FACTORS INFLUENCING ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENTS IN NEPAL

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52nd Master of Public Health/International Course in Health Development
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A thesis submitted in partial fulfilment of the requirement for the degree of
Master of Public Health
By
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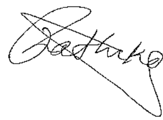
Declaration:
This thesis is a presentation of my original research work. Wherever contributions of others are involved, every effort is made to indicate this clearly with due reference to the mentioned sources i.e. print, Internet, and etc; and acknowledgement of collaborative discussions as per the requirements with respective department.

The thesis **Factors Influencing Access to Sexual and Reproductive Health Services Adolescents in Nepal** is my own work.



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LIST OF ABBREVIATIONS

SRH: Sexual and Reproductive Health
HW: Health Worker
VDC: Village Development Committee
GBV: Gender Based Violence
GDP: Gross Domestic Product
MoHP: Ministry of Health and Population
DoHS: Development of Health Services
PHCC: Primary Health Care Centre
MDG: Millennium Development Goal
NDHS: National Demographic Health Survey
FP: Family Panning
IUCD: Intra Uterine Contraceptive Device
ICPD: International Conference on Population and Development
SLC: School Leaving Certificate
STIs: Sexually Transmitted Infections
MoE: Ministry of Education
HIV: Human Immune Deficiency Virus
AIDS: Acquired Immune Deficiency Syndrome
SEM: Socio-Ecological Model
ART: Ante Retro Therapy
ANC: Ante natal check up
EDR: Eastern Development Region
CDR: Central Development Region
WDR: Western Development Region
MWDR: Mid-Western Development Region
FWDR: Far Western Development Region
NGOs: Non Government Region
INGOs: International Non Government Region
UNICEF: United Nations Children's Fund
AFS: Adolescent Friendly Services
FGD: Focus Group Discussion
WHO: World Health Organization
NHRC: National Health Research Council
PDQ-Y: Partnership Defined Quality for Youth
QID: Quality Improvement Team
BCC: Behaviour Change and Communication
YFS: Youth friendly Services
AYA: African Youth Alliance
AFS: Adolescents Friendly Services
RH: Reproductive Health

GLOSSARY

Adolescent: "World Health Organization (WHO) identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19 years"(1).

Youth: 15-24 years are defined as youth by WHO (2).

Sexual and Reproductive Health (SRH): "Sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so" (3). Major sexual and reproductive health services are comprehensive sex education, contraceptive, antenatal care, safe delivery, HIV&STIs, abortion care and other reproductive illnesses (3)

Comprehensive Sex Education: "To equip young people with the knowledge, skills, attitudes and values they need to determine and entry their sexuality-physically and emotionally, individually and in relationship" (4)**.**

Unsafe Abortion: "Unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both"(5).

Modern Contraceptive: "Modern contraceptive methods were invented so couples could act on natural impulses and desires with diminished risks of pregnancy. Modern contraceptive refers technological advances designed to overcome biology" (6). Modern contraceptives are Intrauterine contraceptive devices, oral pills, injectable, pills etc.

ABSTRACT

Background: Certain cultural restrictions and societal pressure affect the adolescents in Nepal from having qualitative services that could improve their SRH. Therefore, this study was conducted to search and identify the factors that are influencing the adolescents from accessing SRH services.
Objectives: The main aim of this study is to assess the factors that influence adolescents' access to SRH services, and to identify better SRH approach models..
Methodology: Literature review of the articles, reports and documents were used during the thesis writing. Modified and adapted socio-ecological model was used to explore the factors influencing access to SRH services.
Findings: Access to SRH is low among adolescents in Nepal. Limited knowledge, misconception of SRH among adolescents, reluctance of teachers, parents and health workers (HW), strong cultural norms, incompetent HWs and teachers, inadequate curriculum and late initiation of sex education and lack of friendly Adolescents Friendly SRH services are some of the key factors closely interlinked to affect access to SRH services.
Conclusion: Despite the effort from the Government of Nepal and NGOs, access to SRH can be improved through multi-level approach that addresses adolescents' knowledge by a new comprehensive curriculum, media and developing an enabled environment such as well-trained teachers, HWs, friendly (health) services and support from parents and community.
Recommendations: The major recommendations of this study is provision of adolescent friendly (health) services, training to the teachers and HWs, curriculum development and start sex education early for adolescents, mass media and peer education programs.

Key Words: Adolescent, Sexual and Reproductive Health, Access and Nepal.
Word Count: 10,259

INTRODUCTION AND ORGANIZATION OF THESIS

The adolescents, in Nepal, comprises of 23 percent of the total population. It has been reported through various studies that majority of adolescents experience various SRH related issues and challenges because of socio-cultural and traditional harmful practices that occur in the families and communities; inadequate resources, and lack of expertise to design, implement, monitor and evaluate a friendly, comprehensive sexual health services for the adolescents. Although, the Government of Nepal along with private sector are providing various SRH services through health facilities, unfortunately, the adolescents do not have adequate access to qualitative, comprehensive sexual and reproductive health services. Therefore, this study has been carried out to shed the major barriers that are hindering the adolescents from receiving SRH services.

