
- Keep pen and paper ready to take notes

Introduction

Good afternoon and thank you so much for your interest to participate in this research. My name is Pushpa Lata Pandey and I will be taking the interview with you today. This interview is a part of a study being commenced by The University of New South Wales, Sydney, Australia and Ministry of Health, Nepal. The main purpose of the study is to understand what factors impact on the utilization of health services by young people in Nepal. We are interested in finding out your experiences from your recent visit to adolescent-friendly health facility.

You have been invited to this research because you are a young person aged 15-19 years old living in this village and have used adolescent-friendly health facility recently to get sexual and reproductive health services. The duration of the interview will be 30 to 45 minutes. I would like to record this interview as that will help me to accurately translate your response from Nepalese to English and ensure that I am reporting what you have said accurately. However, if you are not comfortable in having this interview recorded, I will just take notes. Is it ok to record the conversation?

[If the participants agree for the audio recording, switch on the recorder]

Thank you for agreeing to record the discussion.

I will also take notes to help me remember our discussion. All the information you will be providing me today will be kept confidential and no name or identification will be revealed in any documentation and report unless there is an issue of safety to you. If such a matter is revealed, I will discuss this with you before sharing the information with anyone else. The information gathered from this interview will be only available to the research team or if required by law. You are free to withdraw from the research at any time. You do not have to answer any questions if you do not want to. Let me know in that case. We hope that the findings from this study will help improve health services for young people in Nepal.

Do you agree to participate in this interview?

[Once the verbal consent has been provided by the participant and has been recorded, start the interview]

Do you have any question before we start the interview? *[Clarify if there is any question or proceed with the discussion]*

1. I would like to know about your visit to the health facility. How was it? Probe:
    - Were you satisfied with the services you received from the health facility? Why or why not?
    - How did the health service provider provide you service? How did he treat you? How did he talk to you?

2. How was the health facility like? Probe:
    - Did the health worker talk to you in a place where no one can see you talking to him? Did they have a separate room or a curtain available?
    - Were you worried about the confidentiality of information you provided to him? If yes why, if no why?
    - Are you satisfied with the arrangement of the facility?
3. How friendly was the health service provider to you while providing services? Probe:
    - How much time did he/she give you?
    - Did the health worker listen to all your issues?
    - Did the health worker discuss about the solution for all of your issues?
    - Are you satisfied with the amount of time provided by the health service provider?
    - Would you use these services again? Why or why not?
4. How comfortable did you feel using the SRH services? Probe:
    - What made you comfortable or what didn't?
5. What will make it easier for you to seek services from health facility? How can services be improved?

6. Would you recommend the sexual and reproductive health service to another young person?

7. If you were given an opportunity to change one thing in the health facility what would you change?

Collect Demographic Information of the participant:

Age:

Sex:

Education:

Closing

Thank you for participating in this research. In this interview, we have covered [Provide a summary of main ideas]. Is there anything more you would like to add?

I will prepare a summary report for this study in 4-6 months. I plan to conduct a workshop with you and other participants to share the findings with the study participants. Will you be interested in participating in that workshop? [Note participant interest and how she/he can be contacted for the workshop invitation] I will also be happy to send you a copy of the summary report at that time for your feedback if you are interested.

I would like to reassure you once again of the confidentiality of the information you have shared with me today. Any information that can identify you or this facility will be removed.

Thank you

A.5.3: In-depth interview guideline for young people who have used sexual and reproductive health service from adolescent-friendly health facility

Pre-interview preparation

- Keep the participant information sheet and consent forms ready
- Pre-test audio recording equipment(s)
- Keep pen and paper ready to take notes

Introduction

Namaste and thank you so much for your participation in this research. My name is Pushpa Pandey. This interview is part of a study undertaken by The University of New South Wales, Sydney, Australia and Ministry of Health, Nepal. The main purpose of the study is to understand what factors impact on the utilisation of health services by young people in Nepal. We are interested in learning about your experiences in accessing sexual and reproductive health services from an adolescent-friendly health facility.

You have been invited to this research because you are a young person aged 15-19 years old living in this village and have used adolescent-friendly health facility in last twelve months. The duration of the interview will be one to one and a half hours. I would like to record this interview as that will help me to accurately translate your response from Nepalese to English and ensure that I am reporting what you have said accurately. However, if you are not comfortable in having this interview recorded, I will just take notes. Is it ok to record the conversation?

[*If the participants agree for the audio recording, switch on the recorder*]

Thank you for agreeing to record the discussion.

I will also take notes to help me remember our discussion. All the information you provide me today will be kept confidential and no name or identification will be revealed in any documentation and report unless there is an issue of safety to you. If such a matter is revealed, I will discuss this with you before sharing the information with anyone else. The information gathered from this interview will be only available to the research team or if required by law. You are free to withdraw from the research at any time. You do not have to answer any questions if you do not want to. Let me know in that case. We hope that the findings from this study will help improve health services for young people in Nepal.

Do you agree to participate in this interview?

[*Once the verbal consent has been provided by the participant and has been recorded, start the interview*]

Do you have any question before we start the interview? [*Clarify if there is any question or proceed with the discussion*]

1. I understand you have used sexual and reproductive health services from an Adolescent-Friendly Health Facility, how did you feel about the service? Probe:
    - What was the purpose of using the service?
    - Were you satisfied with the services you got from the health facility? Why or why not?
    - Would you use these services again? Why or why not?

2. Have you faced any challenges, if any, while accessing services from an AFHF [*use the name of the facility if they have already mentioned a name*]? Probe:
    - How easy or difficult was it to get to the facility?
    - How long did it take to reach the facility and how did you get to the facility?
    - Did you have someone come with you to the health facility? Why or why not?
    - Did you have any issue with the cost of the health services? Why or why not?
    - Did you have any concerns with who provided services in the the health facility? What were these concerns?
3. What was the role of your parents /guardians in you accessing the sexual and reproductive health services?
4. How comfortable did you feel using the SRH services? Probe:
    - What made you comfortable or what didn't?
5. What will make it easier for you to seek services from health facility? How can services be improved?
6. If you were recommending using the sexual and reproductive health services to another young person, what would you say?
7. If you were given an opportunity to change one thing in the health facility you visited what would you change?

Collect Demographic Information of the participants:

Age:

Sex:

Education:

Currently in a steady relationship:

Closing

Thank you for participating in this research. In this interview, we have covered [*Provide a summary of main ideas*]. Is there anything more you would like to add?

I will prepare a summary report for this study in 4-6 months. I plan to conduct a workshop with you and other participants to share the findings with the study participants. Will you be interested in participating in that workshop? [*Note participant interest and how she/he can be contacted for the workshop invitation*] I will also be happy to send you a copy of the summary report at that time for your feedback if you are interested.

I would like to reassure you once again of the confidentiality of the information you have shared with me today. Any information that can identify you or this facility will be removed.

Thank you

A.5.4: In-depth interview guideline for young people who have not used sexual and reproductive health service from adolescent-friendly health facility

Pre-interview preparation

- Keep the participant information sheet and consent forms ready
- Pre-test audio recording equipment(s)
- Keep pen and paper ready to take notes

Introduction

Namaste and thank you so much for your participation in this research. My name is Pushpa Pandey. This interview is part of a study undertaken by The University of New South Wales, Sydney, Australia and Ministry of Health, Nepal. The main purpose of the study is to understand what factors impact on the utilisation of health services by young people in Nepal. We are interested in your views and experiences about accessing sexual and reproductive health services.

You have been invited in this research because you are a young person aged 15-19 years old living in this village. The duration of the interview will be one to one and a half hours. I would like to record this interview as that will help me to accurately translate your response from Nepalese to English and ensure that I am reporting what you have said accurately. However, if you are not comfortable in having this interview recorded, I will just take notes. Is it ok to record the conversation?

[*If the participants agree for the audio recording, switch on the recorder*]

Thank you for agreeing to record the discussion.

I will also take notes to help me remember our discussion. All the information you provide me today will be kept confidential and no name or identification will be revealed in any documentation and report unless there is an issue of safety to you. If such a matter is revealed, I will discuss this with you before sharing the information with anyone else. The information gathered from this interview will be only available to the research team or if required by law. You are free to withdraw from the research at any time. You do not have to answer any questions if you do not want to. Let me know in that case. We hope that the findings from this study will help improve health services for young people in Nepal.

Do you agree to participate in this interview?

[*Once the verbal consent has been provided by the participant and has been recorded, start the interview*]

Do you have any question before we start the interview? [*Clarify if there is any question or proceed with the discussion*]

1. I am going to tell you a short story. Rita 15-year-old girl and Shyam 19-year-old boy love each other for last one year. Recently they have decided to have a sexual relationship with each other.
    - Where would they go to get information and support?
    - Why would they go to [name of the facility they stated]?

2. What do you think will be their challenges to access sexual and reproductive health services? Probe:
    - Why do you think they have these challenges?
    - What kind of services would they prefer to get from the health facility?
    - How do you think they want health workers to provide the service to them?
    - How would they want to be treated by the health worker?
3. What do you think is the role of your parents /guardians to support young people in accessing the sexual and reproductive health services?
4. What would make young you comfortable using the SRH services? What will not? Why?
5. What will make it easier for you to seek services from a health facility? Probe for the following:

- Location of service – where would they prefer service to be located?
- The physical layout of the service
- Who provides the service
- What kind of services are provided
- The way that staff of the facility treat the young people
- How staff communicate with young people

Closing

Thank you for participating in this research. In this interview, we have covered [Provide a summary of main ideas]. Is there anything more you would like to add?

I will prepare a summary report for this study in 4-6 months. I plan to conduct a workshop with you and other participants to share the findings with the study participants. Will you be interested in participating in that workshop? [*Note participant interest and how she/he can be contacted for the workshop invitation*] I will also be happy to send you a copy of the summary report at that time for your feedback if you are interested.

I would like to reassure you once again of the confidentiality of the information you have shared with me today. Any information that can identify you or this facility will be removed.

Thank you

A.5.5: Guide for Focus Group Discussion (FGD) with young people

Focus Group ID:

Time of FGD:

Date:

Place:

Facilitator:

Participant category:

Number of Participants:

Preparation for the FGD

- Choose, recruit, screen and select 8-10 participants for FGD
- Establish the location and time for the FGD
- Keep the participant information sheet and consent forms ready
- Pre-test audio recording equipment(s)
- Keep pen, permanent markers, stickers, notepads, white sheets and scissors ready for the FGD

Introduction

Namaste and thank you so much for your interest to participate in this focus group discussion. My name is Pushpa Pandey and I will be facilitating the discussion today. This FGD is part of a study undertaken by The University of New South Wales, Sydney, Australia and Ministry of Health, Nepal. The main purpose of the study is to understand what factors impact on the utilisation of health services by young people in Nepal. We are interested in finding out what you think about health facilities for adolescents. You have been invited to this FGD because you are a young person aged 15-19 years old living in this village. The duration of the FGD will be one to one and a half hours. During this FGD, I will be asking you questions, and the discussion will be audio recorded. I would like to record this discussion as that will help me to accurately translate your response from Nepalese to English and ensure that I am reporting what you have said accurately. However, if you are not comfortable in having this discussion recorded, I will just take notes. Is it ok to record the conversation?

[*If the participants agree for the audio recording, switch on the recorder*]

Thank you for agreeing to record the discussion.

All the information you provide me today will be kept confidential and no name or identification will be revealed in any documentation and report unless there is an issue of safety to you. If such a matter is revealed, I will discuss this with you before sharing the information with anyone else. The information gathered from this interview will be only available to the research team or if required by law. You are free to withdraw from the research at any time. You do not have to answer any questions if you do not want to. Let me know in that case. However, it will not be possible to withdraw your individual comments from our recordings once the group has started the discussion, as it is a group discussion. We hope that the findings from this study will help improve health services for young people in Nepal.

Do you all agree to participate in this FGD?

[*Once the verbal consent has been provided by the participants and has been recorded, start further discussion*]

Ground Rules

Let us set some ground rules for the discussion. There are no right or wrong answers so please do not hesitate to give your point of view even if it different from others. Please allow one person to finish talking before another one starts so that we all can hear properly when anyone speaks. Please be respectful of what everyone in this group says and shares and listen respectfully when someone speaks even if you may not agree with what that person is saying. And please keep your mobile phone in silence mode or switched off during the discussion. [*allow time for everyone to switch off their phones*]

What is discussed in this group is confidential. So please do not talk about or share the information you hear in this group after you leave this discussion.

Do you any queries and concerns regarding the research. [*Clarify if there is any question and proceed with the discussion*]

1. I am going to tell you a short story. Rita 15-year-old girl and Shyam 19-year-old boy have been in love with each other for last one year. Recently they have decided to have a sexual relationship with each other.
   - Where would they go to get information and support?
   - Why would they go to [*name of the facility they stated*]?
2. Has any of you been to [name of the facility mentioned]? Probe:
   - What do you think about the facility?
   - How do you feel about the service they provided?
   - Did you like the service? Why or why not?
   - What would you like changed in that facility?
3. What would be the kind of health facility, where Rita and Shyam would feel most comfortable to get SRH services from? Probe:
   - What kind of services would they require from that facility?
   - How would they want to be treated by the health workers?
4. What would make a health facility appealing to you, make you feel at ease in seeking services from that facility? Do you want to draw a picture to show what such a facility would look like and where you would like it to be located? [*Distribute the white sheet, stickers, scissors, and markers to the participants. Ask them to draw the location of the facility, show what the inside would look like. Tell them they can use words and pictures*].
5. What kind of services do you want from health facilities? Please write down the type of service on these cards. Write one service only on each card. You can use as many cards as you want. [*Distribute cards and markers to the participants*]
   - Now that you all have noted an essential service for you let's put all group the cards so that all those with similar ideas are in one group.
   - Let us now remove the duplications
   - Is there anything else you will add to this? [*if they mention additional ones, write it on a card and add to the pile*]
   - Ok, now let us select the most important services from what you have written on the cards. [*Go through a process of first asking them to select half of the services*

they have listed. Then from that half go on to select the next half until the top three services are selected]

- So, we now have three of the most important services you want to have in the health facility for you to use the service

6. What qualities and skills would you want in health care providers who deliver SRH services to you? Please write down the characteristics, qualities and skills on these cards. Write only one characteristic or quality or skill on each card. You can use as many cards as you want. [*Distribute cards and markers to the participants*]

- Now that you have noted the qualities, characteristics and skills, let us put all the cards together and group them so that all similar ones are in one group.
- Let us now remove the duplications
- Is there anything else you will add to this? [*if they mention additional ones, write it on a card and add to the pile*]
- Ok, now let us select the most important qualities, characteristics and skills from the list. [*Go through a process of first asking them to select half of what they have listed. Then from that half go on to select the next half until the top five are selected*]
- So, we have now five most important qualities, characteristics or skills you desire in the health worker who provides services for you.

Closing

Thank you for participating in this research. In this interview, we have covered [*Provide a summary of main ideas*]. Is there anything more you would like to add?

I will prepare a summary report for this study in 4-6 months. I plan to conduct a workshop with you and other participants to share the findings with the study participants. Will you be interested in participating in that workshop? [*Note participant interest and how she/he can be contacted for the workshop invitation*] I will also be happy to send you a copy of the summary report at that time for your feedback if you are interested.

I would like to reassure you once again of the confidentiality of the information you have shared with me today. Any information that can identify you or this facility will be removed.

Thank you

A.5.6: In-depth interview guideline for key informants

Pre-interview preparation

- Keep the participant information sheet and consent forms ready
- Pre-test audio recording equipment(s)
- Keep pen and paper ready to take notes

Introduction:

Namaste and thank you so much for participating in this research. My name is Pushpa Pandey. This interview is a part of a study undertaken by The University of New South Wales, Sydney, Australia and Ministry of Health, Nepal. The main purpose of the study is to understand what factors impact on the utilisation of health services by young people in Nepal. We are interested in your views about adolescent-friendly health facilities.

You have been invited to participate in this research because you are community member living in this village. The duration of the interview will be one to one and a half hours. I would like to record this interview as that will help me to accurately translate your response from Nepalese to English and ensure that I am reporting what you have said accurately. However, if you are not comfortable in having this interview recorded, I will just take notes. Is it ok to record the conversation?

[*If the participants agree for the audio recording, switch on the recorder*]

Thank you for agreeing to record the discussion.

I will also take notes to help me remember our discussion. All the information you will be providing me today will be kept confidential and no name or identification will be revealed in any documentation and report unless there is an issue of safety to you. If such a matter is revealed, I will discuss this with you before sharing the information with anyone else. The information gathered from this interview will be only available to the research team or if required by law. You are free to withdraw from the research at any time. You do not have to answer any questions if you do not want to. Let me know in that case. We hope that the findings from this study will help improve health services for young people in Nepal.

Do you agree to participate in this interview?

[*Once the verbal consent has been provided by the participant and has been recorded, start the interview*]

Do you have any question before we start the interview*?* [*Clarify if there is any question or proceed with the discussion*]

1. What is your view of sexual and reproductive health services available for adolescents in your community?
2. I am going to tell you a short story. Rita 15-year-old girl and Shyam 19-year-old boy love each other for last one year. They are yet to get married but recently they have decided to have a sexual relationship with each other.
    - What do you think about this situation?
    - Where would Rita and Shyam go to get information and support?
    - What sort of services should be provided to them?

3. Will it make any difference if Rita and Shyam were married? Why is it different? Probe:
   a. What sort of services should be provided to them?

4. If this was your son or daughter, how would you feel about this? What advice will you give to your daughter or son?
5. What do you know about the adolescent-friendly health facilities in your community? Probe for:

- What does an AFHS mean to you?
- What services are provided by these facilities? How do you feel about such services being provided to young people?
- How are services in AFHS different from services provided by others?
- Does the service provided benefit your community?
- Are these services making the life of adolescents better?
- Should young people be encouraged to use SRH services from these facilities? Why or Why not?

Closing

Thank you for participating in this research. In this interview, we have covered [*Provide a summary of main ideas*]. Is there anything more you would like to add?

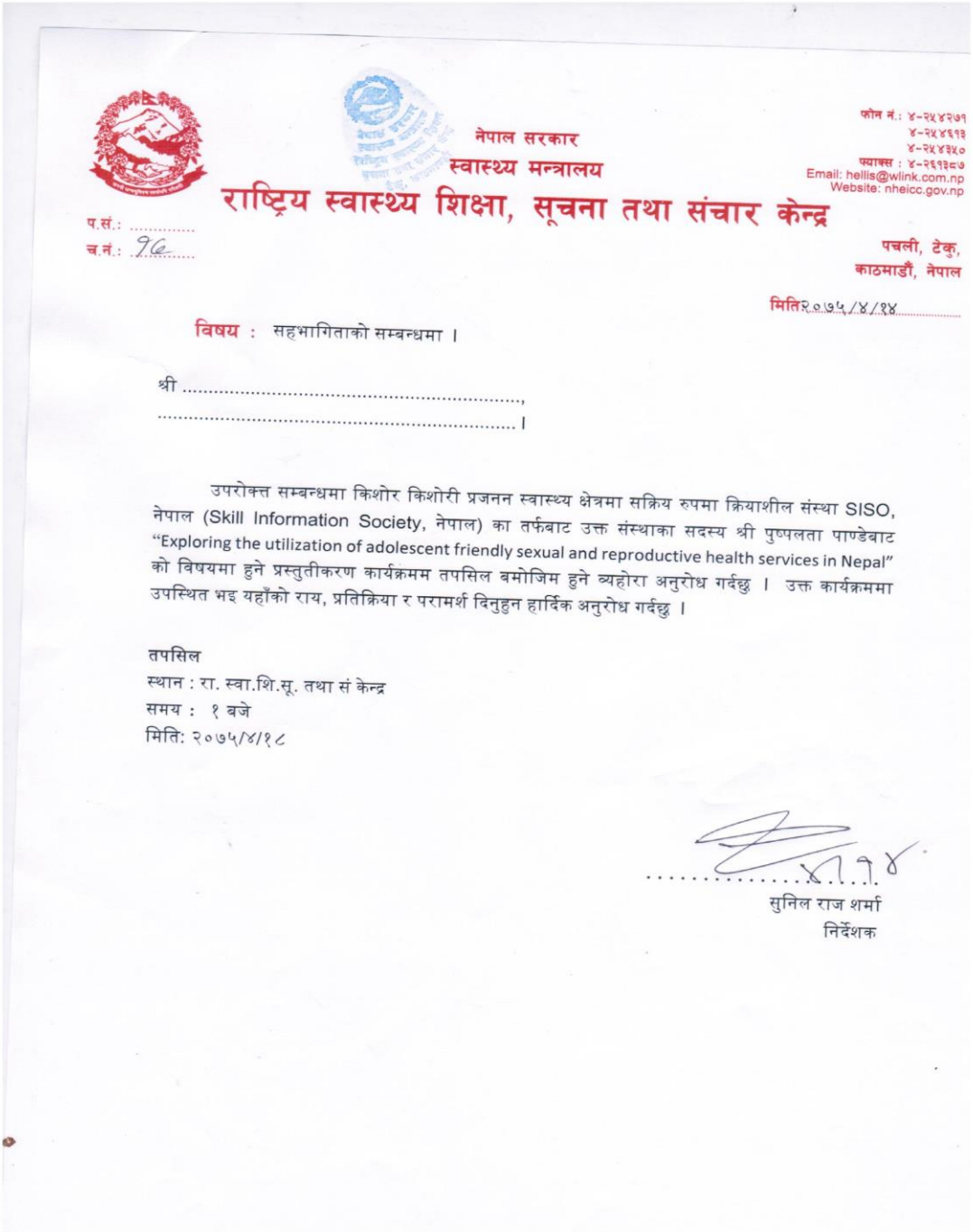
I will prepare a summary report for this study in 4-6 months. I plan to conduct a workshop with you and other participants to share the findings with the study participants. Will you be interested in participating in that workshop? [*Note participant interest and how she/he can be contacted for the workshop invitation*] I will also be happy to send you a copy of the summary report at that time for your feedback if you are interested.

I would like to reassure you once again of the confidentiality of the information you have shared with me today. Any information that can identify you or this facility will be removed.

Thank you

Appendix A.6: Recommendation collection workshop invitation letter, workshop concept and list of participants (third phase of the research)

A.6.1 Invitation letter



नेपाल सरकार
स्वास्थ्य मन्त्रालय
राष्ट्रिय स्वास्थ्य शिक्षा, सूचना तथा संचार केन्द्र

फोन नं.: ४-२५४२७१
४-२५४६१३
४-२५४३५०
फ्याक्स : ४-२६१३८७
Email: hellis@wlink.com.np
Website: nheicc.gov.np

पचली, टेकु,
काठमाडौं, नेपाल

प.सं.: .....
च.नं.: 96

मिति२०७५/४/१४

विषय : सहभागिताको सम्बन्धमा ।

श्री .....,
.....।

उपरोक्त सम्बन्धमा किशोर किशोरी प्रजनन स्वास्थ्य क्षेत्रमा सक्रिय रुपमा क्रियाशील संस्था SISO, नेपाल (Skill Information Society, नेपाल) का तर्फबाट उक्त संस्थाका सदस्य श्री पुष्पलता पाण्डेबाट "Exploring the utilization of adolescent friendly sexual and reproductive health services in Nepal" को विषयमा हुने प्रस्तुतीकरण कार्यक्रमम तपसिल बमोजिम हुने व्यहोरा अनुरोध गर्दछु । उक्त कार्यक्रममा उपस्थित भइ यहाँको राय, प्रतिक्रिया र परामर्श दिनुहुन हार्दिक अनुरोध गर्दछु ।

तपसिल
स्थान : रा. स्वा.शि.सू. तथा सं केन्द्र
समय : १ बजे
मिति: २०७५/४/१८

.....
सुनिल राज शर्मा
निर्देशक

A.6.2 Workshop guideline

Date: 03/08/2018

Venue: NHEICC meeting hall/ FHD meeting hall

2. Background

In Nepal, improving the Sexual Reproductive Health and Rights (SRHR) of adolescent has been a challenge in view of difficult access to and low utilisation of contraceptives and a high number of early marriage and unwanted adolescent pregnancies. Adolescent-Friendly Health Services (AFHS) should improve access to and ensure good quality of SRHR services for adolescents in health facilities, but in reality, in SRHR service utilisation among young people is poor. A total of 1032 primary health care facilities are offering AFHS in Nepal. This research study aims to understand what contributes to the utilisation of adolescent-friendly health services in Nepal. My research generates evidence on the level of SRH service utilisation by adolescent; the level of compliance to the Nepal national standard for adolescent health program; understand the health workers and adolescents' perception, attitudes and experiences to SRH service seeking; and practices of health workers while providing health services to adolescent.