I have been working in the field related to sexual and reproductive health and HIV & AIDS for almost 15 years with several INGOs and UNDP. In this span of time, I got an opportunity to work on SRH issues in the remote as well as in the urban areas of Nepal. Over the years, this field of work has garnered into me much passion leading me to grow professionally in SRH areas so I could contribute and support adolescents to access comprehensive sex education and services. I also dream to write guidelines and make a documentary related to SRH issues. In order to achieve my professional goal in terms of SRH issues, I need to learn and get acquainted with SRH concerns in depth. That is why I have chosen "Factors Influencing Access to Sexual and Reproductive Services among Adolescents in Nepal" as my thesis topic.

This thesis will explore various influencing factors and barriers adolescents find while trying to access SRH services in Nepal. Evidence based national and international SRH best practices will also be identified in this thesis to provide the best reference to replicate successful SRH project model.

The recommendation section in this thesis will provide support to SRH policy makers, planners and implementers to strengthen a friendly SRH services for adolescents in Nepal.

Organization of Thesis

Chapter One of this thesis briefly describes the background of Nepal such as country profile, socio, cultural and religious dimensions, health system and its situation. **Chapter Two** begins with a statement on sexual and reproductive health issues faced by Nepalese adolescents then it focuses onto the objective, methodology and conceptual framework. **Chapter Three** explains the major findings of factors influencing the sexual and reproductive health in Nepal for adolescents by following five major dimensions of Socio-Ecological Model—individual factor, interpersonal factors, institutional and organizational factors, community factors and public policies. **Chapter Four** introduces national and international best SRH programs to strengthen adolescents' friendly SRH program in Nepal. **Chapter Five** is the platform for discussion on all findings then it is followed with a conclusion with specific recommendations.

CHAPTER 1- BACKGROUND INFORMATION OF NEPAL

1.1 Country Profile

Nepal is a small, natural and beautiful country in Southeast Asia with an area of 147,181 square kilometres. Geographically, Nepal is divided into three ecological zones – Mountains with 7% of Nepal's population, Hill with 43% population and Terai (plain fertile area) with 50% of total population. For organizational purposes, The Government of Nepal has divided Nepal in five Development Regions – Eastern, Central, Western, Mid-Western and Far-Western Development Regions as shown in Figure 1. Similarly, this country has 14 Zones, 75 Districts, 3,915 Village Development Committees (VDCs) and 58 Municipalities (7).

Figure 1: Map of Nepal

Source: https://www.google.com.np/search?q=map+of+nepal+with+development+region

According to Nepal census survey 2011, the total population of Nepal was estimated at 26.6 million and population growth rate is 1.35% per annum (8). 82.9% of Nepalese live in rural areas and 17.1% reside in urban areas. In Nepal, female population is higher (51.1%) than male population (48.5%) (9). The highest number of Nepalese population lies between 15 and 60 years age which is adult population then under 15 age group which consist 39.3% and least number of people are over 60 years with 6.7%.The life expectancy of Nepalese at birth is 66.7 years (9).

1.2 Socio-Cultural, Religious Norms and Gender Roles

Nepal is a multi-cultural country representing a diversity of religion, ethnicity and caste. This nation is a home to 125 ethnic groups and 123 local languages are spoken as the mother tongue. Even though Nepali is the official language, several local languages are also commonly spoken in the Nepalese community. Hinduism is the main religion at 81.3 percent, followed by Buddhism, Islam, Christianity and Kirat at 9 percent, 4.4 percent, 3.1 percent and 1.4 percent respectively (7). Among the rural and illiterate communities in Nepal, people follow and practice patriarchal system (10). In a given Nepali society, family defines the gender role in relation to ethnic group, caste, education, religion and socio-economic status. In other words, women do not have the right to make decision in a family even if it's for their personal matters such as use of contraceptives, health check-ups or visit to friends (10).

Out of 187 countries, Nepal stands at 98th position in Gender Inequality Index. There are several traditional harmful practices prevalent in societies that create direct negative impact on girls' and women's health and life. Some of the vicious practices are: preference of son child; stigmatization for single women and widow and early marriage. Gender Based Violence (GBV) is reported frequently in Nepal especially for rape, physical, emotional and sexual violence. Nepal is committed to end GBV and inequality. Therefore, this nation is signatory to 23 treaties and International Human Rights instruments. Nepal has also developed progressive policy, strategy and laws to minimize GBV but the implementation of these documents into practice is a huge challenge (10).

1.3 Economy

Nepal is one of the least developing countries in the world. According to the Nepal Living Standard Survey in 2011 one fourth of Nepalese live under the poverty line (11). In the year 2015, Gross Domestic Product (GDP) of Nepal was estimated at US $19.77 billion with per capita of US $426.48

(12). In 2014, the growth rate of GDP was at 5.1 percent; however, this rate dropped to 3 percent in 2015 due to The Great Earthquake in April, 2015 (9). Agriculture is the main source of economy where nearly 76 percent of households are engaged in this sector and contributes 33 percent of total GDP. Another key source of income is remittance; 56 percent of households receive some number of remittances (9) (11).

1.4 Education

The average literacy rate in Nepal is 77 percent whereby 87 percent of men and 67 percent of women are literate. People in urban areas (89 percent) are more literate compared to their rural compatriots (74 percent) (7). It was also discovered that female from well economical background (79 percent) fared higher in terms of education when compared to female representing poor economical background (45 percent) (7).