Over the period of three years in my PhD study, the primary data has been collected, analysed and preliminary finding is prepared. It is prudent to have a workshop to share the preliminary findings and obtain the recommendation for the policy of Adolescent Sexual Reproductive Health (ASRH). Therefore, the workshop with ASRH key stakeholders is important to share the preliminary findings and obtain the recommendation.

3. Objectives of the workshop

a. To share the stakeholders about the preliminary findings (draft) of the study
b. To obtain stakeholders input into the recommendations for policy on ASRH program

4. Methodology

4.1 Welcome and introduction: 10 min

- Welcome all the invitees and request to take the seat. Allow the participants to be comfortable and settled.
- Arrange the workshop proceedings/protocol – request honourable to chair the workshop, make 1 – 2 guests in the dash and other to take their seat in their respective seats.

- Make a welcome speech, share the objective of workshop and
- Introduce all participants – name, designation, representing the organization, and key experience with Adolescent Sexual Reproductive Health (ASRH).
- Thanks to all the participants for sharing experience and a brief introduction.

4.2 Overview of Research: 10 min

- Researcher background on ASRH
- Build a focus on the workshop by sharing in brief: the introduction of the research study; objectives; rationale; methodology; preliminary findings (draft); timeline;
- Share current program and policy on ASRH

4.3 Case study discussion: 90 min (30 min + 10 min x 4 gr + 05 min x 4gr)

- Arrange the participants (including the dash members) into the four groups.
- Share individual group with a printed copy of different case study (annex no. …) and inform the role and responsibilities: identifying the group leader/facilitator; assigning note taker, and presenter. Inform groups that they will have the time of 30 minutes in the discussion, 10 minutes for presentation and 05 minutes of question/answer each to all four groups.
- Ask participants to analyse the case, review considering existing policy and program on adolescent sexual and reproductive health.
- Identify the issues and pick up two issues to come out with possible recommendations those are feasible, those would give results and enable young people to seek SRH services.

Case study	**Probing questions**	**Associated Findings**
<u>Case 1:</u> Mitra is 40-year-old HCP. He has been providing services for the last 15 years in a health facility. Once day Raghu 18-year-old boy and Rita 17-year-old girl visited him in his health facility. They were not married, but they wanted to learn about family planning methods. Mitra told them that either condom or pills would be an appropriate method of family planning. After Mitra provided the service, he is restless because both Raghu and Rita are unmarried. Moreover, he felt, once they are	• What is/are the issue(s) in this case study? HW values, morale, availability of FP, the role of adolescent, and role of parents. • What is contributing to this case? • What can be done? Are there any policy/strategy that associates with this case study? What are they? Please mention.	Attitude towards adolescence

aware of family planning method, this may lead to sex before marriage. He is also worried that having sex for unmarried is not socially accepted and he might be blamed for promoting sex.	• In your opinion what could be the solution? At policy, strategy, and execution level. • Any more …	
Case 2: Radha is an 18-year-old girl. She has a boyfriend, and they are sexually engaged with each other. Radha decides to go to the nearby health facility and ask about what she could do to prevent sexually transmitted disease and pregnancy. She goes to the health facility and as she was getting herself registered. In the mean time, she overhears two health workers communication in the room inside the registration desk. The health workers were talking about a girl who had come to seek family planning services. Radha is worried that if she talks about her situation the health worker might talk about her too. She cancels her registration and goes back home.	• What is/are the issue(s) in this case study? • What aspects of health workers might have contributed in this case? (Confidentiality) • How can in the future this situation be avoided. • What is the code of conduct for health workers? • How can confidentiality be ensured? • What is in the policy regarding confidentiality? • What could be short and long-term goals? • What will have more impact to utilisation and practical aspect?	Lack of confidentiality
Case 3: Raghu is a 54-year-old school teacher. He recently learnt that the health facility in his village is providing contraception services to both married and unmarried adolescents. A health worker came to his school and informed adolescents and all the teachers in his school a few weeks back about these contraception services. Raghu believes that the health facility should not provide contraception services to adolescents rather tell them that it is a sin to be sexually active before marriage.	• What is/are the issue(s) in this case study? Coordination between HF and school, value system, • How could health worker coordinate with school teachers and community? • How can the value system change process can be triggered? • What are the enablers and inhibitors factors in the value system change process?	The expectation for AFHS to be counselling centre not having sex (expectation to have abstinence)
Case 4: Health facility XYZ is an adolescent-friendly health facility. Rita and Hari are health workers of this health facility, and they had attended adolescent sexual reproductive health orientation and training. Rita and Hari allocated separate time for adolescents and placed the adolescent-friendly board	• What is/are the issue(s) in this case study? Capacity building component, • What can be done for the training purpose • Can there be the digital training of new health workers? Internet,	5.2 Health worker related factors

in the health facility. Adolescents of their village were excited and are regularly getting services. Recently Rita must take leave and go to her village, and Hari was transferred to another health facility in the same district. Adolescents are still coming to the health facility, but they are frustrated that they cannot see Rita or Hari but there is new health worker who is not trained in the AFHS program.	interactive training, digital materials at the health facility level. • What is the feasibility of m-health interventions for health workers? Push messages	

4.4 Policy recommendation: 20 min (05 min x 4 gr)

- Ask the individual group to recommend a possible solution on identified issues at policy, strategy, program and execution level.
- Inform participant to make a recommendation that is appropriate, effective, efficient, sustainable and feasible.

4.5 Summary and thank you: 10 min

- Summarize the workshop with key findings and recommendation
- Inform participant how the workshop findings will benefit the PhD study and
- Ask the guest – 1 to present remarks regarding this workshop
- Ask the chairperson to present remarks and thank all the participant for their valuable time, comment, remarks and recommendation.

Expected outcome

The following are the expected outcomes

- Comment of participants on the case studies issues that are associated with policy, strategy, program and execution level
- The recommendations that are appropriate, effective, efficient, sustainable and feasible at various levels

5. workshop schedule

Time: 1-5 pm Date: 3rd August 2018, Friday

Time	Activities	Objective	Method	Responsibility
10 min	Welcome and Introduction	To familiarise with each other	Self-introduction	
10 mins	Overview of existing ASRH program in Nepal	To inform about the present national		NHEICC

		context of ASRH program		
10 min	Overview of the research	To build a context for the discussion	Presentation	Pushpa Lata Pandey
30 mins	Case study discussions - Four different scenario case studies	To discuss the problem, issues, opportunities and possible solution to address the identified issues.	Group works in 3-4 groups. Each group will be provided with one case study drawn from the findings	All participants
60 minutes	Presentation and question/answer of the major points discussed	To develop common consensus among the participants	Presentation	Group presenter
20 mins	Presentation of the policy recommendations	To develop a common understanding of the policy recommendations	Presentation	Group presenter
10 mins	Summary and thanks			
Refreshment				

6.3 List of materials required

- White butcher papers
- Permanent markers
- Meta Cards
- Masking tapes
- Recorder

A.6.3 List of workshop participants

Workshop

To collect recommendation for Adolescent Sexual and Reproductive Health (ASRH) Program in Nepal

(NHEICC/SISo Nepal)

Attendance Sheet

Date: 2nd August, 2018 Venue: NHIECC, Teku

S.N	Name	Designation	Organization	Contact No.	Email Address	Signature
1	Deepali Thapa	Chairperson	Hamro Chetana Nepal	9841652020	deepalithapa2015@gmail.com	
2	Shristi Mainali	BCC officer	SPN/MSI	9849000755	shristi.mainali@mariestopes.org.np	
3	Neera Thakur	RHO	UNFPA	9801056005	nthakur@unfpa.org	
4	LAXMI TAMANG	vice president	WOREC	9841562502	laxmitamang@gmail.com	
5	Shweta Karna	Research officer	NOREC	9860170391	SKarna000@gmail.com	
6	Bhawani K.C	Asst Research Coordi	WOREC	9841902327	elo.kc2000@gmail.com	
7	Dr. Radhika Tripathiya	Chief HEA	NHEICC	9841528850	radhikaTripathiya@gmail	
8	Kunj Pd. Joshi	Sr. HEA	"	9841392744	KunjJoshi366@gmail.com	
9	Khumananda Suwal	Exe. Dir. SISO Nepal	SISO Nepal	9851087645	Khsuwal@sisonepal.org.np	
10	Dr. Bhakta KC.	HEA	NHEICC	9860820284	bhaktacc52@gmail.com	
11	Ava Shrestha	M.E.O	N.M.E.I.CC	9849440393	avashrestha@gmail.com	
12	Sheela Shrestha	HEA	NHEICC	9841360889	Sheelashra7@gmail.com	

13	Rajmani Niraula	SE Of.	NHEICC	9843773586	Niraularaj mail.com	
14	Lok Raj Pandey	H.E.O	NHEICC	9841689554	mlokpandey@gmail.com	
15	Dr. Rajendra Bhadra	–	–	–	rajendrabhadra@gmail.com	
16	Shankar Dhakal	Account Officer	NHEICC	9849019925	dhakalshankar@yahoo.com	
17	Amrita Pahadi	Com. Mgt. officer	MOHP.	9851181371	pahadiamrita@gmail.com	
18	Kabita Nepal	LCN Mgt Ad	DOHS	9851227991	bitak006@gmail.com	
19	Anjana Khadka	[illegible]	NHEICC	9851269098	anjanaadhk@gmail.com	
20	Samikshya Singh	—	—	9851181367	ssing-2080@hotmail.com	
21	Birendra Prasad	Health Specialist	UNICEF	9751006617	bprasad@unicef.org	
22	Ishwori Chapagai			9860373421	Ishwori.chapagai@gmail	
23	Nischal	Adolescent	—	—	—	
24	Bhola Ghimire	Program Coordinator	NRCS	9851172725	bholaoffical@gmail.com	
25	Shreejana Bajracharya	Ops Manager	SPHM/MSI	9841424487	shreejana.bajracharya@nbrcsthpes.org	
26	Pabitra Subedi	Teacher	RR School Boneshower	9841598597	Pabitrasubedi628@gmail.com	
27	Jalpa Pradhan		SISO Nep	9818122714	jalpa2070@gmail.com	
28	Durga Sapkota	Freelancer Consultant		9862006833	durgasapkota9@gmail.com	
29	Alina Maharjan	Program Manager	PSI/Nepal	9841500312	alinamaharjan@psi.org.np	

30	DEVENDRA LAL SHRESTHA	SR. BCC MANAGER	PSI/NEPAL	9851002818	devendrashrestha@psi.org.np	
31	Raju Prajapati	Manager	PSI/Nepal	9849979308	rajuprajapati@psi.org.np	
32	TEJ B. LAMICHHANE	OFISA	NHEICC	9841055433		
33	Pushpa Subedi	P.C	SISO Nepal	9841049245	Pushpasubedi09@yahoo.com	
34	Saroja Giri	P.O	"	–	Saroja23@gmail.com	
35	Parwati B.K	Adolescent	–	–	–	
36	Nawaraj Sharma	Adolescent	–	–	–	
37	Maiya Rana	Adolescent	–	–	–	
38	Pushpa Lata Pandey	student	UNSW	9841495531	pushpa.pandey@student.unsw.edu.au	
39						
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Appendix A.7: Ethical Approval letters from Human Research Ethics Committee (HREC), UNSW and Nepal Health Research Council (NHRC)

Appendix A.7.1 UNSW ethical approval

Human Research Ethics Committee (HREC)
The University of New South Wales
UNSW Sydney, NSW, Australia, 2052
T: +612 9385 622 or +612 9385 7257
E: humanethics@unsw.edu.au
W:https://research.unsw.edu.au/human-research-ethics-home

04-Jul-2016

Dear Dr Husna Razee,

Project Title	Exploring factors impacting on the utilisation of adolescent health services in Nepal
HC No	HC16427
Re	Notification of Ethics Approval
Approval Period	04-Jul-2016 - 03-Jul-2021

Thank you for submitting the above research project to the **HREC Executive** for ethical review. This project was considered by the **HREC Executive** at its meeting on 28-Jun-2016.

I am pleased to advise you that the **HREC Executive** has granted ethical approval of this research project, subject to the following conditions being met:

Conditions of Approval Specific to Project:
N/A

Conditions of Approval - All Projects:

- The Chief Investigator will immediately report anything that might warrant review of ethical approval of the project.
- The Chief Investigator will notify the **HREC Executive** of any event that requires a modification to the protocol or other project documents and submit any required amendments in accordance with the instructions provided by the **HREC Executive**. These instructions can be found at https://research.unsw.edu.au/research-ethics-and-compliance-support-recs.

- The Chief Investigator will submit any necessary reports related to the safety of research participants in accordance with **HREC Executive** policy and procedures. These instructions can be found at https://research.unsw.edu.au/research-ethics-and-compliance-support-recs.
- The Chief Investigator will report to the **HREC Executive** annually in the specified format and notify the HREC Executive when the project is completed at all sites.
- The Chief Investigator will notify the **HREC Executive** if the project is discontinued at a participating site before the expected completion date, with reasons provided.
- The Chief Investigator will notify the **HREC Executive** of any plan to extend the duration of the project past the approval period listed above and will submit any associated required documentation. Iinstructions for obtaining an extension of approval can be found at https://research.unsw.edu.au /research-ethics-and-compliance-support-recs.

- The Chief Investigator will notify the **HREC Executive** of his or her inability to continue as Coordinating Chief Investigator including the name of and contact information for a replacement.

A copy of this ethical approval letter must be submitted to all Investigators and sites prior to commencing the project.

The **HREC Executive** Terms of Reference, Standard Operating Procedures, membership and standard forms are available from https://research.unsw.edu.au/research-ethics-and-compliance-support-recs.

If you would like any assistance, or further information, please contact the ethics office on:
P: +61 2 9385 6222, + 61 2 9385 7257 or +
61 2 9385 7007 E:
humanethics@unsw.edu.au

The **HREC Executive** wishes you continued success in your research.

Kind Regards

A/Prof John Hunt
HREC Presiding Chairperson

This HREC is constituted and operates in accordance with the National Health and Medical
Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007).* The processes used by this HREC to review multi-centre research proposals have been certified by the National Health and Medical Research Council.

Appendix A.7.2 Nepal Health Research Council Ethics Approval

Government of Nepal

Nepal Health Research Council (NHRC)

Estd. 1991

Ref. No.: 491

05 September 2016

Ms. Pushpa Lata Pandey
Principal Investigator
University of South Wales
Australia

Ref: **Approval of Research Proposal** entitled **Utilization of adolescent friendly sexual and reproductive health services in Dhading district, Nepal**

Dear Ms. Pandey,

It is my pleasure to inform you that the above-mentioned proposal submitted on **13 July 2016 (Reg.no.199/2016** please use this Reg. No. during further correspondence) has been approved by NHRC Ethical Review Board on **31 August 2016**.

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 **March 2019.**

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 total research amount is **AUD 3,000.00** and accordingly the processing fee amount to **NRs. 10,775.00.** It is acknowledged that the above-mentioned processing fee has been received at NHRC.

If you have any questions, please 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 A.7.3 UNSW ethics modification approval

Human Research Ethics Committee (HREC)
The University of New South Wales
UNSW Sydney, NSW, Australia, 2052
T: +612 9385 6222 or +612 9385 7257
E: humanethics@unsw.edu.au
W:https://research.unsw.edu.au/human-research-ethics-home

01-Dec-2016

Dear Dr Husna Razee,

Project Title	Exploring factors impacting on the utilisation of adolescent health services in Nepal
HC No	HC16427
Re	Modification request received 21 November 2016.

The modification to this project was **approved** by the **HREC Executive** on 29-Nov-2016.

If this project is a multicentre project you must forward a copy of this letter to all Investigators at other sites for their records.

Please note that all requirements and conditions of the original ethical approval for this project still apply.

If you would like any assistance, or further information, please contact the ethics office on:

E: humanethics@unsw.edu.au
W:https://research.unsw.edu.au/human-research-ethics-home

The UNSW HREC Executive wishes you every continued success in your research.

Kind Regards

A/Prof John Hunt

HREC Presiding Chairperson

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007).* The processes used by this HREC to review multi-centre research proposals have been certified by the National Health and Medical Research Council.

Appendix A. 8: Participant information and consent forms for health care providers, adolescents and key informants in English

A.8.1 Participant Information and consent form for Health facility In-charge

School of Public Health and Community Medicine Faculty of Medicine	 UNSW AUSTRALIA
PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM Health facility In-charge (Phase 1) Utilisation of SRH services from adolescent-friendly health services in Dhading district, Nepal	

The study is being carried out by the following researchers:		
Role	**Name**	**Organisation**
Chief Investigator	Dr Husna Razee	School of Public Health and Community Medicine, UNSW
Co-Investigator/s	Dr Holly Seale Dr Suresh Mehata	School of Public Health and Community Medicine, UNSW Nepal Health Sector Support Program, Ministry of Health, Nepal
Student Investigator/s	Pushpa Lata Pandey	School of Public Health and Community Medicine, UNSW

What is the research study about?

You are invited to take part in this research study being conducted by researchers from the University of New South Wales, Sydney, Australia and from Ministry of Health, Nepal. Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

Adolescent-Friendly Health Services aim to provide sexual and reproductive health services to young people in Nepal. However, uptake of these services has not been optimal. Previous studies have found that young people know about the availability of these health services however they are not accessing them. The problem is that we do not know why they are not utilising these services.

This new research study aims to understand what factors impact on the utilisation of adolescent-friendly health services in Nepal. As the first step, we would like to quantify the actual level of utilisation of adolescent-friendly health services by young people over the last two years. And observe the health facility using a standard checklist. This forms one part of a larger body of work being undertaken.

You have been invited to participate in this research because your:

- Health facility has implemented an adolescent-friendly program for at least two years
- Health facility has at least one male and one female health care providers currently providing services to young people.

Do I have to take part in this research study?

Participation in this research study is voluntary. It is completely up to you whether or not to participate. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

What does participation in this research require, and are there any risks involved?

With your permission we would like to review the health facility records to quantify the number of times services such as family planning, antenatal care, and delivery and abortion services have been used by young people over the past two years. We would collect information about the age of the patient, their sex and their reason for visiting the facility. We would not collect any identifiable information about the patients from the records. A member of the research will then observe all the rooms and surroundings of your health facility using a standard checklist. No questions will be asked to you or any of the other members of the health facility. We anticipate that it will take around 4-5 hours to go through all the records and observation in your health facility.

Are there risks to me in taking part in this study?

Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study.

Will I be paid to participate in this project?

There are no costs associated with participating in this research study, nor will you be paid.

What are the possible benefits to participation?

We aim to use the findings from this study to help tailor the health services so that they are better utilised by young people in Nepal.

What will happen to information about me?

By signing the consent form, you consent to the research team for collecting and using information about your health facility for the research study. We will keep your data for seven years. We will store information about your health facility at the University of New South Wales (UNSW), Sydney Australia. Your information will only be used for the purpose of this research study, and it will only be disclosed with your permission.

You have the right to request access to the information about your health facility that is collected and stored by the research team. You also have the right to request any information with which you disagree be corrected. You can do this by contacting a member of the research team.

The information obtained will be kept for seven years, and they will be stored at UNSW, Kingston campus. Your confidentiality will be ensured by keeping your recordings on School of Public Health and Community Medicine hard drive and password protected for the research team. The hard drive will be kept in a safe and lockable cabinet at the school's premises.

How and when will I find out what the results of the research study are?

You have a right to receive feedback about the overall results of this study. A summary of the findings from this study will be posted at the Adolescent-Friendly Health Services at the completion of the study.

The data collected in this study will be used as part of Pushpa Pandey's PhD for the University of New South Wales. It is anticipated that the results of this research study will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be published, in a way such that you will not be individually identifiable.

What if I want to withdraw from the research study?

Even if you do consent to participate, you may withdraw at any time. If you do withdraw, you will be asked to complete and sign the 'Withdrawal of Consent Form' which is provided at the end of this document. Alternatively, you can ring the research team and tell them you no longer want to participate. If you decide to leave the research study, the researchers will not collect additional information from you.

You are free to stop the data collection process at any time. Unless you say that you want us to keep them, any information will be erased, and the information you have provided will not be included in the study results.

If you decide to withdraw from the study, we will not collect any more information from you. Please let us know at the time when you withdraw what you would like us to do with the information we have collected about you up to that point. If you wish your information will be removed from our study records and will not be included in the study results, up to the point that we have analysed and published the results.

What should I do if I have further questions about my involvement in the research study?

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems that may be related to your involvement in the project, you can contact the following member/s of the research team:

Research Team Contact

Name	Pushpa Lata Pandey
Position	Student Investigator
Telephone	9841490531 (Nepal number)
Email	Pushpa.pandey@student.unsw.edu.au

Name	Dr Suresh Mehata
Position	Co- Investigator
Telephone	9842036595 (Nepal Number)
Email	sureshmht@gmail.com

What if I have a complaint or any concerns about the research study?

If you have any complaint about any aspect of the project, the way it is being conducted, then you may contact:

Complaints Contact (Nepal)

Position	Ethics Review Board Member Secretary, Nepal Health Research Council
Telephone	977 1 4254220
Email	nhrc@nhrc.org.np
HC Reference Number	[INSERT HC reference number]

(Australia)

Position	Human Research Ethics Coordinator
Telephone	+ 61 2 9385 6222
Email	humanethics@unsw.edu.au

HC Reference Number	[INSERT HC reference number]

Consent Form – Participant providing own consent

Declaration by the participant

- ☐ I have read the Participant Information Sheet or someone has read it to me in a language that I understand;
- ☐ I understand the purposes, study tasks and risks of the research described in the project;
- ☐ I have had an opportunity to ask questions and I am satisfied with the answers I have received;
- ☐ I freely agree to participate in this research study as described and understand that I am free to withdraw at any time during the project and withdrawal will not affect my relationship with any of the named organisations and/or research team members;
- ☐ I understand that I will be given a signed copy of this document to keep;

Participant Signature

Name of Participant (please print)	
Signature of Research Participant	
Date	

Declaration by Researcher*

- ☐ I have given a verbal explanation of the research study, its study activities and risks and I believe that the participant has understood that explanation.

Researcher Signature*

Name of Researcher (please print)	
Signature of Researcher	
Date	

[+]An appropriately qualified member of the research team must provide the explanation of, and information concerning the research study.

Note: All parties signing the consent section must date their own signature.

Form for Withdrawal of Participation

I wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** affect my relationship with The University of New South Wales, School of Public Health and Community Medicine.

Participant Signature

Name of Participant (please print)	
Signature of Research Participant	
Date	

The section for Withdrawal of Participation should be forwarded to:

Co-investigator Name:	**Dr Suresh Mehata**
Email:	**Sureshmht@gmail.com**
Phone:	**977 9842036595**
Postal Address:	Nepal Health Sector Support Program Ministry of Health Ramshah Path Kathmandu, Nepal

A.8.2 Participant Information and Consent form for health care provider

School of Public Health and Community Medicine Faculty of Medicine	 UNSW AUSTRALIA

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM

Health care provider (Phase 2)

Utilisation of SRH services from adolescent-friendly health services in Dhading district, Nepal

The study is being carried out by the following researchers:		
Role	**Name**	**Organisation**
Chief Investigator	Dr Husna Razee	School of Public Health and Community Medicine, UNSW
Co-Investigator/s	Dr Holly Seale Dr Suresh Mehata	School of Public Health and Community Medicine, UNSW Nepal Health Sector Support Program, Ministry of Health, Nepal
Student Investigator/s	Pushpa Lata Pandey	School of Public Health and Community Medicine, UNSW

What is the research study about?

You are invited to take part in this research study being conducted by researchers from the University of New South Wales, Sydney, Australia and from Ministry of Health, Nepal. Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

Adolescent-Friendly Health Services aim to provide sexual and reproductive health services to young people in Nepal. However, uptake of these services has not been optimal. Previous studies have found that young people know about the availability of these sexual and reproductive health (SRH) services however they are not accessing them. The problem is that we do not know why they are not utilising these services.

This new research study aims to understand what factors impact on the utilisation of adolescent-friendly health services in Nepal. We are interested to hear your thoughts, experiences and practices while providing SRH services to adolescents from your health facility. The findings from this study will be used to provide recommendations to Ministry of Health to help tailor the SRH services so that they are better utilised by adolescents.

You have been invited to participate in this research because you are:

- Government Health care provider
- Working in the adolescent-friendly health facility for at least six months.

Do I have to take part in this research study?

Participation in this research study is voluntary. It is completely up to you whether or not to participate. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

What does participation in this research require, and are there any risks involved?

If you decide to take part in the research study, you will be:

- asked to undertake an in-depth interview describing your experience and perspective of providing SRH services to young people
- observed while you provide SRH services to young people in your health facility

The visit length for each activity is as follows:

Visit #	Procedures	Location*	Visit Length
Visit 1	• **In-depth Interview**	**Health Facility**	**1-1.5 hours**
Visit 2	• **Observation of health service delivery**	**Health Facility**	**3 observations lasting for not more than 30-45 minutes**

For interview

During the interview, a member of the research team will ask you questions about your perspectives and experience while providing SRH services to young people from your health facility. With your permission, the interview will be audio recorded and professionally typed into an anonymous transcript. The purpose of recording the interview is to assist with analysing the information collected and presenting an accurate picture of the conversation.

For observation of SRH service delivery

During the observation of SRH service delivery to adolescents by you, the researcher will be present in the consultation room. The researcher will however remain in distance and will take note of the way you delivery health service. The subject matter of the conversation will not be recorded.

Are there risks to me in taking part in this study?

Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study. We will not ask you to reveal any personal information.

Will I be paid to participate in this project?

There are no costs associated with participating in this research study, nor will you be paid. You will be provided with light refreshment package, a mobile recharge card and a small gift to thank you for taking part in this study.

What are the possible benefits to participation?

We aim to use the findings from this study to help tailor the health services so that they are better utilised by young people in Nepal.

What will happen to information about me?
By signing the consent form, you consent to the research team for collecting and using information about you and your health facility for the research study. We will keep your data for seven years. We will store information about you and health facility at the University of New South Wales (UNSW), Sydney Australia. Your information will only be used for the purpose of this research study, and it will only be disclosed with your permission.

You have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request any information with which you disagree be corrected. You can do this by contacting a member of the research team.

The audiotaped digital recordings are for the research study. After the in-depth interview, we will transcribe, translate then store your digital recordings. We will keep your digital recordings in the form of digital recording and transcription for seven years. We will also keep the observation data in a form of transcription. We will store information about you at UNSW, Kingston campus. Your confidentiality will be ensured by keeping your recordings on a hard drive, which is password protected. The hard drive will be kept in a safe and lockable cabinet at the school premises.

How and when will I find out what the results of the research study are?

You have a right to receive feedback about the overall results of this study. A summary of the findings from this study will be posted at the Adolescent-Friendly Health Services at the completion of the study.
The data collected in this study will be used as part of Pushpa Pandey's PhD for the University of New South Wales. It is anticipated that the results of this research study will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be published, in a way such that you will not be individually identifiable.

What if I want to withdraw from the research study?
Even if you do consent to participate, you may withdraw at any time. If you do withdraw, you will be asked to complete and sign the 'Withdrawal of Consent Form' which is provided at the end of this document. Alternatively, you can ring the research team and tell them you no longer want to participate. If you decide to leave the research study, the researchers will not collect additional information from you.
You are free to stop the interview at any time. Unless you say that you want us to keep them, any recordings will be erased, and the information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the interview.
If you decide to withdraw from the study, we will not collect any more information from you. Please let us know at the time when you withdraw what you would like us to do with the information we have collected about you up to that point. If you wish your information will be removed from our study records and will not be included in the study results, up to the point that we have analysed and published the results.

What should I do if I have further questions about my involvement in the research study?
The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems that may be related to your involvement in the project, you can contact the following member/s of the research team:

Research Team Contact

Name	Pushpa Lata Pandey
Position	Student Investigator
Telephone	9841490531 (Nepal number)
Email	Pushpa.pandey@student.unsw.edu.au

Name	Dr Suresh Mehata
Position	Co- Investigator
Telephone	9842036595 (Nepal Number)
Email	sureshmht@gmail.com

What if I have a complaint or any concerns about the research study?

If you have any complaints about any aspect of the project, the way it is being conducted, then you may contact:

Complaints Contact (Nepal)

Position	Ethics Review Board Member Secretary, Nepal Health Research Council
Telephone	977 1 4254220
Email	nhrc@nhrc.org.np
HC Reference Number	HC 16427

(Australia)

Position	Human Research Ethics Coordinator
Telephone	+ 61 2 9385 6222
Email	humanethics@unsw.edu.au
HC Reference Number	HC 16427

Consent Form – Participant providing own consent

Declaration by the participant

- ☐ I have read the Participant Information Sheet or someone has read it to me in a language that I understand;
- ☐ I understand the purposes, study tasks and risks of the research described in the project;
- ☐ I have had an opportunity to ask questions and I am satisfied with the answers I have received;
- ☐ I freely agree to participate in this research study as described and understand that I am free to withdraw at any time during the project and withdrawal will not affect my relationship with any of the named organisations and/or research team members;
- ☐ I understand that I will be given a signed copy of this document to keep;

Participant Signature

Name of Participant (please print)	
Signature of Research Participant	
Date	

Declaration by Researcher*

- ☐ I have given a verbal explanation of the research study, its study activities and risks and I believe that the participant has understood that explanation.

Researcher Signature*

Name of Researcher (please print)	
Signature of Researcher	
Date	

[+]An appropriately qualified member of the research team must provide the explanation of, and information concerning the research study.

Note: All parties signing the consent section must date their own signature.

Form for Withdrawal of Participation

I wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** affect my relationship with The University of New South Wales, School of Public Health and Community Medicine.

Participant Signature

Name of Participant (please print)	
Signature of Research Participant	
Date	

The section for Withdrawal of Participation should be forwarded to:

Co-investigator Name:	**Dr Suresh Mehata**
Email:	**Sureshmht@gmail.com**
Phone:	**977 9842036595**
Postal Address:	Nepal Health Sector Support Program Ministry of Health Ramshah Path Kathmandu, Nepal

A.8.3 Participant information and consent form for adolescents

School of Public Health and Community Medicine Faculty of Medicine	 UNSW AUSTRALIA
PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM Adolescents (Phase 2) Utilisation of SRH services from adolescent-friendly health services in Dhading district, Nepal	

The study is being carried out by the following researchers:		
Role	**Name**	**Organisation**
Chief Investigator	Dr Husna Razee	School of Public Health and Community Medicine, UNSW
Co-Investigator/s	Dr Holly Seale Dr Suresh Mehata	School of Public Health and Community Medicine, UNSW Nepal Health Sector support Program, Ministry of Health, Nepal
Student Investigator/s	Pushpa Lata Pandey	School of Public Health and Community Medicine, UNSW

What is the research study about?

You are invited to take part in this research study being conducted by researchers from the University of New South Wales, Sydney, Australia and from Ministry of Health, Nepal. Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

Adolescent-Friendly Health Services aim to provide sexual and reproductive health services to young people in Nepal. However we know that young people are not accessing these services, but we are not sure of the reasons for this.

This research study aims to understand what factors impact on the utilisation of Adolescent-Friendly Health Services from the perspective of young people in Nepal. We are interested in finding out what young people think about Adolescent-Friendly Health Services, whether they use them and about any barriers that are stopping young people from using these services. The findings from this study will be used to improve the delivery of these services.

You have been invited to participate in this study because you:

- Are aged 15-19 years old

- Live within the catchment area of the adolescent-friendly health facility located at [centre name]
- May have used the health service within the last 12 months. If you haven't used the service, we would still like to talk with you.

Do I have to take part in this research study?
Participation in this study is voluntary. It is completely up to you whether or not to participate. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

What does participation in this research require, and are there any risks involved?
If you decide to take part in the research study, you will be asked to take part in an in-depth interview/ focus group discussion that will last between 1hour and 1.5 hours.

For Focus group discussion

During this focus group discussion, a member of the research team will ask you questions about your views on what adolescent-friendly health services mean and how should it look like. We will no ask you to reveal any personal information on your health.

For in-depth interview

During the in-depth interview, a member of the research team will ask you questions about your experiences and challenges of obtaining health services from these facilities. We will not ask you to reveal any personal information about the reason you visited the health facility. You will also be asked to provide us brief (2 minutes) demographic information of yourself.

With your permission, the interview will be audio recorded and professionally typed into an anonymous transcript. The purpose of recording the interview is to assist with analysing the information collected and presenting an accurate picture of the conversation.

Are there risks to me in taking part in this study?

We do not anticipate any risks to you from being in this study. Some questions ask about your attitudes towards sexual and reproductive health services in a way that you may not have considered before. Thinking about some of these issues may make you worry or feel uncomfortable. If you do feel this way, please speak to the study investigator.

If you feel unhappy or worried at any stage during the study or afterwards, you can speak with the study investigator or alternative you can speak to the Medical Officer in Dhading District Hospital at 010 520126

Will I be paid to participate in this project?

There are no costs associated with participating in this research study, nor will you be paid. You will be provided with light refreshment package, a mobile recharge card and a small gift to thank you for taking part in this study.

What are the possible benefits to participation?
We aim to use the findings from this study to help tailor the health services so that they are better utilised by young people in Nepal.

What will happen to information about me?
By signing the consent form, you consent to the research team collecting and using information about you for the research study. We will keep your data for seven years. We will store information about you at the University of New South Wales (UNSW), Sydney, Australia. Your

information will only be used for the purpose of this research study, and it will only be disclosed with your permission.

You have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. You can do this by contacting a member of the research team.

The audiotaped digital recordings are for the research study. After the in-depth interview/focus group discussion, we will transcribe, translate then store your digital recordings. We will keep your digital recordings in the form of digital recording and transcription for seven years. Your confidentiality will be ensured by keeping your recordings on a hard drive, which is password protected. The hard drive will be kept in a safe and lockable cabinet at the schools premises.

How and when will I find out what the results of the research study are?

You have a right to receive feedback about the overall results of this study. A summary of the findings from this study will be posted at the Adolescent-Friendly Health Service at the completion of the study,
The data collected in this study will be used as part of Pushpa Pandey's PhD for the University of New South Wales. It is anticipated that the results of this research study will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be published, in a way such that you will not be individually identifiable.

What if I want to withdraw from the research study?
Even if you do consent to participate, you may withdraw at any time. If you do withdraw, you will be asked to complete and sign the 'Withdrawal of Consent Form' which is provided at the end of this document. Alternatively, you can ring the research team and tell them you no longer want to participate. If you decide to leave the research study, the researchers will not collect additional information from you.
You are free to stop participating at any stage or to refuse to answer any of the questions. However, it will not be possible to withdraw your individual comments from our records once the group has started, as it is a group discussion.

What should I do if I have further questions about my involvement in the research study?
The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems that may be related to your involvement in the project, you can contact the following member/s of the research team:

Research Team Contact

Name	Pushpa Lata Pandey
Position	Student Investigator
Telephone	9841490531 (Nepal number)
Email	Pushpa.pandey@student.unsw.edu.au
Name	Dr Suresh Mehata
Position	Co- Investigator
Telephone	9842036595 (Nepal Number)
Email	sureshmht@gmail.com

What if I have a complaint or any concerns about the research study?
If you have any complaints about any aspect of the project, the way it is being conducted, then you may contact:

Complaints Contact (Nepal)

Position	Ethics Review Board Member Secretary, Nepal Health Research Council
Telephone	977 1 4254220
Email	nhrc@nhrc.org.np
HC Reference Number	HC 16427

(Australia)

Position	Human Research Ethics Coordinator
Telephone	+ 61 2 9385 6222
Email	humanethics@unsw.edu.au
HC Reference Number	HC 16427

Consent Form – Participant providing own consent

Declaration by the participant

- ☐ I have read the Participant Information Sheet or someone has read it to me in a language that I understand;
- ☐ I understand the purposes, study tasks and risks of the research described in the project;
- ☐ I have had an opportunity to ask questions and I am satisfied with the answers I have received;
- ☐ I freely agree to participate in this research study as described and understand that I am free to withdraw at any time during the project and withdrawal will not affect my relationship with any of the named organisations and/or research team members;
- ☐ I understand that I will be given a signed copy of this document to keep;

Participant Signature

Name of Participant (please print)	
Signature of Research Participant	
Date	

Declaration by Researcher*

- ☐ I have given a verbal explanation of the research study, its study activities and risks and I believe that the participant has understood that explanation.

Researcher Signature*

Name of Researcher (please print)	
Signature of Researcher	
Date	

[+]An appropriately qualified member of the research team must provide the explanation of, and information concerning the research study.

Note: All parties signing the consent section must date their own signature.

Form for Withdrawal of Participation

I wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** affect my relationship with The University of New South Wales, School of Public Health and Community Medicine.

Participant Signature

Name of Participant (please print)	
Signature of Research Participant	
Date	

The section for Withdrawal of Participation should be forwarded to:

Co-investigator Name:	**Dr Suresh Mehata**
Email:	**Sureshmht@gmail.com**
Phone:	**977 9842036595**
Postal Address:	Nepal Health Sector Support Program Ministry of Health Ramshah Path Kathmandu, Nepal

A.8.4 Participants Information and consent form for adolescents exit interview

School of Public Health and Community Medicine Faculty of Medicine	 UNSW AUSTRALIA

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM

Adolescent exit interview (Phase 2)

Utilisation of SRH services from adolescent-friendly health services in Dhading district, Nepal

The study is being carried out by the following researchers:		
Role	**Name**	**Organisation**
Chief Investigator	Dr Husna Razee	School of Public Health and Community Medicine, UNSW
Co-Investigator/s	Dr Holly Seale Dr Suresh Mehata	School of Public Health and Community Medicine, UNSW Nepal Health Sector support Program, Ministry of Health, Nepal
Student Investigator/s	Pushpa Lata Pandey	School of Public Health and Community Medicine, UNSW

What is the research study about?

You are invited to take part in this research study being conducted by researchers from the University of New South Wales, Sydney, Australia and from Ministry of Health, Nepal. Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

Adolescent-Friendly Health Services aim to provide sexual and reproductive health services to young people in Nepal. However we know that young people are not accessing these services, but we are not sure of the reasons for this.

This research study aims to understand what factors impact on the utilisation of sexual and reproductive health services from Adolescent-Friendly Health Facilities from the perspective of young people in Nepal. We are interested in finding out your experiences while receiving sexual and reproductive health services from health facilities. The findings from this study will be used to improve the delivery of these services.

You have been invited to participate in this study because you:

- Are aged 15-19 years old
- You have used sexual and reproductive health services from the health facility within last one week.

Do I have to take part in this research study?
Participation in this study is voluntary. It is completely up to you whether or not to participate. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

What does participation in this research require, and are there any risks involved?
If you decide to take part in the research study, you will be asked to take part in an interview that will last between 45 minutes to one hour.

During the interview, a member of the research team will ask you questions about your experiences from your recent visit to the health facility while obtaining sexual and reproductive health services. We will not ask you to reveal any personal information about the reason you visited the health facility. You will also be asked to provide us brief (2 minutes) demographic information of yourself.

With your permission, the interview will be audio recorded and professionally typed into an anonymous transcript. The purpose of recording the interview is to assist with analysing the information collected and presenting an accurate picture of the conversation.

Are there risks to me in taking part in this study?

We do not anticipate any risks to you from being in this study. Questions about your experiences while receiving sexual and reproductive health services may be asked in a way that you may not have considered before. Talking about some of these issues may make you worry or feel uncomfortable. If you do feel this way, please speak to the study investigator.

If you feel unhappy or worried at any stage during the study or afterwards, you can speak with the study investigator or alternative you can speak to the Medical Officer in Dhading District Hospital at 010 520126

Will I be paid to participate in this project?

There are no costs associated with participating in this research study, nor will you be paid. You will be provided with light refreshment package, a mobile recharge card and a small gift to thank you for taking part in this study.

What are the possible benefits to participation?
We aim to use the findings from this study to help tailor the health services so that they are better utilised by young people in Nepal.

What will happen to information about me?
By signing the consent form, you consent to the research team collecting and using information about you for the research study. We will keep your data for seven years. We will store information about you at the University of New South Wales (UNSW), Sydney, Australia. Your information will only be used for the purpose of this research study, and it will only be disclosed with your permission.

You have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. You can do this by contacting a member of the research team.

The audiotaped digital recordings are for the research study. After the interview, we will transcribe, translate then store your digital recordings. We will keep your digital recordings in the form of digital recording and transcription for seven years. Your confidentiality will be ensured by keeping your recordings on a hard drive, which is password protected. The hard drive will be kept in a safe and lockable cabinet at the schools premises.

How and when will I find out what the results of the research study are?

You have a right to receive feedback about the overall results of this study. A summary of the findings from this study will be posted at the Adolescent-Friendly Health Service at the completion of the study,

The data collected in this study will be used as part of Pushpa Pandey's PhD for the University of New South Wales. It is anticipated that the results of this research study will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be published, in a way such that you will not be individually identifiable.

What if I want to withdraw from the research study?

Even if you do consent to participate, you may withdraw at any time. If you do withdraw, you will be asked to complete and sign the 'Withdrawal of Consent Form' which is provided at the end of this document. Alternatively, you can ring the research team and tell them you no longer want to participate. If you decide to leave the research study, the researchers will not collect additional information from you.

You are free to stop participating at any stage or to refuse to answer any of the questions.

What should I do if I have further questions about my involvement in the research study?

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems that may be related to your involvement in the project, you can contact the following member/s of the research team:

Research Team Contact

Name	Pushpa Lata Pandey
Position	Student Investigator
Telephone	9841490531 (Nepal number)
Email	Pushpa.pandey@student.unsw.edu.au
Name	Dr Suresh Mehata
Position	Co- Investigator
Telephone	9842036595 (Nepal Number)
Email	sureshmht@gmail.com

What if I have a complaint or any concerns about the research study?

If you have any complaints about any aspect of the project, the way it is being conducted, then you may contact:

Complaints Contact (Nepal)

Position	Ethics Review Board Member Secretary, Nepal Health Research Council
Telephone	977 1 4254220
Email	nhrc@nhrc.org.np
HC Reference Number	HC 16427

(Australia)

Position	Human Research Ethics Coordinator
Telephone	+ 61 2 9385 6222
Email	humanethics@unsw.edu.au
HC Reference Number	HC 16427

Consent Form – Participant providing own consent

Declaration by the participant

- ☐ I have read the Participant Information Sheet or someone has read it to me in a language that I understand;
- ☐ I understand the purposes, study tasks and risks of the research described in the project;
- ☐ I have had an opportunity to ask questions and I am satisfied with the answers I have received;
- ☐ I freely agree to participate in this research study as described and understand that I am free to withdraw at any time during the project and withdrawal will not affect my relationship with any of the named organisations and/or research team members;
- ☐ I understand that I will be given a signed copy of this document to keep;

Participant Signature

Name of Participant (please print)	
Signature of Research Participant	
Date	

Declaration by Researcher*

- ☐ I have given a verbal explanation of the research study, its study activities and risks and I believe that the participant has understood that explanation.

Researcher Signature*

Name of Researcher (please print)	
Signature of Researcher	
Date	

[+]An appropriately qualified member of the research team must provide the explanation of, and information concerning the research study.

Note: All parties signing the consent section must date their own signature.

Form for Withdrawal of Participation

I wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** affect my relationship with The University of New South Wales, School of Public Health and Community Medicine.

Participant Signature

Name of Participant (please print)	
Signature of Research Participant	
Date	

The section for Withdrawal of Participation should be forwarded to:

Co-investigator Name:	**Dr Suresh Mehata**
Email:	**Sureshmht@gmail.com**
Phone:	**977 9842036595**
Postal Address:	Nepal Health Sector Support Program Ministry of Health Ramshah Path Kathmandu, Nepal

A.8.5 Participants Information and consent form for key informants

School of Public Health and Community Medicine Faculty of Medicine	 UNSW AUSTRALIA

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM

Key Informants (Phase 2)

Utilisation of SRH services from adolescent-friendly health services in Dhading district, Nepal

The study is being carried out by the following researchers:		
Role	**Name**	**Organisation**
Chief Investigator	Dr Husna Razee	School of Public Health and Community Medicine, UNSW
Co-Investigator/s	Dr Holly Seale Dr Suresh Mehata	School of Public Health and Community Medicine, UNSW Nepal Health Sector Support Program, Ministry of Health, Nepal
Student Investigator/s	Pushpa Lata Pandey	School of Public Health and Community Medicine, UNSW

What is the research study about?

You are invited to take part in this research study being conducted by researchers from the University of New South Wales, Sydney, Australia and from Ministry of Health, Nepal. Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

Adolescent-Friendly Health Services aim to provide sexual and reproductive health services to young people in Nepal. Ministry of Health has added a component of adolescent-friendly health services to its existing public health facilities in more than 1000 health facilities in 56 districts during 2008-2014. Several researches demonstrate that despite young people knowing about the availability of health services many do not access these services. However, none of the studies conducted have explored the reasons for the low service utilisation.

This research study aims to understand what contributes to the utilisation of adolescent-friendly health services in Nepal. We are interested to find out your perspective and ideas about adolescent-friendly health services. The findings from this study will be used to provide recommendations to Ministry of Health to help tailor the sexual and reproductive health services so that they are better utilised by adolescents.

You have been invited to participate in this research because you are:

- Key informant living within the research area

- Health facility Operational and Management Committee member/ school teacher/local leaders/ parents of adolescents/ female community health volunteer

Do I have to take part in this research study?

Participation in this research study is voluntary. It is completely up to you whether or not to participate. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

What does participation in this research require, and are there any risks involved?

If you decide to take part in the research study, we will be conducting an in-depth interview with you. During the interview, a member of the research team will ask you questions about your perspectives and ideas about adolescent-friendly health programs. The duration of the interview will be approximately for 1-1.5 hours.

With your permission, the interview will be audio recorded and professionally typed into an anonymous transcript. The purpose of recording the interview is to assist with analysing the information collected and presenting an accurate picture of the conversation.

Are there risks to me in taking part in this study?

Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study. We will not ask you to reveal any personal information.

Will I be paid to participate in this project?

There are no costs associated with participating in this research study, nor will you be paid. You will be provided with light refreshment package, a mobile recharge card and a small gift to thank you for taking part in this study.

What are the possible benefits to participation?

We aim to use the findings from this study to help tailor the health services so that they are better utilised by young people in Nepal.

What will happen to information about me?

By signing the consent form, you consent to the research team collecting and using information about you and your health facility for the research study. We will keep your data for seven years. We will store information about you at the University of New South Wales (UNSW), Sydney, Australia. Your information will only be used for the purpose of this research study, and it will only be disclosed with your permission.

You have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request any information with which you disagree be corrected. You can do this by contacting a member of the research team.

The audiotaped digital recordings are for the research study. After the in-depth interview, we will transcribe, translate then store your digital recordings. We will keep your digital recordings in the form of digital recording and transcription for seven years. Your confidentiality will be ensured by keeping your recordings on a hard drive, which is password protected. The hard drive will be kept in a safe and lockable cabinet at the school's premises.

How and when will I find out what the results of the research study are?

You have a right to receive feedback about the overall results of this study. A summary of the findings from this study will be posted at the Adolescent-Friendly Health Services at the completion of the study.

The data collected in this study will be used as part of Pushpa Pandey's PhD for the University of New South Wales. It is anticipated that the results of this research study will be published

and/or presented in a variety of forums. In any publication and/or presentation, information will be published in a way such that you will not be individually identifiable.

What if I want to withdraw from the research study?

Even if you do consent to participate, you may withdraw at any time. If you do withdraw, you will be asked to complete and sign the 'Withdrawal of Consent Form' which is provided at the end of this document. Alternatively, you can ring the research team and tell them you no longer want to participate. If you decide to leave the research study, the researchers will not collect additional information from you.

You are free to stop the interview at any time. Unless you say that you want us to keep them, any recordings will be erased, and the information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the interview.

If you decide to withdraw from the study, we will not collect any more information from you. Please let us know at the time when you withdraw what you would like us to do with the information we have collected about you up to that point. If you wish your information will be removed from our study records and will not be included in the study results, up to the point that we have analysed and published the results.

What should I do if I have further questions about my involvement in the research study?

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems that may be related to your involvement in the project, you can contact the following member/s of the research team:

Research Team Contact

Name	Pushpa Lata Pandey
Position	Student Investigator
Telephone	9841490531 (Nepal number)
Email	Pushpa.pandey@student.unsw.edu.au
Name	Dr Suresh Mehata
Position	Co- Investigator
Telephone	9842036595 (Nepal Number)
Email	sureshmht@gmail.com

What if I have a complaint or any concerns about the research study?