1.5 Health System

The Ministry of Health and Population (MoHP) is the major responsible body to formulate health policy in Nepal. One of the major function of MoHP is to provide required support and conduct supportive supervision of Department of Health Services (DoHS) which is responsible to carry out preventive, promotive, diagnostic and curative health services in Nepal through six division namely, Management division, Child Health division, Family health Division, Logistic Management Division, Epidemiology and disease Control division and primary health care revitalization division (Annex 1) (13)(14). Existing national health policy of Nepal was implemented in 1991 and this policy has given outmost priority to provide Primary Health Care (PHC) as a basic health package to all Nepalese people (15).

Department of Health Services has structured its health services for the people at national, regional, zonal, district and community level. Health post (HP) is the first contact point for patient to receive primary health care services (PHC) and female community health workers (FCHVs) is key person to refer cases in health post. Then referral network with in government health structure goes from health post to primary

health post, primary health post to district hospital, district hospital to zonal hospital at regional level and final referral place is tertiary level hospitals. Majority of tertiary health facilities are in capital city (Kathmandu) of Nepal in central developmental region (16). Nepal has allocated 5.89% of budget to invest in health sector of Nepal in fiscal year 2013/2014. Non Governmental organizations, civil society, private sectors are also contributing to provide health services in Nepal with collaboration of Government of Nepal (14).

1.6 Health Situation

Nepal has made good a progress in Millennium Development Goal (MDG) of Maternal and Child Mortality Rate (MMR and CMR). From 1990 to 2013, the Maternal Mortality Rate of Nepal has declined from 539 per 100,000 live births to 170 (17). Infant Mortality Rate has also decreased from 61 per 1000 live birth to 33 and for children under five years of age the mortality dropped to 39 per 1000 live births from 91 between 2001 and 2011 (18) (19). According to National Demographic Health Survey (NDHS) 2011, knowledge of family planning (FP) is universal among 15-49 years of women in Nepal (18). Fertility of Nepal is 2.6 births per women (7). Apart from this progressing result, Nepal also faces an enormous challenge ahead to control and deal with some health issues. For instance, malnutrition, outbreak of communicable disease, lower rate of contraceptive use and unsafe abortion, health hazards during the post disaster period (20).

Nepal is a signatory of ICPD 1994 and this nation is strongly committed to provide adolescents and youth friendly sexual and reproductive health services. National Adolescents' Health Guide lines were formulated in Nepal in the year 2000. And the National Adolescents Sexual and Reproductive Health Guideline were developed in 2007. First Adolescent Sexual and Reproductive Health Program were developed in 2008 in Nepal which was piloted in 23 health facilities. Nepal Heath Plan 2011-2015 has launch 1000 youth friendly facilities by 2015. Contraceptive services like

condoms, oral contraceptive pills and Intra Uterine Contraceptive Devices (IUCD) distribution is free from government health facilities (21).

CHAPTER 2: PROBLEM STATEMENT, JUSTIFICATION, OBJECTIVES AND METHODOLOGY

2.1 Problem Statement & Justification

Adolescents all over the world face remarkable challenges to fulfil their sexual and reproductive health needs and rights. Insufficient access to Sexual and Reproductive Health (SRH) education and services leads to lack of knowledge about sexuality, puberty and reproductive rights which may results to serious problems among adolescents' sexual and reproductive health. According to World Bank Group, Key adolescents issues are adolescent's marriage, low use of family planning and contraceptive, adolescent child bearing, gender based violence, unsafe multiple sexual intercourses, STIs and HIV and unsafe abortion. Female adolescents are more vulnerable to get SRH related problems in compare to male adolescents (22). In Nepal, 23 percent of total population is adolescents (10-19 years) and 33 percent of young people belong to 10-24 years(19). Nepalese adolescents are facing these SRH challenges problems in their life (34).

In a traditional Nepali society, culture plays a very strong role by promoting early marriage especially for female counterparts as the society wants to promote sexual relationship within the marital boundary. According to National Demographic Health Survey report the median age for first marriage of female is 17.5 years and for male is 21.6 year (19). Complication of early pregnancy and childbirth is the one of the leading cause of High Maternal Mortality among girls 15-19 years worldwide (23).Discussion on sexuality related topics is a taboo in Nepal. There are very strong traditional beliefs which discourage adolescents to talk on SRH issues in their family, community and school (24).

In Nepal, the society expects child birth immediately after marriage thus Nepalese girls experience motherhood early although they are not emotionally, physically and mentally prepared (24) (2).The fertility rate of the adolescent in Nepal is 87 births per 1000 women aged 15-19 years which is also one of the higher rate among

the South Asian Countries (7). The adolescent girls in Nepal get pregnant without having sufficient knowledge about contraceptives use. 35 percent of adolescent girls drop out from the school because of early marriage and early pregnancy. This has created a long term negative impact in the life of an adolescent, their community and for nation (25). Adolescents also like to discuss about their sexuality with peers but only 16 percent of lower and higher school run peer education program to provide sexuality education in Nepal (14).