If you have any complaints about any aspect of the project, the way it is being conducted, then you may contact:

Complaints Contact (Nepal)

Position	Ethics Review Board Member Secretary, Nepal Health Research Council
Telephone	977 1 4254220
Email	nhrc@nhrc.org.np
HC Reference Number	HC 16427

(Australia)

Position	Human Research Ethics Coordinator
Telephone	+ 61 2 9385 6222
Email	humanethics@unsw.edu.au
HC Reference Number	HC 16427

Consent Form – Participant providing own consent

Declaration by the participant

- ☐ I have read the Participant Information Sheet or someone has read it to me in a language that I understand;
- ☐ I understand the purposes, study tasks and risks of the research described in the project;
- ☐ I have had an opportunity to ask questions and I am satisfied with the answers I have received;
- ☐ I freely agree to participate in this research study as described and understand that I am free to withdraw at any time during the project and withdrawal will not affect my relationship with any of the named organisations and/or research team members;
- ☐ I understand that I will be given a signed copy of this document to keep;

Participant Signature

Name of Participant (please print)	
Signature of Research Participant	
Date	

Declaration by Researcher*

- ☐ I have given a verbal explanation of the research study, its study activities and risks and I believe that the participant has understood that explanation.

Researcher Signature*

Name of Researcher (please print)	
Signature of Researcher	
Date	

[+]An appropriately qualified member of the research team must provide the explanation of, and information concerning the research study.

Note: All parties signing the consent section must date their own signature.

Form for Withdrawal of Participation

I wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** affect my relationship with The University of New South Wales, School of Public Health and Community Medicine.

Participant Signature

Name of Participant (please print)	
Signature of Research Participant	
Date	

The section for Withdrawal of Participation should be forwarded to:

Co-investigator Name:	**Dr Suresh Mehata**
Email:	**Sureshmht@gmail.com**
Phone:	**977 9842036595**
Postal Address:	Nepal Health Sector Support Program Ministry of Health Ramshah Path Kathmandu, Nepal

Appendix A.9: Participant information and consent forms for health care providers, adolescents and key informants in Nepali

Appendix A.9.1 Participant information and consent form for health facility in-charge in Nepali

School of Public Health and Community Medicine
Faculty of Medicine

UNSW AUSTRALIA

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM
Health facility incharge
Utilisation of SRH services from adolescent friendly health services in Dhading district, Nepal

The study is being carried out by the following researchers: यस अध्ययनमा सम्लग्न अध्ययनकर्ताहरु

Role	Name	Organisation
Chief Investigator	Dr Husna Razee	School of Public Health and Community Medicine, UNSW
Co-Investigator/s	Dr Holly Seale Dr Suresh Mehata	School of Public Health and Community Medicine, UNSW Nepal Health Sector Support Program, Ministry of Health, Nepal
Student Investigator/s	Pushpa Lata Pandey	School of Public Health and Community Medicine, UNSW

What is the research study about?

तपाईलाइ अस्ट्रेलियाको सिड्नी भन्ने ठाउँमा अवस्थित New South Wales विश्व विद्यालय र नेपाल सरकार स्वास्थ्य मन्त्रालयको नेपाल स्वास्थ्य क्षेत्र सहयोग कार्यक्रमले गर्न लागेका यस अध्ययनमा सहभागीहुनका लागि आमन्त्रण (निमन्त्रणा) गर्दछौं । यस अध्ययनमा सहभागी हुने वा नहुने निर्णय गर्नुभन्दा पहिले तपाइलाई यस अध्ययन किन गरिएको हो र यस अध्ययनमा के समावेस गरिएको छ भन्ने जान्नु महत्वपुर्ण छ । कृपया यि जानकारिहरू ध्यानपुर्वक अध्ययन गनुहोला र तपाइ चाहनु हुन्छ भने अरुसँग पनि सल्लाह गर्नसक्नु हुनेछ ।.

किशोर किशोरी मैत्री स्वास्थ्य सेवाको मख्य उद्देश्य नेपालमा किशोर किशोरीलाई मैत्री पूर्ण वातावरणमा यौन तथा प्रजनन स्वास्थ्य सम्बन्धी सेवा प्रदान गर्नु हो । स्वास्थ्य मन्त्रालयले नेपालका ५६ भन्दा बढी जिल्लाहरुका १००० भन्दा बढी स्वास्थ्य संस्थाहरुमा किशोर किशोरी मैत्री स्वास्थ्य सेवा सुरु गरेको छ । विभिन्न अध्ययन अनुसार नेपालमा किशोर किशोरीहरुले यस सेवा बारेमा जानकारी पाएका भए ता पनि यो सेवा लिन उनिहरुको पहुच नभएको देखिएको छ । यति हुँदा पनि कुनैपनि अध्ययनहरुले किशोर किशोरीहरुले किशोर किशोरी मैत्री स्वास्थ्य सेवाको उपयोग नगर्नुको कारण पत्ता लगाएको छैन ।

यस अध्ययनले नेपालमा किशोर किशोरी मैत्री सेवा लिनमा के के तत्वहरुले योगदान (असर) पुऱ्याउँदो रहेछ भन्ने कुरा पत्ता लगाउने छ । हामीहरु गत दुइ बर्षको समयमा किशोर किशोरी तथा युवायुवतिहरुले किशोर किशोरी मैत्री स्वास्थ्य सेवा उपयोग गरेको अवस्था कस्तो छ भनेर जान्न इच्छुक छौं । यो अवस्था (सेवा उपयोग) को जानकारीको प्रतिवेदनले हामीहरुलाई किशोर किशोरी तथा युवायुवतिहरुले किशोर किशोरी मैत्री सेवाको कम उपयोग गर्नुको कारणहरु पत्ता लगाउनका अझै गहन अध्ययन गर्नका लागि स्वास्थ्य संस्थाहरुको छनोट गर्नका लागि सहयोग पुग्नेछ ।

तपाईलाई यस अध्ययनमा किन सहभागी गराएको छ भने

- तपाईको नजिकको स्वास्थ्य संस्थामा कम्तीमा दुई वर्ष देखी किशोर किशोरी मैत्री स्वास्थ्य सेवा लागु गरिएको छ ।
- तपाइको स्वास्थ्य संस्थामा हाल कम्तीमा एक महिला र एक पुरुष स्वास्थ्यकर्मीहरुले किशोरकिशोरी मैत्री स्वास्थ्य सेवा प्रदान गरिरहनु भएको छ ।

के म यस अध्ययनमा सहभागी हुन जरुरी छ ?

यस अध्ययनमा सहभागीहरु स्वयमसेवी रुपमा सहभागी हुन्छन् । यस अध्ययनमा सहभागी हुने वा नहुने भन्ने कुरा पुर्ण रुपमा तपाइको इच्छामा भर पर्दछ । यदी अध्ययनको क्रममा तपाईलाई यस अध्ययनमा सहभागी हुन मन नलागेमा कुनैपनि बेला छोडेर जान सक्नुहुनेछ ।

यस अध्ययनमा सहभागी हुनको लागी के के कुरा हुन जरुरी छ र के यस अध्ययनमा सहभागी हुँदा केही जोखिम हुन्छन् ?

यदी तपाइ यस अध्ययनमा सहभागी हुने निर्णय गर्नु हुन्छ भने तपाइको स्वास्थ्य सस्थाको सेवा उपयोगको अभिलेखहरु (रेकर्डहरु) हेरिनेछ । त्यसबाट किशोरकिशोरीहरुले विगत दुइ वर्ष देखि लिएको सेवाहरु जस्तै परिवारनियोजन, पूर्वप्रसूति सेवा, प्रसूति सेवा, गर्भपतन आदीको तथ्याङ्क लिइनेछ । अभिलेखहरु (रेकर्डहरु) अवलोकन गर्न करिब ४ देखि ५ घण्टा लाग्न सक्नेछ । अभिलेखहरु अध्ययनका क्रममा हामी कुनै सेवाग्राहीको नाम र ठेगाना टिपोट गर्ने छैनौ ।

के यस अध्ययनमा सहभागी हुँदा मलाइ कुनै जोखिम पर्नसक्छ ?

यस अध्ययनमा सहभागी हुँदा हामी तपाइको समय लिने छौ, त्यस बाहेक तपाइलाई कुनै प्रकारको जोखिम वा आर्थिक भार पर्ने छैन ।

यस अध्ययनमा सहभागी हुँदा के मलाइ कुनै आर्थिक लाभ हुनेछ ?

यस अध्ययनमा सहभागी हुँदा तपाइलाइ कुनै आर्थिक लाभ हुनेछैन । तर यस अध्ययनमा सहभागी भए बापत धन्यबाद स्वरुप हामी तपाइलाइ हल्का खाजाको व्यवस्था गर्नेछौ ।

यस अध्ययनमा सहभागी हुँदा के के फाइदा हुने सम्भावना छ ?

यस अध्ययनबाट आएको जानकारी र तथ्यहरुको मद्धतले हामी किशोर किशोरी मैत्री स्वास्थ्य सेवालाइ अझ प्रभावकारी बनाइ धेरै किशोर किशोरी माझ पुऱ्याउन सक्छौ ।

मेरो बारेमा जानकारीहरु के हुनेछन ?

तपाइले यस मन्जुरीनामामा सही गरे पछि मात्र हामीले तपाइको स्वास्थ्यसस्थाबाट यो अध्ययन अनुसन्धानका लागि तथ्याङ्कहरु लिन सक्नेछौ । तपाइको यस स्वास्थ्यसस्थाको तथ्यांक आगामी सात वर्ष सम्म राखिनेछ । यहाँबाट लिइएका तथ्याङ्कहरु यस अध्ययनको लागी मात्र प्रयोग गरिनेछ र तपाइको अनुमती बिना तपाइको जानकारीहरु कतै सार्वजनिक गरिने छैन ।

यस अध्ययनबाट आउने तथ्यहरु तथा परिणामहरु विभिन्न रुपमा प्रकाशन तथा प्रस्तुति गरिनेछ र विभिन्न संचार वा प्रकासनहरुमा प्रकासन गरिनेछ ता पनि तपाइको मन्जुरी बिना कतै पनि तपाइको पहिचान खुलाउने छैनौ ।

तपाइलाई तपाइको स्वास्थ्यसंस्थाबाट अध्ययन टोलिले लिएका जानकारीहरुमा पहुँचका लागि अनुरोध गर्ने अधिकार हुनेछ । कुनै पनि जानकारीहरुमा तपाइको असहमती भए सच्याउनको लागी कुनै पनि अध्ययनकर्ता सँग सम्पर्क गरी अनुरोध गर्न सक्नुहुनेछ ।
तपाइ र तपाइको स्वास्थ्य सस्थाबाट प्राप्त जानकारीहरु UNSW, Kingston campus मा ७ वर्ष सम्म सुरक्षित राखिने छ । यस अध्ययनमा प्राप्त तपाईका तथ्याङ्कहरु यस विश्वविद्यालयको जनस्वास्थ्य तथा सामुदायिक चिकित्शा विद्यालयका उपकरणहरु (Hard drive) मा अध्ययनकर्ताहरुबाट पासवर्डको प्रयोग गरेर शुरक्षित राखेर तपाईको गोपनियताको सुनिश्चतता गरिनेछ । उक्त उपकरणहरु बिद्यालयको क्षेत्र भित्रै ताल्चा लगाएर बन्द गरेर राखिने दराजमा शुरक्षित राखिनेछ ।

यस अध्ययनको परिणामहरु मैलै कहिले र कसरी प्राप्त गर्न सक्नेछु ?

यस अध्ययनको समग्र परिणाममा पृष्ठपोषण पाउन तपाइको अधिकार हुनेछ । यो अध्ययन सकिएपछि यसको सारंश प्रतिवेदन तपाइको किशोरकिशोरी मैत्री स्वास्थ्य सस्थामा पठाइनेछ ।

यस अध्ययनमा सहभागीताको निरन्तरता दिन नचाहेको अवस्थामा मैले के गर्न सक्छु
यदि तपाइ यस अध्ययनमा सहभागीतकको मञ्जुरी दिनुभएता पनि निरन्तरता दिन चाहानुहुन्न भने कुनै पनि समयमा छोडन सक्नुहुनेछ । यदि निरन्तरता दिन चाहानुभएन भने तपाईले यस फारामको अन्तमा भएको फाराममा हस्ताक्षर गर्नु पर्नेछ । अथवा तपाईले अध्ययन टोलिलाई तपाईले सहभागि हुन नचाहाने जानकारी दिन सक्नुहुनेछ । यदि तपाई सहभागि हुन चाहानुभएन भने त्यस पछि हामी तपाइसँग थप जानकारी लिने छैनौ ।

तपाइ कुनै पनि बेला तथ्यांक संकलन कार्यलाइ रोक्न स्वतन्त्र हुनुहुन्छ । तपाइको मन्जुरी बिना हामी कुनै पनि जानकारीहरु राख्ने छैनौ र तपाईको मञ्जुरी बिना तपाइले दिनुभएको कुनै पनि जानकारीहरुलाइ हाम्रो अध्ययनमा समावेश गरिने छैन ।

यदि तपाइ अध्ययनबाट बाहिरिन चानुहुन्छ भने हामी तपाईबाट कुनै जानकारी लिने छैनौ । यदि तपाई अध्ययनबाट बाहिरिन चाहानुहुन्छ भने अध्ययनमा तपाईले छोड्ने बेला सम्ममा तपाईबाट लिईएका जानकारीहरुलाई समावेश गर्ने वा नगर्ने भन्ने बारेमा हामीलाई जानकारी दिनुहोला । यदि तपाईले अध्ययनबाट अलग हुँदाका बेला सम्म दिनुभएका जानकारीहरुलाइ यस अध्ययनको प्रतिवेदनमा समावेश गर्न चाहानुभएन भने हामी ति जानकारीहरुलाई अभिलेखबाट मेटाइ दिनेछौ ।

मेरो सहभागीताको बारे थप कुरा बुझ्नको लागी मैले के गर्नु पर्दछ ?
तपाइले सर्म्पक गर्नु पर्ने व्यक्ति तपाइको प्रश्न र जिज्ञासामा भर पर्छ । यदि तपाइ यस अध्ययनको बारे वा तपाइको संलग्नता बारे अझ धेरै बुझ्न चाहानु हुन्छ भने तल उल्लिखित व्यक्ति सँग सम्पर्क गर्न सक्नु हुनेछ ।

Research Team Contact

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यस अध्ययन सम्बन्धि कुनै गुनासो वा कुनै जिज्ञासा भएमा मैले के गर्नेहोला ?

यदि तपाइ यस अध्ययनको अथवा अध्ययनको तरीका बारे केही गुनासो भए तल उल्लिखित व्यक्ति सँग सम्पर्क गर्न सक्नु हुनेछ ।

Complaints Contact (Nepal)

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(Australia)

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PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM
Health facility incharge
Utilisation of SRH services from adolescent friendly health services in Dhading district, Nepal

Consent Form – Participant providing own consent

Declaration by the participant

- ☐ मैले यो सहभागी जानकारी फारम पढेको छु अथवा अरु कोहीले यो फारम मैले बुझ्ने भाषामा पढेर सुनाउनु भएको छ ।
- ☐ मैले यो अध्ययनको परियोजनामा उल्लिखित उद्देश्य, काम र जोखिमबारे जानकारी पाएको छु ।
- ☐ मैले प्रश्न सोध्ने मौका पाएको थिए र म मैले पाएको उत्तरबाट सन्तुष्ट छु ।
- ☐ म यस अध्ययन अनुसन्धानबाट कुनै पनि बेला अलगहुन सक्ने कुरा जानकारी पाएर र बुझेर स्वतन्त्रपूर्वक सहभागि हुन स्वीकार गर्दछु । मैले अध्ययनको बिचैमा छोडे ता पनि यो अध्ययन गर्ने संस्था वा यस अध्ययनको टोलिका कुनै पनि सदस्यहरु संगको सम्बन्धमा कुनै पनि नकारात्मक असर पर्ने छैन ।
- ☐ म मैले हस्ताक्षर गरेको फारामको एक प्रति मलाई पनि दिइने छ भन्ने कुरा बुझेको छ ।

सहभागीको सही

सहभागीको नाम (प्रिन्ट गर्नुहोस)	
सहभागीको सही	
मिति	

Declaration by Researcher*

☐ मैले यो अध्ययनका सहभागिलाई यो अध्ययन, यसका गतिबिधिहरु र यसमा सहभागि हुदाका जोखिमहरुका बारेमा मौखिक जानकारी दिएको छु र सहभागिहरुले यो कुरा बुझेका छन भन्ने बिशवास गर्दछु ।

Researcher Signature*

अध्ययनकर्ताको नाम (प्रिन्ट गर्नुहोस)	
अध्ययनकर्ताको सही	
मिति	

अध्ययन अनुसन्धानको टोलिका एक योग्य सदस्यले अध्ययन संग सम्बन्धित सबै प्रकारका जानकारीहरु र जिज्ञासाहरुका बारेमा राम्रो संग दिनुपर्दछ ।

Note: All parties signing the consent section must date their own signature.
अनुमति पत्रमा हस्ताक्षर गर्ने सबै पक्षहरुले हस्ताक्षर संगै मिति पनि लेख्नु पर्दछ ।

अध्ययनबाट अलग हुन चाहानेले भर्नु पर्ने फाराम

म माथि उल्लिखित यो अध्ययनबाट अलग हुन चाहान्छु र म अलग भएता पनि यो अध्ययन गर्ने New South Wales विश्व विद्यालयसंग कुनै प्रकारको नसारात्मक असर पर्ने छैन ।

सहभागीको सही

सहभागीको नाम (प्रिन्ट गर्नुहोस)	
सहभागीको सही	
मिति	

अध्ययनका सहभागिले अध्ययनबाट अलग हुने फाराम भरे पछि यो फराम निम्न व्यक्तिलाइ पठाउनु पर्दछ :

Co-investigator Name:	**Dr Suresh Mehata**
Email:	**Sureshmht@gmail.com**
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A.9.2 Participant information and consent form for health care provider in Nepali

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PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM
Health service providers
Utilisation of SRH services from adolescent friendly health services in Dhading district, Nepal

The study is being carried out by the following researchers: यस अध्ययनमा सम्लग्न अध्ययनकर्ताहरु

Role	Name	Organisation
Chief Investigator	Dr Husna Razee	School of Public Health and Community Medicine, UNSW
Co-Investigator/s	Dr Holly Seale Dr Suresh Mehata	School of Public Health and Community Medicine, UNSW Nepal Health Sector Support Program, Ministry of Health, Nepal
Student Investigator/s	Pushpa Lata Pandey	School of Public Health and Community Medicine, UNSW

What is the research studyabout?
यो अध्ययन के को बारे हो

तपाईलाइ अस्ट्रेलियाको सिड्नी भन्ने ठाउँमा अवस्थित New South Wales विश्व विद्यालय र नेपाल सरकार स्वास्थ्य मन्त्रालयको नेपाल स्वास्थ्य क्षेत्र सहयोग कार्यक्रमले गर्न लागेका यस अध्ययनमा सहभागीहुनका लागि आमन्त्रण (निमन्त्रणा) गर्दछौं । यस अध्ययनमा सहभागी हुने वा नहुने निर्णय गर्नुभन्दा पहिले तपाइलाई यस अध्ययन किन गरिएको हो र यस अध्ययनमा के समावेस गरिएको छ भन्ने जान्नु महत्त्वपुर्ण छ । कृपया यि जानकारिहरू ध्यानपुर्वक अध्ययन गनुहोला र तपाइ चाहनु हुन्छ भने अरुसँग पनि सल्लाह गर्नसक्नु हुनेछ ।.

किशोर किशोरी मैत्री स्वास्थ्य सेवाको मख्य उद्देश्य नेपालमा किशोर किशोरीलाई मैत्री पूर्ण वातावरणमा यौन तथा प्रजनन स्वास्थ्य सम्बन्धी सेवा प्रदान गर्नु हो । स्वास्थ्य मन्त्रालयले नेपालका ५६ भन्दा बढी जिल्लाहरुका १००० भन्दा बढी स्वास्थ्य संस्थाहरुमा किशोर किशोरी मैत्री स्वास्थ्य सेवा सुरु गरेको छ । विभिन्न अध्ययन अनुसार नेपालमा किशोर किशोरीहरुले यस सेवा बारेमा जानकारी पाएका भए ता पनि यो सेवा लिन उनिहरुको पहुच नभएको देखिएको छ । यति हुँदा पनि कुनैपनि अध्ययनहरुले किशोर किशोरीहरुले किशोर किशोरी मैत्री स्वास्थ्य सेवाको उपयोग नगर्नुको कारण पत्ता लगाएको छैन ।

यस अध्ययनले नेपालमा किशोर किशोरी मैत्री सेवा लिनमा के के तत्वहरुले योगदान (असर) पुऱ्याउँदो रहेछ भन्ने कुरा पत्ता लगाउने छ । हामीहरु गत दुइ बर्षको समयमा किशोर किशोरी तथा युवायुवतिहरुले किशोर किशोरी मैत्री स्वास्थ्य सेवा उपयोग गरेको अवस्था कस्तो छ भनेर जान्न इच्छुक छौं । यो अवस्था (सेवा उपयोग) को जानकारीको प्रतिवेदनले हामीहरुलाई किशोर किशोरी तथा युवायुवतिहरुले किशोर किशोरी मैत्री सेवाको कम उपयोग गर्नुको कारणहरु पत्ता लगाउनका अझै गहन अध्ययन गर्नका लागि स्वास्थ्य संस्थाहरुको छनोट गर्नका लागि सहयोग पुग्नेछ ।

तपाइलाइ यस अध्ययनमा सहभागी गराइएकोछ किनकी

- तपाइ सरकारी स्वास्थ्यकर्मी हुनुहुन्छ
- तपाइ कम्तिमा बिगत ६ महिना देखि किशोर किशोरी मैत्री स्वास्थ्य सस्थामा कार्यरत हुनुहुन्छ ।

के म यस अध्ययनमा सहभागी हुन जरुरी छ ?

यस अध्ययनमा सहभागीहरु स्वयमसेवी रुपमा सहभागी हुन्छन् । यस अध्ययनमा सहभागी हुने वा नहुने भन्ने कुरा पुर्ण रुपमा तपाइको इच्छामा भर पर्दछ । यदी अध्ययनको क्रममा तपाईलाई यस अध्ययनमा सहभागी हुन मन नलागेमा कुनैपनि बेला छोडेर जान सक्नुहुनेछ ।

यस अध्ययनमा सहभागी हुनको लागी के के कुरा हुन जरुरी छ र के यस अध्ययनमा सहभागी हुँदा के जोखिम हुन्छन् ?

यदी तपाइ यस अध्ययनमा सहभागी हुने निर्णय गर्नु हुन्छ भने विषेश मापदण्ड प्रयोग गरि तपाइको स्वास्थ्य सस्थाको अवलोकन गरिनेछ । हामी:

- तपाइले आफ्नो स्वास्थ्य सस्थामा कुनै किशोरकिशोरीलाइ स्वास्थ्य सेवा दिदै गरेको अवलोकन गर्नेछौ ।
- तपाइसँग किशोरकिशोरीलाइ यौन तथा प्रजनन स्वास्थ्य सेवा दिदाको अनुभव र त्यस बारे तपाइको धारणा बुझ्न अन्तरवार्ता गर्नेछौ ।

The visit length for each activity is as follows:
हरेक क्रियाकलापको लागी लाग्ने समय

Visit #	Procedures क्रियाकलाप	Location* स्थान	Visit Length लाग्ने समय
Visit 1	• Health facility observation • स्वास्थ्य सस्था अवलोकन	Health Facility स्वास्थ्य सस्था	1 hours १ घण्टा
Visit 2	• In-depth Interview स्वास्थ्यकर्मीसँग अन्तरवार्ता	Health Facility स्वास्थ्य सस्था	१ देखि डेढ घण्टा
Visit 2	• Observation of health service delivery स्वास्थ्य सेवाको अवलोकन	Health Facility स्वास्थ्य सस्था	३ अवलोकन

स्वास्थ्य सस्था अवलोकनको लागी

अध्ययन टोलीका एक सदस्यले तपाइको स्वास्थ्य सस्थाको कोठाहरु र त्यहाको वातावरणको अवलोकन गर्नेछन । अध्ययनकर्ताले तपाइलाई वा स्वास्थ्य सस्थाका अरु सदस्यलाइ कुनै प्रश्न सोध्ने छैनन ।

For interview

During the interview, a member of the research team will ask you questions about your perspectives and experience while providing services to young people from your health facility. With your permission, the interview will be audio recorded, and professionally typed into an anonymous transcript. The purpose of recording the interview is to assist with analysing the information collected and presenting an accurate picture of the conversation.