Adolescents understand the issues of sexuality from society's norms and from their own experience during premarital sex, pregnancy and married life rather than from school textbook, discussion and interaction among teachers and parents(24) . There are also limited sessions on adolescent's sexual and reproductive health in school curriculum. Therefore, adolescents are unable to receive complete information about their physiological, psychological and emotional changes that occur during puberty. For instance, menstruation is normal physiological change even though teenage girls often get upset, feel stress and get mentally disturbed during menstruation due to misconceptions about menstruation, lack of fact information and supportive environment at home and school. These misconception and unsupportive environment may discourage them to go school for study (26). Similarly, *"Chhaupadi"* is still a common practice in many societies in Nepal where women and girls are kept in isolated places (usually in cowsheds), far from their family and friends (especially male) during menstruation period. Rape, physical violence and other form GBV has reported during their stay in isolated places (10).
In spite of these societal traditional obstacles, several studies have also presented that premarital sexual is prevalent among adolescents in Nepal. A study carried out among college students in Kathmandu presented that about 40 percent of young unmarried men have experienced of pre-marital sex (27). Another

study conducted with 66 young factory workers in Kathmandu shows 38 percent of unmarried boys and 18 percent of unmarried girls have experienced sex (28). When adolescents and young people involve in unprotected sex it may caused Sexually Transmitted Infections (STIs), Human Immune Deficiency Virus (HIV) infection, unintended pregnancy and unsafe abortion. For instance, a study carried out between children and youth in Kathmandu valley found out that nearly 7.6 percent of HIV is prevalent among the adolescents and youth group (29). In 2015,among the adult age group ranging from 15-49 years 0.20 percent HIV prevalence was found, however 14.7 percent of new HIV infections were reported among 15-24 years age group (30).

Sexual and Reproductive Health Services like STIs and HIV counselling peer education to understand puberty changes, emergency contraceptive use, safe abortion and management of GBV utilization remains low among adolescents in Nepal. For instance, one study conducted in Bhaktapur, one of the urban districts in Nepal, showed that 9.2 percent of adolescents representing Higher Secondary School utilized SRH services and this service utilization was lower when it came to female adolescents (4.35 percent)(31). Majority of unmarried boys and girls feel hesitation to carry and buy condom from health facilities because they don't trust health professional that health professionals can keep their confidentiality. Adolescents also feel embarrassment to talk with shopkeepers, doctors and nurses in health clinics (27).

Use of modern contraceptives is only 14 percent among adolescent girls. Unmet need for Family planning among married female between 15 and 19 years is 42 percent(7). Another survey conducted among adolescents boys reported that 22 percent of boys interviewed had an experience of premarital sexual intercourse. However, only two third of them used condom during sexual intercourse(32). Self reported STIs and symptoms are also low among adolescents (22)(19). Safe abortion has been legalized in Nepal but only 15.3% of safe abortion services users in Nepal

were adolescents and safe abortion rate is very low in rural part of Nepal (14).Adolescents avoid legal and safe abortion services of authorize health facilities because only 45 percent of women know that abortion is legal in Nepal. Negative and judgmental attitude of health care providers towards abortion service especially for unmarried adolescents' girls is another key cause that make adolescents not to prefer health institute for safe abortion (33).

The Government of Nepal recognized adolescents as a vulnerable population to whom SRH services are most necessary. Nepal is also a signatory of 1994 International Conference on Population and Development Program. Hence, Nepal Government is committed to increase the SRH knowledge among adolescents and promote SRH services for adolescents in a friendly environment through public private partnerships. The health services from the government and non-governmental organizations including bilateral and multilateral development partners and UN agencies are engaged in providing SRH services although the universal coverage of comprehensive SRH services is relatively low and less adolescent friendly. Therefore, adolescents are struggling with many sexual and reproductive health related problems in Nepal (34). In order to help the adolescents to increase their SRH knowledge and access them to its services, there's a greater need to understand the factors that influence and affect the comprehensive sexual and reproductive health education and those obstacles that are in the periphery making the adolescents not to use the available SRH services.

Some studies were carried out on SRH issues in Nepal but these studies are not sufficient to understand specific information on the factors that influence access to and utilization of SRH services among adolescents. This study aims to find out the various specific factors which play a vital role in accessing SRH services among the adolescents in Nepal. The findings of this study aim to guide SRH policy makers, program planners and stakeholders to understand the key influencing factors of SRH education and services among

adolescents in Nepal and support them to design and implement a friendly SRH education and services to the adolescents. Ultimately, this will support adolescents to maintain a good SRH by empowering them to be in control of their sexuality and reducing puberty related mental tensions, early pregnancy, unwanted pregnancy, and unsafe abortion, STIs and HIV and GBV.

2.2. Objectives

General Objective

The aim of this study is to analyze the factors that influence adolescent's access to Sexual and Reproductive Health Services and to identify the national and international interventions that have been effective in improving access to SRH services among adolescents in Nepal.

Specific Objectives

- To identify and analyze factors influencing adolescent's use of SRH services
- To review and critically analyze evidence from national and international programs that has been effective in improving access to SRH services
- To make recommendations to Ministry of Health and Population, Ministry of Education and other stakeholders to revise policy and strategies and strengthen interventions addressing SRH of adolescents.

2.3 Research Methodology

This is an exploratory study based on literature review of both published and unpublished articles. The major search databases were Google scholar, PubMed, and Google. Google was used to search for the sources like WHO, UNICEF, Save the Children, NDHS, Ministry of Health and Population Nepal, Ministry of Education Nepal, National Centre for AIDS and STDs Control Nepal, Marie Stopes International Nepal, Department of Health Services Nepal etc. Google scholar and PubMed were used to find the relevant articles for this study. Then the relevant articles were screened by going through the abstract and relevant articles were studied in detail. The relevant articles which full access was not obtained were extracted going through VU-e library. Bibliographies of relevant

articles were also used as mean to search for other related articles. Key words used for the review are listed in table below:

Table 1: Search Table

Objectives	**Sources**	**Key words**
Objective 1	PubMed Google scholar Websites of Ministry of Health, Ministry of Education, National Centre for AIDS and STD Control, Family Health Division, Nepal Demographic Health Survey, Department of Health Service, Central Bureau of Statistics, WHO, Guttermacher Institute	Adolescents, access, Sexual and reproductive health, service utilization, young people, factors influencing access, barriers of SRH, knowledge, attitude and perception of adolescents on access, peer influence, parent communication, cultural norms, national policies of SRH, adolescent friendly services, Nepal
Objective 2	PubMed Google scholar VU e-library	Evidence based intervention, promotion of SRH services, best practices SRH.

2.4. Limitations of the Study

All information in this study was collected from existing literature. There were limited peer reviewed journal articles and studies on SRH of adolescents in Nepal.

2.5. Conceptual Framework

To understand the factors affecting comprehensive sexual and reproductive health education and services, Social Ecological Model (SEM) developed by Kenneth, McLeroy, and Bibeau et.al 1988 (35) was used. Anderson and Newman framework for health service utilization(36) was also reviewed to explore the factors. Both the model have similar factors whereas it was found out that Anderson model is more skewed towards individual and family as a major influential factors and little attention was given towards the social factors and the laws and policies which could be very important factors that could affect the access to SRH services.

The SEM is more comprehensive as it consists of factors from individual level to the environment and also includes the policies and laws. It helps to find the intertwined relationship between various levels. The model addresses the complexities and interdependence between the environments, policies incorporating social and psychological influence on the behaviour (37). Similarly, the flexibility of the model also helps to find the higher level factors. Hence, because of the comprehensive and flexible nature, the SEM is selected over other models. The model explicitly considers multiple level of influence which provides guidance to the development of comprehensive interventions (37). Thus, as this thesis explores the influencing factors and also attempts to identify the best possible interventions to improve access to SRH services by adolescents, the model is best suited in this study. Socio-ecological model is widely used in other studies as well. It was used by Belinda et.al to explore the barriers of accessing SRH and services among couples living with HIV in Malawi (38).

There are various version of socio-ecological model, according to the purpose of the study a

modified version of SEM originally designed by McLeory et.al was used which includes five level factors described as below:

The Individual Factors: This factor includes individual characteristics that influence health seeking behaviour like individual knowledge, attitude, education and marital status.

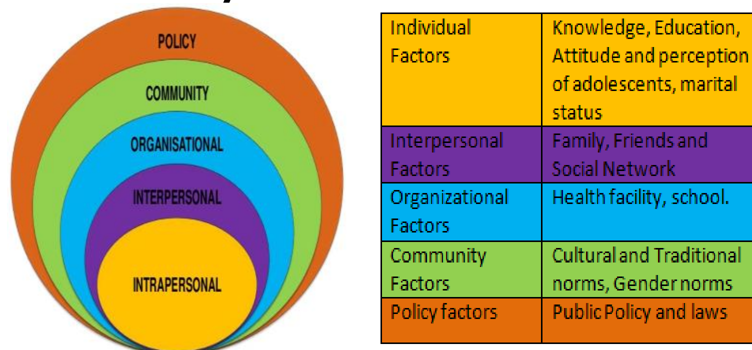
The Interpersonal Factors: In this level, formal and informal social groups like family, friends and peers which provide support are included.

The Institutional and organizational Factors: This factor includes rules, regulation, policies and structure of community organizations which constrains or promotes the behaviour of adolescents in terms of accessing SRH services.

The Community Factor: These are the informal networks like community norms and traditions on SRH which influence the access to services

The Public Policies: This includes the national laws and policies that regulates or support the healthy practices of SRH among adolescents (39)(35).

Figure 2: The Socio Ecological Model adapted from Mcleory et.al



Individual Factors	Knowledge, Education, Attitude and perception of adolescents, marital status
Interpersonal Factors	Family, Friends and Social Network
Organizational Factors	Health facility, school.
Community Factors	Cultural and Traditional norms, Gender norms
Policy factors	Public Policy and laws

CHAPTER 3: DESCRIPTION OF FACTORS INFLUENCING ACCESS TO SRH SERVICES AMONG ADOLESCENTS

The chapter explores and describes the factors influencing access to SRH services among adolescents in Nepal which is in line with the conceptual framework described above and discusses the effect on the access of various sexual and reproductive health components as an outcome of conceptual framework.

3.1 Current situation on the access of various components of Sexual and Reproductive Health in Nepal

Availability, accessibility and utilization of sexual and reproductive health services among adolescents are poor in Nepal. There are disparities in access and resource allocation within 75 districts of Nepal due to geographic difficulties, poor infrastructure in health system structure, resource constraints, gender relations, cultural traditions, stigma, high turnover of health trained workforce (40). A descriptive study conducted among 15-19 years students describes limited sexual and reproductive health services utilization among adolescents in Nepal. It shows only 9.2 percent of students utilize sexual and reproductive health services and among this 4.3 percent of SRH service is utilized by female and 12.5 percent was by male students (31).