अन्तरवार्ताको लागि
अन्तरवार्ताको क्रममा अध्ययन टोलीका एक सदस्यले तपाइसँग किशोरकिशोरीलाइ सेवा दिदाको अनुभव र धारणाको बारेमा प्रश्न गर्नेछन् । तपाइको अनुमति लिएर तपाइसँगको अन्तरवार्ता रेकर्ड गरिनेछ र टाइप गरिनेछ । तपाइको अन्तरवार्ता रेकर्ड गर्नुको उद्देश्य अध्ययनको लागी सहज होस र तपाइले भनेको कुनैपनि कुरा नछुटोस भन्नको लागि हो ।

For observation of health service delivery स्वास्थ्य सेवाको प्रदान गरेको अवलोकन
किशोरकिशोरीलाइ स्वास्थ्य सेवाको प्रदान गरेको अवलोकन गर्ने क्रममा अध्ययनकर्ता तपाइ सँगै सेवा कक्षमा उपस्थित हुनेछन । अध्ययनकर्ताले तपाइले स्वास्थ्य सेवाको प्रदान गरेको तरिका टिपोट गर्नेछन तर सेवा र छलफको विषयवस्तु भने टिपोट गर्नेछैनन् ।

के यस अध्ययनमा सहभागी हुँदा मलाइ कुनै जोखिम पर्नसक्छ ?
यस अध्ययनमा सहभागी हुँदा हामी तपाइको समय लिने छौ, त्यस बाहेक तपाइलाई कुनै प्रकारको जोखिम वा आर्थिक भार पर्ने छैन ।

यस अध्ययनमा सहभागी हुँदा के मलाइ कुनै आर्थिक लाभ हुनेछ ?
यस अध्ययनमा सहभागी हुँदा तपाइलाइ कुनै आर्थिक लाभ हुनेछैन । तर यस अध्ययनमा सहभागी भए बापत धन्यबाद स्वरुप हामी तपाइलाइ हल्का खाजाको व्यवस्था गर्नेछौं ।

यस अध्ययनमा सहभागी हुँदा के के फाइदा हुने सम्भावना छ ?
यस अध्ययनबाट आएको जानकारी र तथ्यहरुको मद्धतले हामी किशोर किशोरी मैत्री स्वास्थ्य सेवालाइ अझ प्रभावकारी बनाइ धेरै किशोर किशोरी माझ पुऱ्याउन सक्छौं ।

मेरो बारेमा जानकारीहरु के हुनेछन ?

तपाइले यस मन्जुरीनामामा सही गरे पछि मात्र हामीले तपाइको स्वास्थ्यसस्थाबाट यो अध्ययन अनुसन्धानका लागि तथ्याङ्कहरु लिन सक्नेछौं । तपाइको यस स्वास्थ्यसस्थाको तथ्यांक आगामी सात वर्ष सम्म राखिनेछ । यहाँबाट लिइएका तथ्याङ्कहरु यस अध्ययनको लागी मात्र प्रयोग गरिनेछ र तपाइको अनुमती बिना तपाइको जानकारीहरु कतै सार्वजनिक गरिने छैन ।

यस अध्ययनबाट आउने तथ्यहरु तथा परिणामहरु विभिन्न रुपमा प्रकाशन तथा प्रस्तुति गरिनेछ र विभिन्न संचार वा प्रकासनहरुमा प्रकासन गरिनेछ ता पनि तपाइको मन्जुरी बिना कतै पनि तपाइको पहिचान खुलाउने छैनौं ।

तपाइलाई तपाइको स्वास्थ्यसंस्थाबाट अध्ययन टोलिले लिएका जानकारीहरुमा पहुँचका लागि अनुरोध गर्ने अधिकार हुनेछ । कुनै पनि जानकारीहरुमा तपाइको असहमती भए सच्याउनको लागी कुनै पनि अध्ययनकर्ता सँग सम्पर्क गरी अनुरोध गर्न सक्नुहुनेछ ।

तपाइको अन्तरवार्ताको अडियो रेकर्ड र तपाइबाट प्राप्त जानकारीहरु UNSW, Kingston campus मा ७ वर्ष सम्म सुरक्षित राखिने छ । यस अध्ययनमा प्राप्त अडियो रेकर्ड र तपाइबाट प्राप्त जानकारीहरु यस विश्वविद्यालयको जनस्वास्थ्य तथा सामुदायिक चिकित्शा विद्यालयका उपकरणहरु (Hard drive) मा अध्ययनकर्ताहरुबाट पासवर्डको प्रयोग गरेर शुरक्षित राखेर तपाईको गोपनियताको सुनिश्चतता गरिनेछ । उक्त उपकरणहरु विद्यालयको क्षेत्र भित्रै ताल्चा लगाएर बन्द गरेर राखिने दराजमा शुरक्षित राखिनेछ ।

यस अध्ययनको परिणामहरु मैलै कहिले र कसरी प्राप्त गर्न सक्नेछु ?

यस अध्ययनको समग्र परिणाममा पृष्ठपोषण पाउन तपाइको अधिकार हुनेछ। यो अध्ययन सकिएपछि यसको सारंश प्रतिबेदन तपाइको किशोरकिशोरी मैत्री स्वास्थ्य सस्थामा पठाइनेछ।

यस अध्ययनमा सहभागीताको निरन्तरता दिन नचाहेको अवस्थामा मैले के गर्न सक्छु

यदि तपाइ यस अध्ययनमा सहभागीतकको मञ्जुरी दिनुभएता पनि निरन्तरता दिन चाहानुहुन्न भने कुनै पनि समयमा छोडन सक्नुहुनेछ। यदि निरन्तरता दिन चाहानुभएन भने तपाईले यस फारामको अन्तमा भएको फाराममा हस्ताक्षर गर्नु पर्नेछ। अथवा तपाईले अध्ययन टोलिलाई तपाईले सहभागि हुन नचाहाने जानकारी दिन सक्नुहुनेछ। यदि तपाई सहभागि हुन चाहानुभएन भने त्यस पछि हामी तपाइसँग थप जानकारी लिने छैनौ।

तपाइ कुनै पनि बेला तथ्यांक संकलन कार्यलाइ रोक्न स्वतन्त्र हुनुहुन्छ। तपाइको मन्जुरी बिना हामी कुनै पनि जानकारीहरु राख्ने छैनौ र तपाईको मञ्जुरी बिना तपाइले दिनुभएको कुनै पनि जानकारीहरुलाइ हाम्रो अध्ययनमा समावेश गरिने छैन।

यदि तपाइ अध्ययनबाट बाहिरिन चानुहुन्छ भने हामी तपाईबाट कुनै जानकारी लिने छैनौ। यदि तपाई अध्ययनबाट बाहिरिन चाहानुहुन्छ भने अध्ययनमा तपाईले छोड्ने बेला सम्ममा तपाईबाट लिईएका जानकारीहरुलाई समावेश गर्ने वा नगर्ने भन्ने बारेमा हामीलाई जानकारी दिनुहोला। यदि तपाईले अध्ययनबाट अलग हुँदाका बेला सम्म दिनुभएका जानकारीहरुलाइ यस अध्ययनको प्रतिवेदनमा समावेश गर्न चाहानुभएन भने हामी ति जानकारीहरुलाई अभिलेखबाट मेटाइ दिनेछौ।

मेरो सहभागीताको बारे थप कुरा बुझ्नको लागी मैले के गर्नु पर्दछ ?

तपाइले सर्म्पक गर्नु पर्ने व्यक्ति तपाइको प्रश्न र जिज्ञासामा भर पर्छ। यदि तपाइ यस अध्ययनको बारे वा तपाइको संलग्नता बारे अझ धेरै बुझ्न चाहानु हुन्छ भने तल उल्लिखित व्यक्ति सँग सम्पर्क गर्न सक्नु हुनेछ।

Research Team Contact

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यस अध्ययन सम्बन्धि कुनै गुनासो वा कुनै जिज्ञासा भएमा मैले के गर्नेहोला ?

यदि तपाइ यस अध्ययनको अथवा अध्ययनको तरीका बारे केही गुनासो भए तल उल्लिखित व्यक्ति सँग सम्पर्क गर्न सक्नु हुनेछ ।

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PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM
Health service providers
Utilisation of SRH services from adolescent friendly health services in Dhading district, Nepal

Consent Form – Participant providing own consent

Declaration by the participant

- ☐ मैले यो सहभागी जानकारी फारम पढेको छु अथवा अरु कोहीले यो फारम मैले बुझ्ने भाषामा पढेर सुनाउनु भएको छ ।
- ☐ मैले यो अध्ययनको परियोजनामा उल्लिखित उद्देश्य, काम र जोखिमबारे जानकारी पाएको छु ।
- ☐ मैले प्रश्न सोध्ने मौका पाएको थिए र म मैले पाएको उत्तरबाट सन्तुष्ट छु ।
- ☐ म यस अध्ययन अनुसन्धानबाट कुनै पनि बेला अलगहुन सक्ने कुरा जानकारी पाएर र बुझेर स्वतन्त्रपूर्वक सहभागि हुन स्वीकार गर्दछु । मैले अध्ययनको बिचैमा छोडे ता पनि यो अध्ययन गर्ने संस्था वा यस अध्ययनको टोलिका कुनै पनि सदस्यहरु संगको सम्बन्धमा कुनै पनि नकारात्मक असर पर्ने छैन ।
- ☐ म मैले हस्ताक्षर गरेको फारामको एक प्रति मलाई पनि दिइने छ भन्ने कुरा बुझेको छ ।

सहभागीको सही

सहभागीको नाम (प्रिन्ट गर्नुहोस)	
सहभागीको सही	
मिति	

Declaration by Researcher*

☐ मैले यो अध्ययनका सहभागिलाई यो अध्ययन, यसका गतिविधिहरु र यसमा सहभागि हुदाका जोखिमहरुका बारेमा मौखिक जानकारी दिएको छु र सहभागिहरुले यो कुरा बुझेका छन भन्ने विशवास गर्दछु ।

Researcher Signature*

अध्ययनकर्ताको नाम (प्रिन्ट गर्नुहोस)	
अध्ययनकर्ताको सही	
मिति	

अध्ययन अनुसन्धानको टोलिका एक योग्य सदस्यले अध्ययन संग सम्बन्धित सबै प्रकारका जानकारीहरु र जिज्ञासाहरुका बारेमा राम्रो संग दिनुपर्दछ ।

Note: All parties signing the consent section must date their own signature.
अनुमति पत्रमा हस्ताक्षर गर्ने सबै पक्षहरुले हस्ताक्षर संगै मिति पनि लेख्नु पर्दछ ।

अध्ययनबाट अलग हुन चाहानेले भर्नु पर्ने फाराम

म माथि उल्लिखित यो अध्ययनबाट अलग हुन चाहान्छु र म अलग भएता पनि यो अध्ययन गर्ने New South Wales विश्व विद्यालयसंग कुनै प्रकारको नसारात्मक असर पर्ने छैन ।

सहभागीको सही

सहभागीको नाम (प्रिन्ट गर्नुहोस)	
सहभागीको सही	
मिति	

अध्ययनका सहभागिले अध्धयनबाट अलग हुने फाराम भरे पछि यो फराम निम्न ब्यक्तिलाइ पठाउनु पर्दछ :

Co-investigator Name:	**Dr Suresh Mehata**
Email:	**Sureshmht@gmail.com**
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Postal Address:	Nepal Health Sector Support Program Ministry of Health Ramshah Path Kathmandu, Nepal

Appendix B

A.9.3 Participant information and consent form for adolescents in Nepali

School of Public Health and Community Medicine

UNSW AUSTRALIA

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM
Adolescents
Utilisation of SRH services from adolescent friendly health services in Dhading district, Nepal

The study is being carried out by the following researchers: यस अध्ययनमा सम्लग्न अध्ययनकर्ताहरु		
Role	**Name**	**Organisation**
Chief Investigator	Dr Husna Razee	School of Public Health and Community Medicine, UNSW
Co-Investigator/s	Dr Holly Seale Dr Suresh Mehata	School of Public Health and Community Medicine, UNSW Nepal Health Sector Support Program, Ministry of Health, Nepal
Student Investigator/s	Pushpa Lata Pandey	School of Public Health and Community Medicine, UNSW

What is the research study about?
यो अध्ययन के को बारेमा हो ?

तपाईलाइ अस्ट्रेलियाको सिड्नी भन्ने ठाउँमा अवस्थित New South Wales विश्व विद्यालय र नेपाल सरकार स्वास्थ्य मन्त्रालयको नेपाल स्वास्थ्य क्षेत्र सहयोग कार्यक्रमले गर्न लागेका यस अध्ययनमा सहभागीहुनका लागि आमन्त्रण (निमन्त्रणा) गर्दछौं । यस अध्ययनमा सहभागी हुने वा नहुने निर्णय गर्नुभन्दा पहिले तपाइलाई यस अध्ययन किन गरिएको हो र यस अध्ययनमा के समावेस गरिएको छ भन्ने जान्नु महत्त्वपुर्ण छ। कृपया यि जानकारिहरू ध्यानपुर्वक अध्ययन गनुहोला र तपाइ चाहनु हुन्छ भने अरुसँग पनि सल्लाह गर्नसक्नु हुनेछ ।.

किशोर किशोरी मैत्री स्वास्थ्य सेवाको मख्य उद्देश्य नेपालमा किशोर किशोरीलाई मैत्री पूर्ण वातावरणमा यौन तथा प्रजनन स्वास्थ्य सम्बन्धी सेवा प्रदान गर्नु हो । स्वास्थ्य मन्त्रालयले नेपालका ५६ भन्दा बढी जिल्लाहरुका १००० भन्दा बढी स्वास्थ्य संस्थाहरुमा किशोर किशोरी मैत्री स्वास्थ्य सेवा सुरु गरेको छ । विभिन्न अध्ययन अनुसार नेपालमा किशोर किशोरीहरुले यस सेवा बारेमा जानकारी पाएका भए ता पनि यो सेवा लिन उनिहरुको पहुच नभएको देखिएको छ । यति हुँदा पनि कुनैपनि अध्ययनहरुले किशोर किशोरीहरुले किशोर किशोरी मैत्री स्वास्थ्य सेवाको उपयोग नगर्नुको कारण पत्ता लगाएको छैन ।

यस अध्ययनले नेपालमा किशोर किशोरी मैत्री सेवा लिनमा के के तत्वहरुले योगदान (असर) पुऱ्याउँदो रहेछ भन्ने कुरा पत्ता लगाउने छ । हामीहरु गत दुइ बर्षको समयमा किशोर किशोरी तथा युवायुवतिहरुले किशोर किशोरी मैत्री स्वास्थ्य सेवा उपयोग गरेको अवस्था कस्तो छ भनेर जान्न इच्छुक छौं । यो अवस्था (सेवा उपयोग) को जानकारीको प्रतिवेदनले हामीहरुलाई किशोर किशोरी तथा युवायुवतिहरुले किशोर किशोरी मैत्री सेवाको कम उपयोग गर्नुको कारणहरु पत्ता लगाउनका अझै गहन अध्ययन गर्नका लागि स्वास्थ्य संस्थाहरुको छनोट गर्नका लागि सहयोग पुग्नेछ ।

तपाइलाइ यस अध्ययनमा सहभागी गराइएको छ किनकि

- तपाइको १५ देखि १९ वर्षको उमेर भित्र पर्नुहुन्छ ।
- तपाइ किशोरकिशोरी मैत्रि स्वास्थ्य सेवा भएको स्वास्थ्य संस्था नजिक बस्नुहुन्छ ।

- तपाइ गएको १२ महिना भित्र स्वास्थ्य सेवा लिन स्वास्थ्य संस्था आउनुभएको छ । तपाइले स्वास्थ्य सेवा नलिनुभएको भएपनि हामी तपाइसँग कुरा गर्नेछौ ।

के म यस अध्ययनमा सहभागी हुन जरुरी छ ?

यस अध्ययनमा सहभागीहरु स्वयमसेवी रुपमा सहभागी हुन्छन् । यस अध्ययनमा सहभागी हुने वा नहुने भन्ने कुरा पुर्ण रुपमा तपाइको इच्छामा भर पर्दछ । यदी अध्ययनको क्रममा तपाईलाई यस अध्ययनमा सहभागी हुन मन नलागेमा कुनैपनि बेला छोडेर जान सक्नुहुनेछ ।

यस अध्ययनमा सहभागी हुनको लागी के के कुरा हुन जरुरी छ र के यस अध्ययनमा सहभागी हुँदा केही जोखिम हुन्छन् ?

यदी तपाइ यस अध्ययनमा सहभागी हुने निर्णय गर्नु हुन्छ भने तपाइ अन्तरवार्ता र समूह छलफलमा सहभागी हुनुपर्नेछ जसको लागी १ देखि डेढ घण्टा लाग्नेछ । यस अध्ययनमा सहभागी हुँदा तपाइलाइ कुनै जोखिम पर्नेछैन ।

समूह छलफलको लागी (Focus group discussion)

समूह छलफलको बेलामा अध्ययन टोलीका एक सदस्यले किशोरकिशोरी मैत्री स्वास्थ्य सेवा सम्बन्धी तपाइको धारणा र यो कस्तो हुनु पर्दछ भन्ने बारे प्रश्न सोध्नेछन् । हामी तपाइको व्यक्तिगत जानकारी माग्ने छैनौ ।

For in-depth interview
अन्तरवार्ताको लागी
अन्तरवार्ताको बेलामा अध्ययन टोलीका एक सदस्यले किशोरकिशोरी मैत्री स्वास्थ्य सेवा सम्बन्धी तपाइको धारणा, अनुभव, सेवा लिँदा परेको समस्या बारे प्रश्न सोध्नेछन् । हामी तपाइको स्वास्थ्य सस्था आउनुको कारण सोध्ने छैनौ । हामी तपाइको व्यक्तिगत जानकारी माग्ने छैनौ ।

तपाइको अनुमति लिएर तपाइसँगको अन्तरवार्ता रेकर्ड गरिनेछ र टाइप गरिनेछ । तपाइको अन्तरवार्ता रेकर्ड गर्नुको उद्देश्य अध्ययनको लागी सहज होस र तपाइले भनेको कुनैपनि कुरा नछुटोस भन्नको लागि हो ।

के यस अध्ययनमा सहभागी हुँदा मलाइ कुनै जोखिम पर्नसक्छ ?
यस अध्ययनमा सहभागी हुँदा तपाइलाइ कुनै जोखिम पर्नेछैन । हामी यौन तथा प्रजनन स्वास्थ्य सँग सम्बन्धीत तपाइको विचार र धारणा बारे केही प्रश्न गर्नेछौ । यस विषयमा कुरा गर्दा तपाइलाइ असहज महशूस हुनसक्छ । यस्तो महशूस भए अध्ययनकर्तासँग कुरा गर्नसक्नुहुनेछ ।

यदि तपाइलाइ असहज महसूस भए कोही अरु अध्ययनकर्ता वा धादिङ जिल्ला अस्पताल (०१० ५२०१२६) का स्वास्थ्यकर्मी सँग कुरा गर्नसक्नुहुनेछ ।

यस अध्ययनमा सहभागी हुँदा के मलाइ कुनै आर्थिक लाभ हुनेछ ?

यस अध्ययनमा सहभागी हुँदा तपाइलाइ कुनै आर्थिक लाभ हुनेछैन । तर यस अध्ययनमा सहभागी भए बापत धन्यबाद स्वरुप हामी तपाइलाइ हल्का खाजाको व्यवस्था, एउटा मोबाइल रिचार्ज कार्ड र एउटा सानो उपहार प्रदान गर्नेछौ ।

यस अध्ययनमा सहभागी हुँदा के के फाइदा हुने सम्भावना छ ?
यस अध्ययनबाट आएको जानकारी र तथ्यहरुको मद्धतले हामी किशोर किशोरी मैत्री स्वास्थ्य सेवालाइ अझ प्रभावकारी बनाइ धेरै किशोर किशोरी माझ पुऱ्याउन सक्छौ ।

मेरो बारेमा जानकारीहरु के हुनेछन ?

तपाइले यस मन्जुरीनामामा सही गरे पछि मात्र हामीले तपाइबाट यो अध्ययन अनुसन्धानका लागि जानकारीहरु लिन सक्नेछौ । तपाइबाट पाएका जानकारीहरु आगामी सात वर्ष सम्म राखिनेछ । यहाँबाट लिइएका तथ्याङ्कहरु यस अध्ययनको लागी मात्र प्रयोग गरिनेछ र तपाइको अनुमती बिना तपाइको जानकारीहरु कतै सार्वजनिक गरिने छैन ।

यस अध्ययनबाट आउने तथ्यहरु तथा परिणामहरु विभिन्न रुपमा प्रकाशन तथा प्रस्तुति गरिनेछ र विभिन्न संचार वा प्रकासनहरुमा प्रकासन गरिनेछ ता पनि तपाइको मन्जुरी बिना कतै पनि तपाइको पहिचान खुलाउने छैनौ ।

तपाइलाई तपाइबाट अध्ययन टोलिले लिएका जानकारीहरुमा पहुँचका लागि अनुरोध गर्ने अधिकार हुनेछ । कुनै पनि जानकारीहरुमा तपाइको असहमती भए सच्याउनको लागी कुनै पनि अध्ययनकर्ता सँग सम्पर्क गरी अनुरोध गर्न सक्नुहुनेछ ।

तपाइको अन्तरवार्ताको अडियो रेकर्ड र जानकारीहरु UNSW, Kingston campus मा ७ वर्ष सम्म सुरक्षित राखिने छ । यस अध्ययनमा प्राप्त तपाईका अन्तरवार्ताको अडियो रेकर्ड यस विश्वविद्यालयको जनस्वास्थ्य तथा सामुदायिक चिकित्शा विद्यालयका उपकरणहरु (Hard drive) मा अध्ययनकर्ताहरुबाट पासवर्डको प्रयोग गरेर शुरक्षित राखेर तपाईको गोपनियताको सुनिश्चतता गरिनेछ । उक्त उपकरणहरु बिद्यालयको क्षेत्र भित्रै ताल्चा लगाएर बन्द गरेर राखिने दराजमा शुरक्षित राखिनेछ ।

यस अध्ययनको परिणामहरु मैलै कहिले र कसरी प्राप्त गर्न सक्नेछु ?

यस अध्ययनको समग्र परिणाममा पृष्ठपोषण पाउन तपाइको अधिकार हुनेछ । यो अध्ययन सकिएपछि यसको सारंश प्रतिवेदन तपाइको किशोरकिशोरी मैत्री स्वास्थ्य सस्थामा पठाइनेछ ।

यस अध्ययनमा सहभागीताको निरन्तरता दिन नचाहेको अवस्थामा मैले के गर्न सक्छु
यदि तपाइ यस अध्ययनमा सहभागीतकको मञ्जुरी दिनुभएता पनि निरन्तरता दिन चाहानुहुन्न भने कुनै पनि समयमा छोडन सक्नुहुनेछ । यदि निरन्तरता दिन चाहानुभएन भने तपाईले यस फारामको अन्तमा भएको फाराममा हस्ताक्षर गर्नु पर्नेछ । अथवा तपाईले अध्ययन टोलिलाई तपाईले सहभागि हुन नचाहाने जानकारी दिन सक्नुहुनेछ । यदि तपाई सहभागि हुन चाहानुभएन भने त्यस पछि हामी तपाइसँग थप जानकारी लिने छौनौ । त

मेरो सहभागीताको बारे थप कुरा बुझ्नको लागी मैले के गर्नु पर्दछ ?

तपाइले सम्पर्क गर्नु पर्ने व्यक्ति तपाइको प्रश्न र जिज्ञासामा भर पर्छ। यदि तपाइ यस अध्ययनको बारे वा तपाइको संलग्नता बारे अझ धेरै बुझ्न चाहानु हुन्छ भने तल उल्लिखित व्यक्ति सँग सम्पर्क गर्न सक्नु हुनेछ।

Research Team Contact

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Email	Pushpa.pandey@student.unsw.edu.au

यस अध्ययन सम्बन्धि कुनै गुनासो वा कुनै जिज्ञासा भएमा मैले के गर्नेहोला ?