Not enough specific literature was found to figure out the information regarding utilization of HIV and STIs counselling and treatment services among Nepalese adolescents. Whereas one survey carried out in four districts presents that adolescents who visited health facilities sought counselling sessions on sexual and reproductive related issues and concerns (41). Similarly, there is no specific data to identify the number of adolescents under Anti-Retro Viral Therapy (ART) but 10,407 people were under ART in 2014 and 92 percent of this treatment people were between 15-49 years of age (42). On maternal health, adolescents' aged pregnant women are not fully aware of the importance of all four ante-natal checks up in pregnancy period. For instance, 19.7 percent were pregnant adolescent women who

visited for first antenatal check up (within the first 3 months of pregnancy) out of all first antenatal checkups in 2015. This proportion dropped to 16.7 percent for fourth ante-natal checkups (15). In 2014/2015, 78,611 women used safe abortion services and 15.3 percent (12,030) of them were adolescents. The highest proportion (26.4%) of safe abortion service adolescents users were from in Mid-Western Development Region and lowest proportion of abortion service users were in Far Western Development Region with 8.7 percent as shown in table 2. Statistical information on utilization of safe abortion service among adolescents shows variation and this might have happened because of social stigma and sensitive issues related to that of family and society, availability of safe abortion services in long distance though abortion is legalized in Nepal (21)(43). Far Western Development Region is the most rural part of the Nepal and there is a great difficulty in accessing safe abortion services because this service is only available in district hospitals and people need to walk 7-8 hours to reach to the district hospitals. Turnover of trained health workforce is also high in rural health facilities of Nepal and this factor also influences among adolescents to get abortion friendly services in health facilities (15)(21)(43) (44).

Table 2: Proportion of safe abortion services used by the adolescents in areas where safe abortion services are provided

Indicator	National	Regions				
		EDR	CDR	WDR	MWDR	FWDR
Total safe abortion service users	**78,611**	**-**	**-**	**-**	**-**	**-**
Proportion of adolescents' safe abortion service users	**15.3%** **12,030**	**12.1%** **(1848)**	**18.2%** **(4825)**	**12.6%** **(2617)**	**26.4%** **(2007)**	**8.7%** **(733)**

Source: Annual Report 2014/2015 (15)

According to the National Adolescents and Youth Survey 2011, knowledge on condom is universal and condom is the most common method of contraceptive in practice among female adolescents (19). This survey also described about the variance of knowledge level among adolescents on contraceptive based on urban and rural communities, ecological region and aged group. For example, the proportion of knowledge level of emergency contraceptive among urban adolescents male is 28.2 percent and this knowledge level found 18.11 percent among rural male adolescents. Similarly, adolescents girls aged group 16-19 years are more aware of contraceptives than girls between 14 and 15 years. Likewise, 85 percent of adolescents who are in between 16 to 19 years are aware that oral pills is a means of contraceptive, however, this awareness level was found among 62 percent of girls aged 14-15 years (45).

3.2 Factors influencing SRH services:

3.2.1 Individual Factors:

Knowledge:

Studies done in Nepal shows that adolescent have a remarkable unmet need of comprehensive SRH knowledge and services. Although awareness

regarding HIV and STIs is high but comprehensive knowledge regarding HIV prevention is very low, less than one third of adolescents have comprehensive knowledge, girls are more aware than the boys. Likewise, comprehensive knowledge of Family planning and pregnancy is also low and adolescents have lot of misperception (46). A qualitative study done on the rural and urban areas of Kathmandu and Chitwan district reported that the rural youths have poor sexual health knowledge resulting in low service utilization and at the same time involvement in unsafe sexual practices (27).

> In a qualitative study, an unmarried school dropout male from rural area aged 18 years reported that "I cannot remember when I did it first time (laughs). When I shared it with my friends, they told me that I might have AIDS. I had heard of some advertisements; so, I was not serious about it, although I was very scared at that time" (27).

However, in Nepal almost all adolescents are aware about at least one method of contraceptive. Whereas, it was found that adolescents do not always convert knowledge into practice as the prevalence rate for contraceptive was only 14.4 percent among the currently married adolescents in 2011 (7). According to NDHS 2011 around 60 percent of the adolescents between 15-19 years did not know about the safe abortion services. Hence, it shows that the knowledge regarding SRH is low and not comprehensive, and it has a significant effect in regards to the access to services.

Education:

Evidence from various studies suggests that education among adolescents have a multiplier effect on adolescent's sexual and reproductive behaviour including safer sexual practices (47). In Nepal, sex education and some parts of reproductive health are first introduced at secondary level (48). Whereas, only 16.5 percent of female and 20.8 percent of male between the

age group of 15-19 years have completed secondary level education (7).

It was found that education have positive impact on the access and utilization of SRHR services. In a study conducted among adolescents girls in Nepal, it was found that the proportion of adolescent girls seeking treatment for sexual and reproductive health problems is the lowest among primary level education and with the increase in level of education, the proportion of seeking treatment increases steadily (47). Likewise, 53.7 percent of young men between 15-24 years with education of School Leaving Certificate (SLC) and above use condom in comparison to 5.3 percent with no education. Similarly, fertility is also inversely proportional to the education level of adolescent which is 3.7 births among adolescent with no education whereas it is only 1.7 births among girls with SLC and above (7). Therefore, education empowers the knowledge and also increases decision making power of adolescents resulting in improvement in the use of SRH services.