यदि तपाइ यस अध्ययनको अथवा अध्ययनको तरीका बारे केही गुनासो भए तल उल्लिखित व्यक्ति सँग सम्पर्क गर्न सक्नु हुनेछ।

Complaints Contact (Nepal)

Position	Ethics Review Board Member Secretary, Nepal Health Research Council
Telephone	977 1 4254220
Email	nhrc@nhrc.org.np
HC Reference Number	HC 16427

(Australia)

Position	Human Research Ethics Coordinator
Telephone	+ 61 2 9385 6222
Email	humanethics@unsw.edu.au
HC Reference Number	HC 16427

Consent Form – Participant providing own consent

Declaration by the participant

- ☐ मैले यो सहभागी जानकारी फारम पढेको छु अथवा अरु कोहीले यो फारम मैले बुझ्ने भाषामा पढेर सुनाउनु भएको छ ।
- ☐ मैले यो अध्ययनको परियोजनामा उल्लिखित उद्देश्य, काम र जोखिमबारे जानकारी पाएको छु ।
- ☐ मैले प्रश्न सोध्ने मौका पाएको थिए र म मैले पाएको उत्तरबाट सन्तुष्ट छु ।
- ☐ म यस अध्ययन अनुसन्धानबाट कुनै पनि बेला अलगहुन सक्ने कुरा जानकारी पाएर र बुझेर स्वतन्त्रपूर्वक सहभागि हुन स्वीकार गर्दछु । मैले अध्ययनको बिचैमा छोडे ता पनि यो अध्ययन गर्ने संस्था वा यस अध्ययनको टोलिका कुनै पनि सदस्यहरु संगको सम्बन्धमा कुनै पनि नकारात्मक असर पर्ने छैन ।
- ☐ म मैले हस्ताक्षर गरेको फारामको एक प्रति मलाई पनि दिइने छ भन्ने कुरा बुझेको छ ।

सहभागीको सही

सहभागीको नाम (प्रिन्ट गर्नुहोस)	
सहभागीको सही	
ितिमति	

Declaration by Researcher*

☐ मैले यो अध्ययनका सहभागिलाई यो अध्ययन, यसका गतिबिधिहरु र यसमा सहभागि हुदाका जोखिमहरुका बारेमा मौखिक जानकारी दिएको छु र सहभागिहरुले यो कुरा बुझेका छन भन्ने बिशवास गर्दछु ।

Researcher Signature*

अध्ययनकर्ताको नाम (प्रिन्ट गर्नुहोस)	
अध्ययनकर्ताको सही	
ितिमति	

अध्ययन अनुसन्धानको टोलिका एक योग्य सदस्यले अध्ययन संग सम्बन्धित सबै प्रकारका जानकारीहरु र जिज्ञासाहरुका बारेमा राम्रो संग दिनुपर्दछ ।

Note: All parties signing the consent section must date their own signature.
अनुमति पत्रमा हस्ताक्षर गर्ने सबै पक्षहरुले हस्ताक्षर संगै मिति पनि लेख्नु पर्दछ ।

अध्ययनबाट अलग हुन चाहानेले भर्नु पर्ने फाराम

म माथि उल्लिखित यो अध्ययनबाट अलग हुन चाहान्छु र म अलग भएता पनि यो अध्ययन गर्ने New South Wales विश्व विद्यालयसंग कुनै प्रकारको नसारात्मक असर पर्ने छैन ।

सहभागीको सही

सहभागीको नाम (प्रिन्ट गर्नुहोस)	
सहभागीको सही	
ीमति	

अध्ययनका सहभागिले अध्धयनबाट अलग हुने फाराम भरे पछि यो फराम निम्न व्यक्तिलाइ पठाउनु पर्दछ :

Co-investigator Name:	**Dr Suresh Mehata**
Email:	**Sureshmht@gmail.com**
Phone:	**977 9842036595**
Postal Address:	Nepal Health Sector Support Program Ministry of Health Ramshah Path Kathmandu, Nepal

A.9.4 Participant information and consent form for adolescents exit interview in Nepali

Appendix: 5

School of Public Health and Community Medicine
Faculty of Medicine

UNSW AUSTRALIA

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM
Adolescents (Phase 2)
Utilisation of adolescent friendly sexual and reproductive health services in Dhading District, Nepal

यस अध्ययनमा सम्लग्न अध्ययनकर्ताहरु		
भुमिका	**नाम**	**संस्था**
प्रमुख अध्ययनकर्ता	Dr Husna Razee (डा. हुस्ना रजि)	युनिभर्सिटी अफ न्यु साउथ वेल्स (UNSW), अस्ट्रेलिया
सहायक अध्ययनकर्ता	Dr Holly Seale (डा. हली शिल) Dr Suresh Mehata(डा. सुरेस मेहता)	युनिभर्सिटी अफ न्यु साउथ वेल्स (UNSW), अस्ट्रेलिया नेपाल स्वास्थ्य क्षेत्र सहयोग कार्यकम, स्वास्थय मन्त्रालय, नेपाल
विधार्थी अध्ययनकर्ता	Pushpa Lata Pandey (पुष्प लता पाण्डे)	युनिभर्सिटी अफ न्यु साउथ वेल्स (UNSW), अस्ट्रेलिया

यो अध्ययन के को बारेमा हो ?

तपाईलाइ युनिभर्सिटी अफ न्यु साउथ वेल्स (University of New South Wales) सिड्नी, अस्ट्रेलिया र नेपाल सरकार स्वास्थ्य मन्त्रालयको नेपाल स्वास्थ्य क्षेत्र सहयोग कार्यक्रमले गर्न लागेका यस अध्ययनमा सहभागीहुनका लागि आमन्त्रण (निमन्त्रणा) गर्दछौं । यस अध्ययनमा सहभागी हुने वा नहुने निर्णय गर्नुभन्दा पहिले तपाइलाई यस अध्ययन किन गरिएको हो र यस अध्ययनमा के समावेस गरिएको छ भन्ने जान्नु महत्त्वपुर्ण छ । कृपया यि जानकारिहरू ध्यानपुर्वक अध्ययन गनुहोला र तपाइ चाहनु हुन्छ भने अरुसँग पनि सल्लाह गर्नसक्नु हुनेछ ।.

किशोर किशोरी मैत्री स्वास्थ्य सेवाको मख्य उद्देश्य नेपालमा किशोर किशोरीलाई मैत्री पूर्ण वातावरणमा यौन तथा प्रजनन स्वास्थ्य सम्बन्धी सेवा प्रदान गर्नु हो । विभिन्न अध्ययन अनुसार नेपालमा किशोर किशोरीहरुले यस सेवा बारेमा जानकारी पाएका भए ता पनि यो सेवा लिन उनिहरुको पहुच नभएको देखिएको छ । हामीलाई यी सेवाहरु किन किशोर किशोरीहरुले उपयोग गरेका छैनन भन्ने कुरा थाहा छैन ।

यस अध्ययनले नेपालमा किशोर किशोरी मैत्री सेवा लिनमा के के तत्वहरुले योगदान (असर) पुऱ्याउँदो रहेछ भन्ने कुरा पत्ता लगाउने छ । हामीहरु तपाईको किशोर किशोरी मैत्री स्वास्थ्य संस्थाबा सेवा लिदा रहेका अनुभव कस्तो छ भन्ने बारेमा जान्न चाहन्छौ । तपाईले दिनुभएको जानकारीले हामीले स्वास्थ्य मन्त्रालयलाई किशोर किशोरी मैत्री स्वास्थ्य सेवा प्रदान गर्न आवश्यक परिवर्तनहरु बरे सुझाव दिन सहयोग गर्ने छ ।

तपाइलाइ यस अध्ययनमा सहभागी गराइएको छ किनकि

- तपाइको १५ देखि १९ वर्षको उमेर भित्र पर्नुहुन्छ ।
- तपाइ गएको १ हप्ता भित्र स्वास्थ्य सेवा लिन स्वास्थ्य संस्था आउनुभएको छ ।

के म यस अध्ययनमा सहभागी हुन जरुरी छ ?

यस अध्ययनमा सहभागीहरु स्वयमसेवी रुपमा सहभागी हुन्छन् । यस अध्ययनमा सहभागी हुने वा नहुने भन्ने कुरा पुर्ण रुपमा तपाइको इच्छामा भर पर्दछ । यदी अध्ययनको क्रममा तपाईलाई यस अध्ययनमा सहभागी हुन मन नलागेमा कुनैपनि बेला छोडेर जान सक्नुहुनेछ ।

यस अध्ययनमा सहभागी हुनको लागी के के कुरा हुन जरुरी छ र के यस अध्ययनमा सहभागी हुँदा केही जोखिम हुन्छन् ?

यदी तपाइ यस अध्ययनमा सहभागी हुने निर्णय गर्नु हुन्छ भने तपाइ एउटा अन्तरवार्तामा सहभागी हुनुपर्नेछ जसको लागी ४५ मिनेट देखि १ घण्टा लाग्नेछ । यस अध्ययनमा सहभागी हुँदा तपाइलाइ कुनै जोखिम पर्नेछैन ।

अन्तरवार्ताको बेलामा अध्ययन टोलीका एक सदस्यले किशोरकिशोरी मैत्री स्वास्थ्य संस्थाबाट सेवा लिँदा रहेका तपाईका अनुभव बारे प्रश्न सोध्नेछन् । हामी तपाइको स्वास्थ्य सस्था आउनुको कारण सोध्ने छैनौ । हामी तपाइको व्यक्तिगत जानकारी माग्ने छैनौ । तर २ मिनेट तपाईको बसोबासको बारेमा सोध्ने छौ।

तपाइको अनुमति लिएर तपाइसँगको अन्तरवार्ता रेकर्ड गरिनेछ र टाइप गरिनेछ । तपाइको अन्तरवार्ता रेकर्ड गर्नुको उद्देश्य अध्ययनको लागी सहज होस र तपाइले भनेको कुनैपनि कुरा नछुटोस भन्नको लागि हो ।

के यस अध्ययनमा सहभागी हुँदा मलाइ कुनै जोखिम पर्नसक्छ ?
यस अध्ययनमा सहभागी हुँदा तपाइलाइ कुनै जोखिम पर्नेछैन । हामी यौन तथा प्रजनन स्वास्थ्य सेवा लिदा तपाईका अनभवका बारेमा केही प्रश्न गर्नेछौ । यस विषयमा कुरा गर्दा तपाइलाइ असहज महशूस हुनसक्छ । यस्तो महशूस भए अध्ययनकर्तासँग कुरा गर्नसक्नुहुनेछ ।

यदि तपाइलाइ असहज महसूस भए कोही अरु अध्ययनकर्ता वा धादिङ जिल्ला अस्पताल (०१० ५२०१२६) का स्वास्थ्यकर्मी सँग कुरा गर्नसक्नुहुनेछ ।

यस अध्ययनमा सहभागी हुँदा के मलाइ कुनै आर्थिक लाभ हुनेछ ?
यस अध्ययनमा सहभागी हुँदा तपाइलाइ कुनै आर्थिक लाभ हुनेछैन । तर यस अध्ययनमा सहभागी भए बापत धन्यबाद स्वरुप हामी तपाइलाइ हल्का खाजाको व्यवस्था, एउटा मोबाइल रिचार्ज कार्ड र एउटा सानो उपहार प्रदान गर्नेछौ ।

यस अध्ययनमा सहभागी हुँदा के के फाइदा हुने सम्भावना छ ?
यस अध्ययनबाट आएको जानकारी र तथ्यहरुको मद्धतले हामी किशोर किशोरी मैत्री स्वास्थ्य सेवालाइ अझ प्रभावकारी बनाइ धेरै किशोर किशोरी माझ पुऱ्याउन सक्छौ ।

मेरो बारेमा जानकारीहरु के हुनेछन ?

तपाइले यस मन्जुरीनामामा सही गरे पछि मात्र हामीले तपाइबाट यो अध्ययन अनुसन्धानका लागि जानकारीहरु लिन सक्नेछौ । तपाइबाट पाएका जानकारीहरु आगामी सात वर्ष सम्म राखिनेछ । यहाँबाट लिइएका तथ्याङ्कहरु यस अध्ययनको लागी मात्र प्रयोग गरिनेछ र तपाइको अनुमती बिना तपाइको जानकारीहरु कतै सार्वजनिक गरिने छैन ।

यस अध्ययनबाट आउने तथ्यहरु तथा परिणामहरु विभिन्न रुपमा प्रकाशन तथा प्रस्तुति गरिनेछ र विभिन्न संचार वा प्रकासनहरुमा प्रकासन गरिनेछ ता पनि तपाइको मन्जुरी बिना कतै पनि तपाइको पहिचान खुलाउने छैनौ ।

तपाइलाई तपाइबाट अध्ययन टोलिले लिएका जानकारीहरुमा पहुँचका लागि अनुरोध गर्ने अधिकार हुनेछ । कुनै पनि जानकारीहरुमा तपाइको असहमती भए सच्याउनको लागी कुनै पनि अध्ययनकर्ता सँग सम्पर्क गरी अनुरोध गर्न सक्नुहुनेछ ।

तपाइको अन्तरवार्ताको अडियो रेकर्ड र जानकारीहरु युनिभर्सिटी अफ न्यु साउथ वेल्स (UNSW), अस्ट्रेलिया मा ७ वर्ष सम्म सुरक्षित राखिने छ । यस अध्ययनमा प्राप्त तपाईका अन्तरवार्ताको अडियो रेकर्ड यस विश्वविद्यालयको जनस्वास्थ्य

तथा सामुदायिक चिकित्शा विद्यालयका उपकरणहरु (Hard drive) मा अध्ययनकर्ताहरुबाट पासवर्डको प्रयोग गरेर शुरक्षित राखेर तपाईको गोपनियताको सुनिश्चतता गरिनेछ। उक्त उपकरणहरु बिद्यालयको क्षेत्र भित्रै ताल्चा लगाएर बन्द गरेर राखिने दराजमा शुरक्षित राखिनेछ।

यस अध्ययनको परिणामहरु मैले कहिले र कसरी प्राप्त गर्न सक्नेछु ?

यस अध्ययनको समग्र परिणाममा पृष्ठपोषण पाउन तपाइको अधिकार हुनेछ। यो अध्ययन सकिएपछि यसको सारंश प्रतिबेदन तपाइको किशोरकिशोरी मैत्री स्वास्थ्य सस्थामा पठाइनेछ।

यस अध्ययनमा सहभागीताको निरन्तरता दिन नचाहेको अवस्थामा मैले के गर्न सक्छु

यदि तपाइ यस अध्ययनमा सहभागीतकको मञ्जुरी दिनुभएता पनि निरन्तरता दिन चाहानुहुन्न भने कुनै पनि समयमा छोडन सक्नुहुनेछ। यदि निरन्तरता दिन चाहानुभएन भने तपाईले यस फारामको अन्तमा भएको फाराममा हस्ताक्षर गर्नु पर्नेछ। अथवा तपाईले अध्ययन टोलिलाई तपाईले सहभागि हुन नचाहाने जानकारी दिन सक्नुहुनेछ। यदि तपाई सहभागि हुन चाहानुभएन भने त्यस पछि हामी तपाइसँग थप जानकारी लिने छैनौ।

मेरो सहभागीताको बारे थप कुरा बुझ्नको लागी मैले के गर्नु पर्दछ ?

तपाइले सर्म्पक गर्नु पर्ने व्यक्ति तपाइको प्रश्न र जिज्ञासामा भर पर्छ। यदि तपाइ यस अध्ययनको बारे वा तपाइको संलग्नता बारे अझ धेरै बुझ्न चाहानु हुन्छ भने तल उल्लिखित व्यक्ति सँग सम्पर्क गर्न सक्नु हुनेछ।

अध्ययन टोलीको सम्पर्क

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यस अध्ययन सम्बन्धि कुनै गुनासो वा कुनै जिज्ञासा भएमा मैले के गर्नेहोला ?

यदि तपाइ यस अध्ययनको अथवा अध्ययनको तरीका बारे केही गुनासो भए तल उल्लिखित व्यक्ति सँग सम्पर्क गर्न सक्नु हुनेछ।

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सहमती – सहभागी आफैले सहमती दिदां

सहभागीको घोषणा

- ☐ मैले यो सहभागी जानकारी फारम पढेको छु अथवा अरु कोहीले यो फारम मैले बुझ्ने भाषामा पढेर सुनाउनु भएको छ ।
- ☐ मैले यो अध्ययनको परियोजनामा उल्लिखित उद्देश्य, काम र जोखिमबारे जानकारी पाएको छु ।
- ☐ मैले प्रश्न सोध्ने मौका पाएको थिए र म मैले पाएको उत्तरबाट सन्तुष्ट छु ।
- ☐ म यस अध्ययन अनुसन्धानबाट कुनै पनि बेला अलगहुन सक्ने कुरा जानकारी पाएर र बुझेर स्वतन्त्रपूर्वक सहभागि हुन स्वीकार गर्दछु । मैले अध्ययनको बिचैमा छोडे ता पनि यो अध्ययन गर्ने संस्था वा यस अध्ययनको टोलिका कुनै पनि सदस्यहरु संगको सम्बन्धमा कुनै पनि नकारात्मक असर पर्ने छैन ।
- ☐ म मैले हस्ताक्षर गरेको फारामको एक प्रति मलाई पनि दिइने छ भन्ने कुरा बुझेको छ ।

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सहभागीको सही

सहभागीको नाम (प्रिन्ट गर्नुहोस)	
सहभागीको सही	
मिति	

अनुसन्धानकर्ताको घोषणा

- ☐ मैले यो अध्ययनका सहभागिलाई यो अध्ययन, यसका गतिबिधिहरु र यसमा सहभागि हुदाका जोखिमहरुका बारेमा मौखिक जानकारी दिएको छु र सहभागिहरुले यो कुरा बुझेका छन भन्ने बिशवास गर्दछु ।

अनुसन्धानको सही

अध्ययनकर्ताको नाम (प्रिन्ट गर्नुहोस)	
अध्ययनकर्ताको सही	
मिति	

अध्ययन अनुसन्धानको टोलिका एक योग्य सदस्यले अध्ययन संग सम्बन्धित सबै प्रकारका जानकारीहरु र जिज्ञासाहरुका बारेमा राम्रो संग दिनुपर्दछ ।
अनुमति पत्रमा हस्ताक्षर गर्ने सबै पक्षहरुले हस्ताक्षर संगै मिति पनि लेख्नु पर्दछ ।

अध्ययनबाट अलग हुन चाहानेले भर्नु पर्ने फाराम

म माथि उल्लिखित यो अध्ययनबाट अलग हुन चाहान्छु र म अलग भएता पनि यो अध्ययन गर्ने New South Wales विश्व विद्यालयसंग कुनै प्रकारको नसारात्मक असर पर्ने छैन ।

सहभागीको सही

सहभागीको नाम (प्रिन्ट गर्नुहोस)	
सहभागीको सही	
मिति	

अध्ययनका सहभागिले अध्धयनबाट अलग हुने फाराम भरे पछि यो फराम निम्न व्यक्तिलाइ पठाउनु पर्दछ :

सह अध्ययनकर्ताको नाम:	**Dr Suresh Mehata (डा. सुरेस मेहता)**
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पत्राचार ठेगाना:	नेपाल स्वास्थ्य क्षेत्र सहयोग कार्यकम, स्वास्थय मन्त्रालय, नेपाल

A.9.5 Participant information and consent form for key informants in Nepali

School of Public Health and Community Medicine
Faculty of Medicine

UNSW AUSTRALIA

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM
Key Informants
Utilisation of SRH services from adolescent friendly health services in Dhading district, Nepal

The study is being carried out by the following researchers: यस अध्ययनमा सम्लग्न अध्ययनकर्ताहरु		
Role	**Name**	**Organisation**
Chief Investigator	Dr Husna Razee	School of Public Health and Community Medicine, UNSW
Co-Investigator/s	Dr Holly Seale Dr Suresh Mehata	School of Public Health and Community Medicine, UNSW Nepal Health Sector Support Program, Ministry of Health, Nepal
Student Investigator/s	Pushpa Lata Pandey	School of Public Health and Community Medicine, UNSW

What is the research studyabout?

तपाईलाइ अस्ट्रेलियाको सिड्नी भन्ने ठाउँमा अवस्थित New South Wales विश्व विद्यालय र नेपाल सरकार स्वास्थ्य मन्त्रालयको नेपाल स्वास्थ्य क्षेत्र सहयोग कार्यक्रमले गर्न लागेका यस अध्ययनमा सहभागीहुनका लागि आमन्त्रण (निमन्त्रणा) गर्दछौं । यस अध्ययनमा सहभागी हुने वा नहुने निर्णय गर्नुभन्दा पहिले तपाइलाई यस अध्ययन किन गरिएको हो र यस अध्ययनमा के समावेस गरिएको छ भन्ने जान्नु महत्त्वपुर्ण छ । कृपया यि जानकारिहरू ध्यानपुर्वक अध्ययन गनुहोला र तपाइ चाहनु हुन्छ भने अरुसँग पनि सल्लाह गर्नसक्नु हुनेछ ।.

किशोर किशोरी मैत्री स्वास्थ्य सेवाको मख्य उद्देश्य नेपालमा किशोर किशोरीलाई मैत्री पूर्ण वातावरणमा यौन तथा प्रजनन स्वास्थ्य सम्बन्धी सेवा प्रदान गर्नु हो । स्वास्थ्य मन्त्रालयले नेपालका ५६ भन्दा बढी जिल्लाहरुका १००० भन्दा बढी स्वास्थ्य संस्थाहरुमा किशोर किशोरी मैत्री स्वास्थ्य सेवा सुरु गरेको छ । विभिन्न अध्ययन अनुसार नेपालमा किशोर किशोरीहरुले यस सेवा बारेमा जानकारी पाएका भए ता पनि यो सेवा लिन उनिहरुको पहुच नभएको देखिएको छ । यति हुँदा पनि कुनैपनि अध्ययनहरुले किशोर किशोरीहरुले किशोर किशोरी मैत्री स्वास्थ्य सेवाको उपयोग नगर्नुको कारण पत्ता लगाएको छैन ।

यस अध्ययनले नेपालमा किशोर किशोरी मैत्री सेवा लिनमा के के तत्वहरुले योगदान (असर) पुऱ्याउँदो रहेछ भन्ने कुरा पत्ता लगाउने छ । हामीहरु गत दुइ वर्षको समयमा किशोर किशोरी तथा युवायुवतिहरुले किशोर किशोरी मैत्री स्वास्थ्य सेवा उपयोग गरेको अवस्था कस्तो छ भनेर जान्न इच्छुक छौं । यो अवस्था (सेवा उपयोग) को जानकारीको प्रतिवेदनले हामीहरुलाई किशोर किशोरी तथा युवायुवतिहरुले किशोर किशोरी मैत्री सेवाको कम उपयोग गर्नुको कारणहरु पत्ता लगाउनका अझै गहन अध्ययन गर्नका लागि स्वास्थ्य संस्थाहरुको छनोट गर्नका लागि सहयोग पुग्नेछ ।

You have been invited to participate in this research because you are:
तपाइलाइ यस अध्ययनमा सहभागी गराइएको छ किनकि

- तपाइ यस अध्ययन क्षेत्रमा बस्ने मूख्य स्रोत व्यक्ति (Key informant) हुनुहुन्छ ।
- तपाइ स्वास्थ्य संस्था संचालन तथा व्यवस्थापन समितिको सदस्य/शिक्षक/अभिभावक/महिला स्वयमसेवी हुनुहुन्छ ।

के म यस अध्ययनमा सहभागी हुन जरुरी छ ?

यस अध्ययनमा सहभागीहरु स्वयमसेवी रुपमा सहभागी हुन्छन् । यस अध्ययनमा सहभागी हुने वा नहुने भन्ने कुरा पुर्ण रुपमा तपाइको इच्छामा भर पर्दछ । यदी अध्ययनको क्रममा तपाईलाई यस अध्ययनमा सहभागी हुन मन नलागेमा कुनैपनि बेला छोडेर जान सक्नुहुनेछ ।

यस अध्ययनमा सहभागी हुनको लागी के के कुरा हुन जरुरी छ र के यस अध्ययनमा सहभागी हुँदा केही जोखिम हुन्छन् ?