Attitude and Perception of Adolescent:

Adolescent have many misperception related to sexual and reproductive health issues. For instance, young people avoid using condoms with whom they consider safe on the basis of their partners' physical appearance. A study done around the border areas of Nepal in 2009 reported that 69 percent married and 56 percent unmarried young men between 18-24 years did not use condom during sexual intercourse with their causal partner which also included sex workers. The reason behind not using condom is that they consider their partners without disease. Other reasons are in order to increase enjoyment and some were unable to buy condom due to embarrassment (49). Similarly, another study shows that young people avoid seeking condoms because of the fear of being recognized by the pharmacists and health workers, and they may share the information to their friends and families. This leads to stigmatization and feeling of embarrassment especially among the unmarried

adolescents to visit health centres (27). Hence, because of such attitude and perception of adolescents, they avoid to seek services.

> An urban female in the focus group discussion said, "We know that condoms should be used but we cannot buy these easily. Even if you go to a shop for this purpose, the shopkeeper looks at you differently"(27).

In a mixed method study done among unmarried adolescents between 14-19 years in Nepal, it showed that adolescent girls don't perceive SRH problems severe. It was found that most of the adolescent girls reported problem related to menstruation and white discharge as normal and perceived it to be due to physical weakness. As a result they avoid accessing to SRH services (50).

Marital Status:

In Nepal, SRH issues among girls basically is recognized only in the context of marital sexual relationship (51). Although, pre-marital sexual relationship occurs but it is rarely, openly discussed because of fear and strong cultural norm relating to restricted pre-marital sexual intercourse (32). Because of the sensitivity of pre-marital sexuality, adolescents don't receive adequate information, services and guidance on sexual and reproductive health problems (32).

Whereas, it was found in a survey that access to reproductive health services for young girls is poor even in the case of married girls. This is because the service providers are reluctant and feel embarrassment to discuss about SRH topics with adolescents (51) which will be described in detail under organizational factors.

3.2.2 Interpersonal Factors:

Family:

In Nepal, parents are reluctant to talk about sexual and reproductive health issues with their children. There is a general notion among parents that adolescents are too young to discuss about

SRH and providing sex education will encourage their children to engage in sexual relationship (52). However, evidence shows the opposite. In a cross sectional study done among 14-17 years old adolescents, it was found that, the mother who discuss condom use before sexual debut of children, they are three times more likely to use condom than the adolescent whose mother never discussed or discussed about condom use after being sexually active (53).

In a study done among 3,041 adolescents between 15-19 years, it was reported that over half of adolescents (53.2%; males 50.8% and females 55.4%) obtain information about puberty and bodily changes from their parents (54). Studies suggest that the parents who discussed much about SRH issues with their children, the children are more likely to delay sexual debut and have safer sexual behaviour(54). Another belief of parents in Nepal is, contraceptives are only meant for married couples not for the unmarried, because of this belief, unmarried adolescents avoid seeking contraceptive services as they fear of being recognized from their parents (46). Such restriction of parents on providing SRH education and services makes the adolescents less aware, more curious and perform sex out of curiosity without adequate knowledge and at the same time avoid seeking services.

A parent in the focus group discussion carried out in Jumla said, "We prefer that our children should not be given temporary contraceptives until they get married"(46).

Friends:

In Nepal, peers have a great influence in the access to SRH services as it is a difficult topic to discuss openly with family, teachers and even with the health workers. A study done in the three regions out of five regions in Nepal, reported that friends/peers and school books is the most common source of information for SRH services rather than internet, telephone hotlines or

religious leaders (32). Peer pressure has both significant positive as well as negative impact on SRH behaviours as the youths are more likely to engage in sexual practices, which they believe that their friends are involved (55). In another study, it was also found that young people seek SRH advice from their friends and sometimes get wrong information as well (27). A recent case study shows that the support of peer is important for the use of SRH services (56). Thus competent peer educator will have a positive impact on access to SRH whereas peer education program on sexual and reproductive health issues is conducted by only 16 percent of school in Nepal (15).

> In a qualitative study done in 2015, an adolescent boy in focus group discussion reported, "If we have any RH problems, we seek advice from the friend first and we go to either private
> or government health facility as per their advice" (46).

Social Networks:

Media is also an important source of information on SRH in Nepal. However, there is an inadequate coverage of media and most of the information adolescents gain is through the information targeted to general population (57). Some of the NGOs/INGOs have done a mass media program targeting adolescents. For instance, one radio program named "Sathi Sanga Mann Ka Kura" (Talking With Friends) launched by UNICEF is effectively running in which SRH issues of young people are listened, solved and information regarding SRH and availability of services are also provided (58). Therefore, age appropriate and adequate coverage of media increases the awareness of adolescent on sexual and reproductive health resulting in increment in seeking services.

3.2.3 Organizational Factors:

Health Facility:

In Nepal, Adolescent Friendly Services (AFS) targeting adolescents includes comprehensive

SRH services such as family planning including emergency contraceptives, counselling, maternal health care, comprehensive abortion care, HIV STI prevention, sexual and Gender Based Violence (GBV) management was initiated in 2011 and now it has started in 1,140 government health facilities in 63 districts out of 75 districts (46). However, majority of adolescents are not aware about the availability of such facilities which acts as a barrier for seeking health services. Surprisingly, in a qualitative study done in 72 health facilities where AFS was initiated, it was found that there wasn't a single participation of adolescent girls except for a few adolescent boys in the Focus Group Discussion (FGD). The FGD, mainly comprised of other age group, and awareness was raised to them with the message that such specific services are available in their area (46). Likewise, in an intervention study done in four districts of Nepal, it was found out that half of the respondents were unaware about the availability of ASRH services in their community (41).