यदी तपाइ यस अध्ययनमा सहभागी हुने निर्णय गर्नु हुन्छ भने अध्ययनकर्ताले तपाइ सँग अन्तरवार्ता लिनेछन् । अन्तरवार्ताको क्रममा अध्ययन टोलीका एक सदस्यले तपाइसँग किशोरकिशोरीलाइ सेवा दिदाको अनुभव र धारणाको बारेमा प्रश्न गर्नेछन् । अन्तरवार्ता नजिकैको सामुदायिक भवन वा तपाइलाइ सहज हुने ठाउमा गर्न सकिनेछ। अन्तरवार्ता गर्दा गोपनियताको ध्यान दिइनेछ। अन्तरवार्ताको समय १ देखि डेढ घण्टा हुनेछ ।
तपाइको अनुमति लिएर तपाइसँगको अन्तरवार्ता रेकर्ड गरिनेछ र टाइप गरिनेछ । तपाइको अन्तरवार्ता रेकर्ड गर्नुको उद्देश्य अध्ययनको लागी सहज होस र तपाइले भनेको कुनैपनि कुरा नछुटोस भन्नको लागि हो ।

के यस अध्ययनमा सहभागी हुँदा मलाइ कुनै जोखिम पर्नसक्छ ?
यस अध्ययनमा सहभागी हुँदा हामी तपाइको समय लिने छौ, त्यस बाहेक तपाइलाई कुनै प्रकारको जोखिम वा आर्थिक भार पर्ने छैन ।

यस अध्ययनमा सहभागी हुँदा के मलाइ कुनै आर्थिक लाभ हुनेछ ?
यस अध्ययनमा सहभागी हुँदा तपाइलाइ कुनै आर्थिक लाभ हुनेछैन । तर यस अध्ययनमा सहभागी भए बापत धन्यबाद स्वरुप हामी तपाइलाइ हल्का खाजाको व्यवस्था, रु ५० को मोबाइल रिचार्ज कार्ड र रु.८०० बराबरको उपहार प्रदान गर्नेछौ ।

यस अध्ययनमा सहभागी हुँदा के के फाइदा हुने सम्भावना छ ?
यस अध्ययनबाट आएको जानकारी र तथ्यहरुको मद्धतले हामी किशोर किशोरी मैत्री स्वास्थ्य सेवालाइ अझ प्रभावकारी बनाइ धेरै किशोर किशोरी माझ पुऱ्याउन सक्छौ ।

मेरो बारेमा जानकारीहरु के हुनेछन ?

तपाइले यस मन्जुरीनामामा सही गरे पछि मात्र हामीले तपाइको स्वास्थ्यसस्थाबाट यो अध्ययन अनुसन्धानका लागि तथ्याङ्कहरु लिन सक्नेछौ । तपाइको यस स्वास्थ्यसस्थाको तथ्यांक आगामी सात वर्ष सम्म राखिनेछ । यहाँबाट लिइएका तथ्याङ्कहरु यस अध्ययनको लागी मात्र प्रयोग गरिनेछ र तपाइको अनुमती बिना तपाइको जानकारीहरु कतै सार्वजनिक गरिने छैन ।

यस अध्ययनबाट आउने तथ्यहरु तथा परिणामहरु विभिन्न रुपमा प्रकाशन तथा प्रस्तुति गरिनेछ र विभिन्न संचार वा प्रकासनहरुमा प्रकासन गरिनेछ ता पनि तपाइको मन्जुरी बिना कतै पनि तपाइको पहिचान खुलाउने छैनौ ।

तपाइलाई तपाइको स्वास्थ्यसंस्थाबाट अध्ययन टोलिले लिएका जानकारीहरुमा पहुँचका लागि अनुरोध गर्ने अधिकार हुनेछ । कुनै पनि जानकारीहरुमा तपाइको असहमती भए सच्याउनको लागी कुनै पनि अध्ययनकर्ता सँग सम्पर्क गरी अनुरोध गर्न सक्नुहुनेछ ।

तपाइको अन्तरवार्ताको अडियो रेकर्ड र तपाइबाट प्राप्त जानकारीहरु UNSW, Kingston campus मा ७ वर्ष सम्म सुरक्षित राखिने छ । यस अध्ययनमा प्राप्त अडियो रेकर्ड र तपाइबाट प्राप्त जानकारीहरु यस विश्वविद्यालयको जनस्वास्थ्य तथा सामुदायिक चिकित्शा विद्यालयका उपकरणहरु (Hard drive) मा अध्ययनकर्ताहरुबाट पासवर्डको प्रयोग गरेर शुरक्षित राखेर तपाईको गोपनियताको सुनिश्चतता गरिनेछ । उक्त उपकरणहरु विद्यालयको क्षेत्र भित्रै ताल्चा लगाएर बन्द गरेर राखिने दराजमा शुरक्षित राखिनेछ ।

यस अध्ययनको परिणामहरु मैलै कहिले र कसरी प्राप्त गर्न सक्नेछु ?

यस अध्ययनको समग्र परिणाममा पृष्ठपोषण पाउन तपाइको अधिकार हुनेछ । यो अध्ययन सकिएपछि यसको सारंश प्रतिबेदन तपाइको किशोरकिशोरी मैत्री स्वास्थ्य सस्थामा पठाइनेछ ।

यस अध्ययनमा सहभागीताको निरन्तरता दिन नचाहेको अवस्थामा मैले के गर्न सक्छु

यदि तपाइ यस अध्ययनमा सहभागीतकको मञ्जुरी दिनुभएता पनि निरन्तरता दिन चाहानुहुन्न भने कुनै पनि समयमा छोडन सक्नुहुनेछ । यदि निरन्तरता दिन चाहानुभएन भने तपाईले यस फारामको अन्तमा भएको फाराममा हस्ताक्षर गर्नु पर्नेछ । अथवा तपाईले अध्ययन टोलिलाई तपाईले सहभागि हुन नचाहाने जानकारी दिन सक्नुहुनेछ । यदि तपाई सहभागि हुन चाहानुभएन भने त्यस पछि हामी तपाइसँग थप जानकारी लिने छैनौ ।

तपाइ कुनै पनि बेला तथ्यांक संकलन कार्यलाइ रोक्न स्वतन्त्र हुनुहुन्छ । तपाइको मन्जुरी बिना हामी कुनै पनि जानकारीहरु राख्ने छैनौ र तपाईको मञ्जुरी बिना तपाइले दिनुभएको कुनै पनि जानकारीहरुलाइ हाम्रो अध्ययनमा समावेश गरिने छैन ।

यदि तपाइ अध्ययनबाट बाहिरिन चानुहुन्छ भने हामी तपाईबाट कुनै जानकारी लिने छैनौ । यदि तपाई अध्ययनबाट बाहिरिन चाहानुहुन्छ भने अध्ययनमा तपाईले छोड्ने बेला सम्ममा तपाईबाट लिईएका जानकारीहरुलाई समावेश गर्ने वा नगर्ने भन्ने बारेमा हामीलाई जानकारी दिनुहोला । यदि तपाईले अध्ययनबाट अलग हुँदाका बेला सम्म दिनुभएका जानकारीहरुलाइ यस अध्ययनको प्रतिवेदनमा समावेश गर्न चाहानुभएन भने हामी ति जानकारीहरुलाई अभिलेखबाट मेटाइ दिनेछौ ।

मेरो सहभागीताको बारे थप कुरा बुझनको लागी मैले के गर्नु पर्दछ ?

तपाइले सर्म्पक गर्नु पर्ने व्यक्ति तपाइको प्रश्न र जिज्ञासामा भर पर्छ । यदि तपाइ यस अध्ययनको बारे वा तपाइको संलग्नता बारे अझ धेरै बुझ्न चाहानु हुन्छ भने तल उल्लिखित व्यक्ति सँग सम्पर्क गर्न सक्नु हुनेछ ।

Research Team Contact

Name	Pushpa Lata Pandey पुष्पलता पाण्डे

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यस अध्ययन सम्बन्धि कुनै गुनासो वा कुनै जिज्ञासा भएमा मैले के गर्नेहोला ?

यदि तपाइ यस अध्ययनको अथवा अध्ययनको तरीका बारे केही गुनासो भए तल उल्लिखित व्यक्ति सँग सम्पर्क गर्न सक्नु हुनेछ ।

Complaints Contact (Nepal)

Position	Ethics Review Board Member Secretary, Nepal Health Research Council
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(Australia)

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HC Reference Number	HC 16427

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM
Key Informants
Utilisation of SRH services from adolescent friendly health services in Dhading district, Nepal

Consent Form – Participant providing own consent

Declaration by the participant

- ☐ मैले यो सहभागी जानकारी फारम पढेको छु अथवा अरु कोहीले यो फारम मैले बुझ्ने भाषामा पढेर सुनाउनु भएको छ ।
- ☐ मैले यो अध्ययनको परियोजनामा उल्लिखित उद्देश्य, काम र जोखिमबारे जानकारी पाएको छु ।
- ☐ मैले प्रश्न सोध्ने मौका पाएको थिए र म मैले पाएको उत्तरबाट सन्तुष्ट छु ।
- ☐ म यस अध्ययन अनुसन्धानबाट कुनै पनि बेला अलगहुन सक्ने कुरा जानकारी पाएर र बुझेर स्वतन्त्रपूर्वक सहभागि हुन स्वीकार गर्दछु । मैले अध्ययनको बिचैमा छोडे ता पनि यो अध्ययन गर्ने संस्था वा यस अध्ययनको टोलिका कुनै पनि सदस्यहरु संगको सम्बन्धमा कुनै पनि नकारात्मक असर पर्ने छैन ।
- ☐ म मैले हस्ताक्षर गरेको फारामको एक प्रति मलाई पनि दिइने छ भन्ने कुरा बुझेको छ ।

सहभागीको सही

सहभागीको नाम (प्रिन्ट गर्नुहोस)	
सहभागीको सही	
ितमि	

Declaration by Researcher*

☐ मैले यो अध्ययनका सहभागिलाई यो अध्ययन, यसका गतिबिधिहरु र यसमा सहभागि हुदाका जोखिमहरुका बारेमा मौखिक जानकारी दिएको छु र सहभागिहरुले यो कुरा बुझेका छन भन्ने बिशवास गर्दछु ।

Researcher Signature*

अध्ययनकर्ताको नाम (प्रिन्ट गर्नुहोस)	
अध्ययनकर्ताको सही	
ितमि	

अध्ययन अनुसन्धानको टोलिका एक योग्य सदस्यले अध्ययन संग सम्बन्धित सबै प्रकारका जानकारीहरु र जिज्ञासाहरुका बारेमा राम्रो संग दिनुपर्दछ ।

Note: All parties signing the consent section must date their own signature.
अनुमति पत्रमा हस्ताक्षर गर्ने सबै पक्षहरुले हस्ताक्षर संगै मिति पनि लेख्नु पर्दछ ।

अध्ययनबाट अलग हुन चाहानेले भर्नु पर्ने फाराम

म माथि उल्लिखित यो अध्ययनबाट अलग हुन चाहान्छु र म अलग भएता पनि यो अध्ययन गर्ने New South Wales विश्व विद्यालयसंग कुनै प्रकारको नसारात्मक असर पर्ने छैन ।

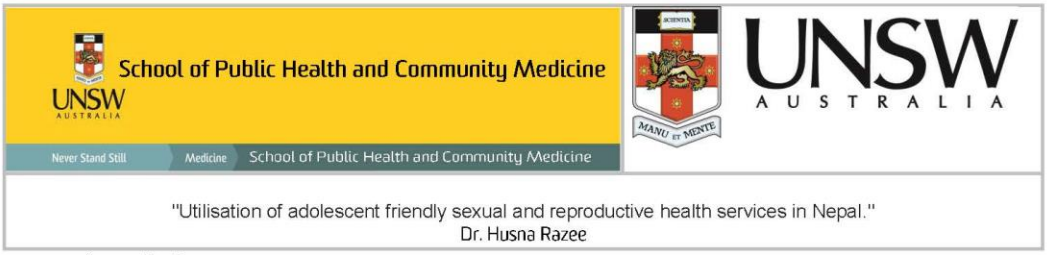
सहभागीको सही

सहभागीको नाम (प्रिन्ट गर्नुहोस)	
सहभागीको सही	
ीमति	

अध्ययनका सहभागिले अध्धयनबाट अलग हुने फाराम भरे पछि यो फराम निम्न ब्यक्तिलाइ पठाउनु पर्दछ :

Co-investigator Name:	**Dr Suresh Mehata**
Email:	**Sureshmht@gmail.com**
Phone:	**977 9842036595**
Postal Address:	Nepal Health Sector Support Program Ministry of Health Ramshah Path Kathmandu, Nepal

A.10 Home Interview Safety Protocol



Appendix: 7

Protocol for Conducting Interviews in Participants Homes

Researchers will be conducting interviews at participants' homes in Dhading district, Nepal. A local supervisor (Dr Suresh Mehata) will be overseeing this project in Nepal as the main supervisor of this project lives in Sydney, Australia. One person will be required to carry out interviews in people's homes, but the researcher must text the local supervisor that she is going into home to do the interview and must retext when she leaves. If there is any safety or security concern during the interview, the interviewer will immediately inform the local supervisor. For any reason, if the interview last more than one hour, the interviewer will have to inform the local supervisor, in case she does not, the local supervisor will call her to make sure she is alright. The interviewer's mobile device has to be fully charged before the interview.

Dr Suresh Mehata Mob no: 9842036595

Before the Home Visit: Prior to the home visit, the interviewer should check the information in the table below, with the participant and pass it on to the local Supervisor, Dr Suresh Mehata. When a risk is identified, a safety plan must be created and adapted as necessary before home interview and a plan of action to reduce or minimize that risk implemented. When the risk is determined to be too great or is unable to be minimized through the use of normal precautions, the interviewer should advise the supervisor and together develop an alternative plan until the risk or the unfavourable condition is minimized by changed conditions or when appropriate measure is available. The appropriate measure may include changing the day or time of the visit, changing the site of the visit to a safer venue, telephone interview or postponing the visit.

Pre- Interview Checklist with the participant
☐ Availability of street parking
☐ Location of entry door (front, back, side)
☐ How many people home during the home visit?
☐ Who are they?
☐ What is their relationship to the participant?
☐ Will they be sitting in on the assessment?
☐ Are there any pets at the home?
☐ Will they pose a risk? (e.g., vicious dogs, overfriendly large dogs). Can they be restrained or kept separate during the interview?

N.B:

Appendix: 7

Confirmation of home visits: The researcher will telephone the participant the day before or on the day of the appointment to confirm the arrangements and check that they are in a receptive state of mind.

Confirmation with your supervisor: Before interviewing participants in their own homes the interviewer must first obtain permission from the local supervisor. Once approval has been obtained the interviewer must advise the supervisor of the time which she intends to visit the participant home and confirm the time which the interview is expected to end. This will be communicated by telephone.

Home visits are not to be conducted if a participant has a history of aggressive behavior, violence or sexual harassment or if the interviewer believes there she is at risk. This includes cancelling an interview on the day if the interviewer feels the client's condition has deteriorated since the last point of contact. Most interviews can be conducted over the phone, so if the interviewer is unsure, reschedule for a telephone interview. The interviewer will check with the supervisor if she has any doubts about conducting home interviews.

In addition, be sure to take the following precautions when conducting interviews at participants' homes:

The interviewer will:

- Park where she can't be obstructed from leaving or parked in;
- Be aware of potential slip/trip hazards;
- Check pets are restrained or kept separate during the visit;
- Carry ID (although do not show ID containing your address or phone number);
- Check consent remains valid;
- Check who else is at the premises;
- Identify exit routes;
- Do not sit with back to the door, keep doorways clearly in sight and the exit doors easily reachable;
- Position herself so that she is closest to the exit route and it cannot be blocked;
- Check before sitting if , it is safe to do so e.g. no needles or sharps left on/near the seat
- Keep personal documents, mobile, personal possessions secure at all times.

Appendix B: Manuscript under review and conference abstracts

The Appendix B consists of manuscript submitted to the peer review journal which is under review and abstract of the oral presentation made from this thesis.

Appendix B.1: Manuscript submitted to PLOS One

Appendix B.2 Abstract for oral presentation made in International Sociological Association (ISA) Research Committees RC06 (Family) and RC41 (Population) Conference 2018 with the theme “changing Demography- Changing Families”, 17-19 May 2018, Singapore

Appendix B.3 Abstract for oral presentation made in Research for Development Impact (RDI) Conference, Partnering for Impact on Sustainable Development, 13-14 June 2017, University of Sydney, Australia

Appendix B.1: Manuscript submitted to PLOS One

Exploring the factors impacting on access and acceptance of sexual and reproductive health services provided by adolescent-friendly health services in Nepal

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ABSTRACT

Background: While adolescent-friendly health programs have been in place in Nepal since 2008, uptake of the services for sexual and reproductive health remains suboptimal. In order to improve uptake of these services, it is important to gather a rich understanding of the factors impacting their acceptance and utilization from the perspectives of the adolescents, health care staff, and key community informants.

Methods: The study applied a qualitative research design which involved six focus groups with 52 adolescents and in-depth interviews with 16 adolescents, 13 key informants and 9 health care providers from six adolescent-friendly health facilities in Nepal. Thematic analysis was conducted for data analysis.

Results: The key themes identified as barriers were access issues due to travel, perceived lack of privacy and confidentiality, and the unprofessional attitudes of staff towards the sexual health needs of adolescents. Embedded in these themes were what we have argued is gendered ideology and a moral framework around the sexual behavior of adolescents. Interview responses suggested that health care providers are taking a policing role in prescribing adolescents' conformity to this moral framework through the way they deliver reproductive health care and services.

Conclusion: While physical access to health services may be problematic for some adolescents, this is not the priority issue. Focus needs to be on increasing the capacity of health care providers to deliver services without imposing their own and socially sanctioned moral frameworks around adolescent sexual behavior. Such capacity building should include training that is experiential and emphasizes the importance of confidentiality and non-judgmental attitudes.

INTRODUCTION

It is well established that young people face numerous challenges in accessing sexual and reproductive health services (1-5). Concerns center on privacy and confidentiality. The World Health Organization (WHO) has argued that making sexual reproductive health services "adolescent-friendly" is key to improving access to sexual reproductive health services for young people (6). Adolescent-friendly health services (AFHS) are defined by the WHO as those services that are accessible, acceptable, equitable, appropriate and effective for adolescents (7). In other words, health care services that don't restrict adolescents, but guarantee confidentiality, treat adolescents with respect and without judging them, and are within easy reach of and affordable for adolescents (7). To deliver adolescent-friendly health services many countries have made efforts to incorporate these features into their health services with the aim of improving the arrangement, provision, and quality of sexual and reproductive health (SRH) services for adolescents (8-12). AFHS are meant to attract young people to these services and thereby increase adolescent uptake of SRH services (6, 7).

Nepal has been progressively implementing the adolescent-friendly health program since 2008. As of 2017, the program has been implemented in 70 of 75 districts (1134 public health facilities) (13). Despite rapid scaling up of AFHS, studies show utilization of SRH services has not changed. A study conducted in the Bhaktapur district of Nepal in 2015 showed that only 9.2% of the adolescents (n=338) participating in the study had utilized SRH services from the health facility (14). A second study conducted by the United Nations Population Fund (UNFPA) in the same year in another 12 districts, which included 72 health facilties with AFHS, revealed that 80% of participating adolescents had never visited the health facilities (15).

This paper attempts to present an in-depth account of barriers associated with adolescents' access to SRH care from AFHS in Nepal.

METHODS

Study setting

The study took place in the Dhading district of Nepal, a semi-cosmopolitan district comprising of both rural and urban populations. To select the facilities, health service utilization data for the two years preceding this current study from a total of 26 AFHS was collected and analyzed. Also, observation of the facilities was undertaken using the Nepal National Standards for AFHS (16). Based on the findings from

health service utilization data and observations, the 26 health facilities (HF) were then rated into three categories: ≥70% compliance = Good or performing well; 40-69% = Medium or need some improvement; and ≤39% = Poor or need considerable improvement. These categories were made based on reference to Chandra-Mouli, Chatterjee (17). In researching eight low and middle-income countries, Chandra-Mouli, Chatterjee (17) looked at the national quality standards and criteria for AFHS developed by each country and assessed the quality of health service provision depending on compliance with the required standards of quality, ranking each according to the above-mentioned three categories. Two HF from each category, or a total of six facilities, were purposively selected for the current study.

Study design

The study design followed a qualitative approach, since we were interested in obtaining an in-depth understanding of the barriers to accessing SRH services from the adolescents' perspectives and in their natural setting (18). Our study was informed by a social constructionist stance, that is, knowledge and reality are viewed as being constructed through social interactions (19). We drew upon principles of grounded theory for data collection and analysis, which helped us to stay close to our data and allowed us to be flexible with the data collection as the study proceeded (20).

Participant recruitment

We used purposive sampling for selecting adolescents, key informants (KIs) and health care providers (HCPs) for in-depth interviews (21). We also applied maximum variation sampling (22), to ensure we had a diverse range of perspectives from both male and female, and school attending and non-attending adolescents, as well as adolescents from marginalized groups and those with different socioeconomic backgrounds. To facilitate recruitment of adolescents we displayed research flyers in schools and health facilities with the help of HCPs and school teachers.

KIs were drawn from school teachers, health facility operation and management committees (HFOMC), female community health volunteers (FCHVs), non-government organizations (NGOs), and government employees.

KIs were notified about the research with the support of HCPs and local NGOs and through the distribution of research flyers. Snowball sampling was also used to recruit the KIs (22).

The HCPs were recruited from the six facilitites selected as study sites. Only those HCPs who had obtained government-sponsored adolescent sexual and reproductive health (ASRH) program orientation,

and who had been working in the selected health facility for at least six months were recruited as research participants. Participant selection continued until the researchers were satisfied that adequate data would be provided to respond to the research questions (23).

Data collection

Semi-structured in-depth interviews (IDIs) with adolescents, KIs and HCPs, and focus group discussions (FGDs) with adolescents were the methods of data collection. IDI and FGD guidelines were developed informed by the literature and WHO quality standards for AFHS (7). The IDIs and FGDs for adolescents explored their challenges in accessing SRH services from AFHS. In interviews with HCPs we explored their attitudes towards and perceptions and experiences of provision and delivery of SRH services to adolescents. Similarly with KIs, we explored their perceptions and attitudes regarding AFHS and existing sociocultural beliefs and understandings about the SRH of adolescents. The IDI and FGD guides were translated into the Nepali language. Given the sensitive nature of the study's topic of sexual and reproductive health within the Nepalese context, we developed vignettes to use as triggers for the interviews and FGDs. Vignettes are used to elicit information on sensitive topics when participants are not comfortable talking about themselves, and instead are encouraged to discuss the situation of the vignette character (24, 25). In this study, participants were told a story about a 15-year-old girl and 19-year-old boy who were in love and wanted to have sex with each other. In their responses, they were asked to think about what information and support that this couple would need, where they could seek support, and what barriers and challenges the couple might face.

The interviews and FGDs were conducted in venues chosen by participants that offered privacy and allowed free and open communication. A male interviewer was trained to conduct the interviews and FGDs in the case where a participant was not comfortable sharing information with the female researcher and first author, PP. The first author is a Nepalese who has worked in the area of SRH for more than 12 years. She also has played a major role in design, implementation and policy development around AFHS. All data collection was done by PP, except for one IDI and two FGDs. All the interviews and FGDs were audio-recorded, and the main points noted down. The duration of the IDIs was 35 minutes to 1.15 hours, on average, and FGDs between 2-2:30 hours. FGDs were held separately for male and female adolescents to encourage free and open expression about sexual health matters.

Data management and analysis

The first author, PP, who is fluent in both English and Nepali, transcribed the audio tapes verbatim from Nepali to English directly. Prior to transcribing all interviews into English, however, three interviews were first transcribed in Nepali, and were then translated into English by PP. The English language transcripts were then back-translated by an independent person, whose translation was compared with the original Nepali transcript. This process ensured that no major differences were evident in the translation. All transcripts were then saved on a password-protected computer accessible only to the researchers. Trustworthiness (26) of the data was ensured by i) employing methodological triangulation by using IDIs and FGDs, ii) data source triangulation by interviewing different groups of participants (adolescents, health care providers and key informants), iii) member checking by clarifying the information obtained from the participants through summarizing and obtaining their validation during the interview itself, and iv) the involvement of the senior author, HR, who, as an experienced qualitative researcher, ensured confirmability by reviewing the coding of the IDI and FGD transcripts.

We used NVIVO 11 for coding and management of the data. Data was then thematically analyzed using an inductive approach and drawing on principles of grounded theory (27). Data analysis followed the steps proposed by Braun and Clarke (28), that is, familiarization by reading and re-reading during verbatim transcribing, generating initial codes, generating themes, reviewing themes, and defining and naming themes. PP developed initial codes which were then discussed with HR to reach consensus. Codes were refined and final themes generated to answer the research questions (28). During the analysis process regular meetings between the three researchers were held to discuss the coding and themes generated.

Ethical consideration

Ethical clearance for the study was received from the University of New South Wales (UNSW) Human Research Ethics Board, Sydney, Australia, and from the Nepal Health Research Council (NHRC). Informed consent was obtained from all the participants, who were assured of confidentiality of information. Pseudonyms have been used throughout to protect participant identity.

RESULTS

A total of 68 adolescents participated in the study; 52 of them took part in six FGDs (three male groups and three female groups) and 16 adolescents participated in IDIs. Also, IDIs were held with 13 KIs and 9

HCPs. All in all, the study had 43 female and 47 male participants. The findings are presented according to the themes generated, reflecting barriers to accessing SRH services.

Poor access to health services

Both adolescents and HCPs saw the location of the HF as a barrier to utilizing AFHS. This was highlighted in the FGDs; adolescents would go to a private pharmacy near their homes rather than invest the time to get to the health facility in their village.

> *It takes one hour for me to reach the health facility in my village. So, I go to a private pharmacy near my home*. (Male, FGD participant)

> *This HF is accessible to only wards 1, 2, 3 and 4. We cannot reach adolescents of other wards from this HF. Most of them from other wards go to HF of adjoining village. Others who have resources [money] go to Kathmandu.* (Shiva, male, HCP)

Although some adolescents mentioned accessing SRH services when the facilities were close to their school or home, physical location of AFHS was not their only accessibility concern. Availability of SRH supplies such as contraceptives at affordable prices also contributed to poor access. Adolescents frequently experienced SRH supplies and medicines being out of stock. As noted by interview participant Muna, then a 19-year-old female adolescent, except for medicines for fever, they had "*to buy all other medicines from [private pharmacy]*."

According to the Department of Health Service, Nepal (29), 14% of family planning commodities and 34% of essential drugs are out of stock in health facilities throughout the country. Therefore, it is not surprising that adolescents may have to buy medicines from pharmacies. Given that many adolescents do not have money to pay for contraceptives and other requisite SRH supplies, it may be expected that they will not be motivated to visit AFHS.

Lack of privacy and confidentiality

Almost all of the adolescents, KIs and HCPs noted that adolescents hesitated utilizing AFHS because they had experienced lack of privacy and confidentiality. The built environment of the facility did not afford them privacy, as clearly noted in the female adolescents' focus group.

> *The health facility is open from everywhere. If there are some issues with private body parts, we feel shame to show those [body parts] as others might see.* (Female, FGD participant)

> *There is only one examination room. Sometimes males enter when we are talking to the HCP. Sometimes male may be present in the room when a female's check-up is taking place or vice-versa. This makes very uneasy to share the problem.* (Mira, female, IDI participant, 15 years)

Both male and female adolescents seemed cautious of seeking help from HCPs who were often from the same community as them, with adolescents fearing there could be a breach of their confidentiality. What is very interesting is that for a very few adolescents, such as Aarati, they did not even want their cases to be discussed among the HCPs themselves. This shows how important confidentiality is to adolescents.

> *Some of these issues need to be kept a secret between the HCP and us. I like HCP not sharing my visit to anyone. But they normally discuss our matters among them. I wish they would not do that and keep our issues confidential.* (Aarati, female, IDI participant, 16 years)

> *Most HCP are socially known person in the community, and they know about our home and family. Moreover, we are afraid that they might share with our parents and our parents will scold us if they know we go to the HF*. (Indra, male, IDI participant, 19 years)

This feeling of lack of confidentiality was shared by almost all adolescents. Moreover, some adolescents had firsthand experience of their confidentiality being breached, as clearly pointed out by Nita, a 16-year-old female adolescent.

> *I heard when the private [SRH] issues was shared outside. My aunt is a best friend of the one of the HCP. I heard this HCP talking to my aunt who is not a HCP. Even if they have some close friends, they should not be sharing the private matter of another person in the HF. Such type of subject matter usually spread fast in the community from one to another.*
> (Nita, female, IDI participant, 16 years)

Adolescents' privacy and confidentiality concerns being a barrier to utilizing SRH services from AFHS were echoed by HCPs.

> *Many [adolescents] might not come here because they are not confident and might have doubt that when they come here for services, their issues are not kept confidential*.
> (Kiran, female, HCP)

Kiran's comment suggests that HCPs are not trusted to keep things confidential. It wasn't only lack of trust that prevented adolescents from utilizing these facilities. Ram, an HCP, noted that adolescents would not seek SRH services from him because he was a member of their local community. This is more of an issue in rural areas, where communities are close-knit and most people know each other. Under those circumstances, adolescents may not want a member of their own community knowing that they are

engaging in sexual activity, which is a socially unacceptable behavior. This is further discussed under the later theme, *Socio-cultural norms and attitudes towards adolescent SRH in the community*.

Health care providers' characteristics

The responses of both adolescents and HCPs highlighted a number of HCP-related characteristics that contributed to the poor utilization of AFHS. For adolescents, the age and gender of HCPs was important. Adolescents felt that HCPs who were much older than they were, treated them like children and would not understand their SRH issues.

> *Health workers are of the age of the mother. We do not know a lot of things [SRH]. They should understand the issues and give proper advice, but they start to give a lecture* (Male, FGD participant)

Adolescents' experiences seemed to suggest that younger HCPs were more understanding and perhaps less judgmental of their problems, having been through similar experiences.

> *I have a friend who has completed a course on health. He belongs to my age, and he is working in the HF. So, I ask him if I have any query. He can understand the issue of my age. He knows it all, so it is comfortable seeking advice from him. It is easy to talk to people of your age.* (Indra, male, IDI participant,19 years)

It is likely that in such a case, being friends with the HCP may play a role. However, Indra's use of the words "*it is easy to talk to people of your age*" clearly suggests the importance of a narrower age difference between the practitioner and adolescent client.

Concerns about the age of the HCP were shared not only among adolescents. HCPs also felt that adolescents were not comfortable with them and, often, a much older HCP was regarded as a senior guardian by adolescents, who would therefore hesitate to share their SRH issues. For example, as HCP Krishna mentioned:

> *They [adolescents] sees HCPs [of more than 30 years age difference] as guardian to them, so they cannot share their problems openly.* (Krishna, male, HCP)

Both male and female adolescents commonly expressed apprehension about the gender of the HCP, as the quote below clearly reflects.

> *It is uncomfortable for male adolescents to share a problem with female staffs and female adolescents with male staffs.* (Mira, female, IDI participant, 15 years)

> *It is difficult to show [genitals] when there is the presence of nurses [female staff]. The male HCP should be present there.* (Sam, male, IDI participant, 15 years)

HCPs noted that gender was a concern even when adolescents consulted the HCP for non-SRH related issues.

> *If female adolescents have any issue, they often don't tell me when I am in the clinic. They would tell it to my wife and then my wife would ask me what to do. I would then give the advice accordingly.* (Ram, male, HCP)

In addition to age and gender, adolescents spoke of the HCP's attitude as an important factor in their decision to access SRH services from AFHS. Unprofessional HCP attitudes especially have been previously documented as a significant characteristic affecting the utilization of SRH services by adolescents (3, 30). There were heated discussions in the focus groups when adolescents were asked about how HCPs treated them; they raised their voices when they spoke of the "condescending attitudes" of the HCPs which had often prevented them from visiting AFHS for SRH services. Speaking of his experiences, Indra angrily stated:

> *HF do not provide us with contraceptives such as condom when we are in need. Instead, they [HCP] show attitude, anger and speak to us harshly when we request condoms which makes it difficult for us to access SRH services.* (Indra, male, IDI participant, 19 years)

Like Indra, most of the unmarried adolescents who sought SRH services had had negative experiences. Maya, for example, a 16-year-old female adolescent, reported that "*HCPs would say contraceptive is of no use to unmarried adolescents and they should not use it before marriage."*

The following explanation from Ram clearly shows his hesitation to provide SRH services to unmarried adolescents. It is likely that such reluctance arises from deeply rooted sociocultural norms and beliefs around adolescent sexuality and sexual behavior which may lead HCPs to make moral judgements about those who engage in premarital sex.

> *There is some difference in how I deal with married and unmarried adolescents. If married adolescents come, I could easily provide counselling services and tell about contraceptives. But if unmarried adolescent comes, I would myself feel like why this adolescent has come here, and I wish this person would not use hormonal contraceptives as it might have side effects. I feel they should not use family planning before marriage.* (Ram, male, HCP)

Negative attitudes towards unmarried adolescents were expressed by both male and female HCPs, and as such are likely to prevent HCPs from promoting the SRH of unmarried adolescents. Moreover, judgmental attitudes will be a barrier to adolescents seeking help from HCPs who hold them.

> *Unmarried adolescents do not understand. They are young and have no idea of what could happen when they do this or that. They do so many things [sex] hiding from the parents* (Sara, female, HCP)

Sara's views are not surprising given that in Nepalese society, even now it remains unacceptable for unmarried adolescents to be sexually active. Sara's emphasizing that *"unmarried adolescents do not understand*," the way she spoke, and her facial expression all indicated her stern disapproval of adolescents' engaging in sexual activity.

The poor professional attitude of HCPs may partly be shaped by their misunderstanding what an "adolescent-friendly" health service means. Asked about the procedures and requirements of providing AFHS, their responses suggested a poor understanding of the AFHS concept. Yet all the HCPs interviewed had attended ASRH training provided by the Ministry of Health and Population and should, therefore, have specific knowledge about providing SRH services to adolescents.

Some HCPs did not know whether the AFHS was supposed to be an ongoing program or a one-time program, or if it was an NGO-supported program.

> *This program is lost for almost three years in our health facility. I do not know if it is a Government of Nepal program or it was supported by some NGO/INGO [temporary program]. Or if that particular NGO/INGO phased out. We are neither asked for any report nor are we providing it to the district.* (Sarala, female, HCP)

HCPs had received only an initial orientation to the program three years previously, and it is therefore likely that their poor understanding was due to the absence of any regular follow-up training or reporting since then.

Another contributor to poor HCP attitudes towards SRH services for adolescents could be the frequent transfer of HF staff. In Nepal, it is not unusual for HCPs working in one health facility to be transferred to another, either in the same district or another elsewhere in the country (31). When these transfers occur, formal handovers are not a usual practice and this can result in confusion about responsibilities for

ensuring adolescent-friendly health services at the new place of appointment. For example, HCP Shiva, already working in an AFHS, was transferred to another facility which was also an AFHS. One would assume in this case that the HCP would be aware of his role in providing SRH services to adolescents. However, as there was no handover, Shiva stated that he did not know if he should be accountable for AFHS in his new position. Interestingly, this situation seems to be peculiar to Nepal, where HCPs apparently feel that they need training in each new facility they go to, even when they already have the relevant training. In Shiva's case, the absence of further training at his new place of work meant that he was unsure of his responsibility for AFHS. Thus, these circumstances can affect how some HCPs might treat adolescents who come to seek SRH services.

Shortage of and overburdened HCPs

Shortage of staff in health facilities and overburdened HCPs impacts their capacity to provide SRH services to adolescents. Most of the HCPs noted that they were overtaxed with several responsibilities, including administrative work. Consequently, they had limited time to provide services to adolescents. One of the adolescents indicated that busy HCPs provided a hasty service which discouraged them from utilizing AFHS.

> *They are available every time I go there. However, they are normally very busy and do not have time to talk to us unless we are ill.* (Maya, female, 15 years)

In Nepal, the upgrading of sub-health post (1 paramedic) to health post (3 paramedics) has been operating since the fiscal year 2011-12. However, there is still a gap in the deputation of staff in an upgraded health facility (29). This may have resulted in staff working in the health facility being overburdened, since the health post has responsibilities additional to the sub-health post.

Lack of information on SRH

All participants spoke of the difficulty of talking about sex and sexual relations openly, a situation that affords adolescents very little opportunity to learn about SRH either at home or in education institutions. As school teacher Tek noted, *"Our culture, religion, and tradition do not allow talking openly about sex and sexual matters."*

Krishna, a male HCP, said that *"families are not habitual in talking about (sex),"* highlighting that, generally, *"the practice of sharing or talking about reproductive health in front of family or father or*

brother is absent in our society." These responses suggest the existence of a "culture of silence" on the topic of sexual and reproductive health.

Adolescents, too, noted how difficult it was for teachers to discuss SRH topics; when teachers focused on SRH they would skip or rush through some topics, providing little opportunity for discussion. This was also observed by health care providers, reflected in the following quote.

> *Whenever teachers had to teach about sexual health or bodily changes, they ask students to study themselves, and they would go out of the room*. (Nirmaya, female, KI)

Teachers found it even more difficult to teach SRH topics if they belonged to the same community as the adolescents, since there was the likelihood that "*one of the teacher's daughter, son or sister will be in the same class."*

The culture of silence surrounding SRH suggests not only poor health literacy in SRH topics, but also the high likelihood of these adolescents having poor knowledge of SRH services offered by AFHS.

Socio-cultural norms and attitudes towards adolescent SRH in the community

Throughout the interviews with adolescents, key informants and HCPs, as well as in FGDs with adolescents, a consistent and recurring theme involved the underlying socio-cultural norms and attitudes towards adolescents' sexual behavior. It is clear from our findings that prevailing norms are a major factor influencing adolescents' poor utilization of SRH services from AFHS. Any sexual behaviors, especially for an unmarried adolescent were considered to be "Kharab Bani" which literally means "bad behavior". Further, being sexually active was judged to be "BIKRITI" or a "bad influence" on other adolescents. *Kharab Bani* and *BIKRITI* are quite derogatory terms in Nepalese. Thus, such labels also reflect a code of morality that governs adolescent sexual behavior. Notions that adolescent sexual behavior is "bad" leads to the stigmatization or community rejection of unmarried adolescents.
What is interesting is that when participants spoke of *Kharab Bani* or *BIKRITT* they were mostly referring to female adolescents. Moreover, they spoke as though sexual behaviors were initiated by females, and then spread across society. This view of females reflects the gendered ideology of morality; this form of labelling is also a form of social control over female sexuality and sexual behavior (32).

> *It will be bad if their [female adolescents] character is wrong. For instance, if a girl has a sexual relationship and gets pregnant and could not get the baby aborted, her future will be ruined. Even if she tells about it to the boy whom she had a relation, he might not accept her, or it could be that she had a relationship with several boys.* (Lalit, male, KI)

Lalit's comment shows his concerns about an adolescent girl becoming pregnant, and the associated risks, if she engages in sexual activities. However, it also indicates the gendered attitudes inherent in Nepalese society. Lalit's suggesting that *"it could be that she had a relationship with several boys"* reveals the belief that female sexuality is responsible for what society deems *bad behavior*.

These deep-seated cultural and social norms and attitudes towards female adolescents' SRH can prevent them from accessing AFHS for fear of being labelled or socially stigmatized for being sexually active. Even male adolescents were afraid of bringing shame to their families if they visited AFHS for SRH care, as Raj, a 19-year-old male adolescent, makes explicit:

> *If I visit the health facility and if this information reaches from HCP to my villagers, then it is a matter of shyness in public. My parents will get embarrassed, and in total, if all society knows this information, they will make gossip*. (Raj, male, 19 years)

DISCUSSION

A clear moral framework around sexual behavior, especially if practiced by unmarried adolescents, is evident from our study. This framework is rooted in the prevalent morality relating to premarital sexual activity in Nepalese society, where it is considered unacceptable (33, 34). Foucault explains morality as a set of values or "rules of action" that people are expected to follow which are prescribed by various parties within a society (35). In our study, these parties included families, schools and religious institutions, as well as health facilities. HCPs such as Ram and Sara are clearly guided by the moral values they learnt through socialization within the Nepalese culture. The moral framework that seems to guide HCPs shapes how they deliver SRH services. This was especially apparent for older HCPs interviewed for our study. When a significant practitioner-adolescent age gap existed, it was difficult, particularly for older HCPs, to accept adolescents being sexually active. Thus, while HCP Ram found it easy to talk about contraceptives to married adolescents, he questioned why unmarried adolescents needed contraceptives.

One of the key themes to emerge was the idea that HCPs find it challenging to communicate and disseminate information on SRH to unmarried adolescents, especially if they live in the same community

as the adolescents. It was suggested that some HCPs are quick to judge unmarried adolescents, and that their attitudes were mirrored by how they treated adolescents who came to the facility. Indra and Maya related how the HCP was angry and shouted at them when they went to the health facility to get condoms; others spoke of being "lectured at" for seeking SRH services. It could be argued that displaying this kind of attitude is a form of "moral policing", making HCPs appear unfriendly or judgmental towards adolescents, or at least towards unmarried adolescents, or married adolescents wanting an abortion. When adolescents deviated from this moral framework, they were subject to disparaging labels such as *Kharab Bani* or *BIKRITI.* The purpose of such derogatory labelling is to suppress behaviors that deviate from the socially acceptable, as Bob Fine (36) has noted; in the current study, the behavior is the sexual activity of unmarried adolescents. However, what was more apparent from our findings is the gendered ideology that the labelling expresses. Female adolescents were found to be more vulnerable to the "bad behavior" label, even though their male counterparts are presumably equal partners in the behavior. From my own experience of growing up and working in Nepal, I am aware that this gendered ideology is commonly accepted. As in most South Asian societies (37), sexual behavior is a gendered phenomenon in Nepal, and sexual intercourse is predominantly socially sanctioned for females only within the boundary of marriage (38). Yuval-Davis (39), in her book *Gender and Nation*, argues that in many countries women are the bearers of honor in the family and community. In some countries, bringing dishonor has resulted in extreme consequences, such as the phenomenon of honor killings (40). While there is no empirical evidence of honor killings in Nepal, there has been some media attention on these kind of consequences occurring recently (41, 42). Connell (43) makes the point that premarital sex has few repercussions for men; rather, it is associated with men's position in a patriarchal society. Connell's statement is certainly true in the context of our study and made explicit in the application of the derogatory *BIKRITI* label solely to female adolescents. Patriarchal attitudes are certainly evident in Nepalese society when adolescent boys are not blamed or judged in the same manner as girls, and do not face the same consequences for engaging in premarital sex.

Within a society where premarital sexual activity is not socially sanctioned, for adolescents to access and use SRH facilities they must have some level of trust in the health care providers. But as the results of this study demonstrate, the perceived lack of privacy and confidentiality experienced by Nepalese adolescents leads to them being unable to trust the health care providers. Trust is identified as an essential element in

a successful provider-patient relationship (44); it is the element which determines adolescents' willingness to seek care and utilize health services (45, 46). Having trust in their local HCP is crucial for unmarried adolescents in a moral context where sexual behavior is not acceptable. Adolescents in this study feared the consequences of visiting the health facility for SRH services and having details of their consultation disclosed to their parents or other significant adults in their communities. The adolescents felt ashamed and fearful that their actions would bring shame to their families. Thus, their being able to trust HCPs to keep their visit and their information confidential, including not sharing it with another HCP, as reported by respondents in the study, is absolutely essential for adolescents if they are to utilize AFHS.

While our study shows how the built environment of the AFHS impacts the privacy of visitors, trust in HCPs goes beyond the physical facility. Literature suggests that inadequate HCP capacity building can result in negative attitudes towards adolescents SRH (30, 47). To examine their own values and address their communication skills, training for HCPs needs to be experiential and immersive, so that they do not impose their personal moral framework on their provision of adolescent SRH services (48). Value clarification has been successfully applied to reduce HIV stigma (49), and improve medical abortion care (48, 50, 51).

LIMITATIONS

This study has two key limitations. We chose six AFHS that were in geographically accessible locations of Nepal. This was due to the time and resource constraints of the study. However, choosing only those facilities within easy reach means that the barriers to SRH services faced by adolescents living in more remote locations are not adequately reflected in this study. Their challenges are likely to be different to those of adolescents living in the catchment areas of the six selected research sites. Further, we selected participants from the ethnic groups represented in each district, and these included Brahmins, Chhetries, Tamang, Newar and Chepangs (Chepangs are one of the highly marginalized indigenous groups in Nepal). These groups are all Hindu castes (In Nepal, caste is used traditionally for social stratification. More recently, caste has become accepted as a more generic term to represent the identity of an ethnic group), and our study did not include participants from Muslim or Christian minorities. The availability of those groups at our study sites might have provided additional information to our study. Despite these limitations, the study has various strengths. Using creative methods of data collection such as vignettes

and drawings elicited rich information, helping us to gain an in-depth understanding of the experiences of adolescents seeking SRH services. The primary researcher was known to and trusted by the health care providers and the Nepalese community in general. This enabled the researchers to build rapport and trust among study participants, which strengthens the trustworthiness and credibility of the data collected.

CONCLUSION

AFHS may conceptually be the ideal way to provide SRH services to adolescents. As this study has shown, however, the implementation of AFHS needs to be revisited within the context of Nepal, particularly from the point of questioning what "adolescent-friendly" means within the Nepalese context. While WHO guidelines place much emphasis on the physical structure of AFHS, geographical location, cost of services to adolescents, and ready availability of supplies, this study has raised the question of how "friendly" these facilities are for adolescents in a society which views adolescent sexual behavior through a moral lens. Services provided can be physically accessible and affordable to adolescents, but unless sociocultural attitudes towards adolescent sexual behavior change, these health facilities cannot be truly adolescent-friendly. Thus, there is a need to address not only the 'hardware" of these facilities, but also the "software". Software in this sense includes building the capacity of health care providers to set aside their own perceptions of morality to meet the needs of adolescents in a friendly and non-judgmental manner that assures adolescents of their trustworthiness. At the same time, it is essential to involve whole communities and policy makers in raising awareness of gender ideology and the prevailing moral framework around adolescent sexual behavior.

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Appendix B.2 Abstract for oral presentation made in International Sociological Association (ISA) Research Committees RC06 (Family) and RC41 (Population) Conference 2018 with the theme "changing Demography- Changing Families", 17-19 May 2018, Singapore

International Sociological Association

Changing Demography Changing Families

Singapore

17-19 May 2018

Title: Exploring community perception and attitudes towards adolescent-friendly health program in Nepal

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Paper relevant to sub theme: Sexuality and Reproductive health

Abstract

Objective: In Nepal, 30% of adolescent females are sexually active, however, only one-third uses any contraceptive method. Almost 17% of adolescents 15-19 years are already pregnant or mother, where rural adolescents start childbearing even earlier. In 2010, the Government of Nepal introduced adolescent-friendly health services (AFHS) with the aim of increasing sexual and reproductive health service utilisation by adolescents and decrease early pregnancy. While awareness about the availability of AFHS is high, service utilisation is poor at 10%. However, the reasons why utilisation is suboptimal are unknown. This study aimed to explore the community perceptions and attitudes towards AFHS that might have impact on poor health service utilisation by adolescents.

Method: In-depth interviews with 13 key informants from community such as parents, religious leaders, and school teachers were undertaken. All the interviews were tape-recorded and transcribed verbatim. Thematic analysis was used to analyse the data collected.

Results:There were varying views about the AFHS. For example, participants were positive towards the provision of these services for young people. However they preferred that the services discourage sexual activities. It was postulated that increased access to services and information from AFHS increases promiscuity among young people. However, they did acknowledge that the availability of family planning devices including condoms reduces the burden from STI and HIV/AIDS. In contrary, this had equally contributed in early sex which is socially not acceptable practices, and parents are held responsible for young people's sexual behaviour.

Conclusion: Community perception is deeply rooted in practices which are culturally and socially defined and inherited from generation in Nepali society, which had challenged the change in favour of young people in accessing the AFHS. Community perception and attitude require transformation from current social and cultural practices to sex positivity gradually with time and innovative approach that can be accounted through engagement of community.

Appendix B.3 Abstract for oral presentation made in Research for Development Impact (RDI) Conference, Partnering for Impact on Sustainable Development, 13-14 June 2017, University of Sydney, Australia

Research for Development Impact (RDI) Conference 2017

Partnering for Impact on Sustainable Development

University of Sydney

13-14 June 2017

Title: Utilisation of adolescent-friendly sexual and reproductive health services in Nepal

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Abstract

Background*:* In Nepal, 30% of adolescent females are sexually active, while only one-third of them uses any method of contraception, and unmet need for contraception is 42%. The government of Nepal introduced adolescent-friendly health services (AFHS) as per WHO framework in public health facilities aiming to increase health service utilisation by adolescents. The awareness of AFHS service availability stands 94% whereas; service utilisation is poor 10%. Little is known about the reasons of poor utilisation. Thus, this research will contribute to the understanding of the poor utilisation of SRH services in adolescents.

Method*:* Adolescent health service utilisation data for the period 2015 to 2016 collected from 26 AFHS, and a standard health facility observation tool used to assess compliance with National Standards of AFHS. 12 health workers interviewed to understand attitude and practices towards delivering health services to adolescents, 12 interviews and six focus group discussions with adolescents to understand perception and attitude of AFHS. Descriptive analysis was undertaken together with a scoring system, and thematic analysis used to analyse the qualitative data.

Results: Among 26 health facilities, five scored >70% compliance with standards of AFHS, but service utilisation remain minimal change with <8%. Preliminary analysis of the health worker interviews suggests a longevity of deputation to same health facility enhances health worker capacity to deliver AFHS. Adolescent interviews suggest a lack of confidentiality and poor sensitivity of health workers to SRH services. These preliminary findings suggest the importance of the capacity of health workers to deliver AFHS services.