The AFS includes all guidelines of friendly services as approved by WHO (Annex 2) like privacy, confidentiality, appropriate opening hours, health workers of both sex etc. Whereas, it also found that privacy is not maintained in most of the health facilities. In a qualitative study done in 72 health facilities in 2016 where AFS were initiated, it was reported that government health facilities is preferred source of information and services for many of the adolescents 82 percent boys and 78 percent girls as government health facilities are free of cost and provides a wide range of services, whereas some adolescents avoid seeking government services because of privacy and confidentiality issues. They prefer private health facilities as they provide high quality and private services (46). Hence, it shows that although government facilities are free and have initiated friendly services, still some adolescents avoid access to the services because of lack of confidentiality and privacy issues.

A 16 years old unmarried adolescent girl in the in-depth study said, "Though the service is costly, private clinics have all the facilities; they have good doctors as well as they maintain privacy" (46).

Likewise, the service providers' behaviour and attitude also affects the access to SRH services. Mathur et. al reported in his study that the health providers in any health facilities are reluctant in providing information to the adolescents, they lack counselling skills, are unable to identify the difference in need between married and unmarried adolescents and also shows judgmental attitude in providing information and services to unmarried adolescents (51). Although the written policies does not differentiate married and unmarried young people for SRH services but the service providers shows negative and judgmental attitude toward unmarried adolescents coming for contraceptives and abortion services (33). Similarly, a study done in 2016 by Khanal P. found that in majority of health facilities, the health workers attitude are not friendly (59).

A female 16 years old in a study done by Khanal said, "It was just a few months ago that I went to the health post to buy some medicine for my mother, the nurse stationed there was so rude to me. She said my mom should visit the post herself. That was okay but she was not so friendly enough to say that"(59).

The opening hours of health facility is also one of the barriers to access of SRH services. The opening hours of the school and health facilities coincide because of which the adolescents have to skip school to access the services (60). In Nepal, it was also found that most of the health facilities are concentrated in the urban area (15) whereas 53 percent of the adolescent populations are residing in rural areas (61). In addition, still nearly half of the population are away from 30 minutes walking distance from the health facilities (7).

School:

As mentioned earlier, evidences from other countries reported that SRH education provided in school have a positive impact on young people's knowledge, behaviour as well as in their personal and social development which helps in delaying

sexual debut, following safer sexual practices that ultimately prevents negative health outcomes like STIs and unintended pregnancies. However, for a sustainable change, sex education should start early, before young people become sexually active and the myths become deep rooted (48). Also mentioned earlier, in Nepal, SRH education started only from secondary level under the subject Health Population and Environment. A study conducted in measuring the effectiveness of sex education in Nepalese schools argue that, sex education started late due to which adolescents have risk of acquiring misperception from other sources. In addition, the study shows that sex education lacks comprehensive information on sexual health, behaviour and attitude, social issues and life skills. Various issues like sexual harassment, gender inequalities, stigma and discrimination are also lacking in the curriculum (62).

The quality of sex education is also poor. Teachers are reluctant to discuss openly about the topic because of the embarrassment, they lack adequate knowledge and have poor teaching techniques. Teachers only focus on the biological part; issues of feelings and relationship are often overlooked (52). Some of the schools have involved health professionals and expertise in educating young people about SRH with the help of NGOs (52). In Nepal, proper training to teachers is a must. Studies have shown that professional training to teachers enables them to develop knowledge, skills and confidence in providing sex education effectively (62). Hence, reluctance of the teachers and lack of competence makes the adolescent less aware resulting to limited access to the services.

3.2.4 Community Factors:

Cultural and Traditional Norms:

Nepal has strong traditional norms regarding sex and sexuality. The topic of sex is taken as a taboo. Sexual and reproductive health issues are not discussed openly in the family environment (54). Similarly, the tradition of early marriage is also persistent in Nepal. According to NDHS 2011,

40.7 percent of females and 11.1 percent of males between 20-24 years were married by the age of 18 years although law does not permit marriage before 20 years without parental consent and before 18 years with permission of parents (63). Marriage provides approval for sexual relation in Nepal whereas young people are in pressure to prove their fertility within 2 or 3 years of marriage due to which young people avoid seeking contraceptives and there is a high chance of teenage pregnancy (34). Thus, because of these traditional and cultural norms young people do not have adequate access to information on sexual and reproductive health information and services.

Gender Norms:

The gender norm existing in Nepalese society also influences on access to SRH services. Nepal is a patriarchal society where decision making power is on men's hand (10). The norm of obtaining permission from husband or elderly member from the family will impact access to services. A cross sectional study done among 210 young women in Nepal reported that among 90 percent of young adults, husband in case of married adolescent, is the most influential member in decision making for utilization of antenatal care and delivery services (64). Gender norms assign initiation and act of sexual relation to men, sometimes forcefully within marriage as well, which may increase the chance of unintended pregnancy and STIs (60). Likewise, studies have shown that boys have more information about SRH as they have more freedom and access to both formal (school, health facility) and informal (media) sources (65) (51). Hence, the lack of power on decision making and dependence of females to males causes limited access to SRH services among females.

3.2.5 Public Policy and Laws:

Government of Nepal has shown commitment to provide SRH to all citizens as a signatory of ICPD 1994. National Reproductive Health (RH) policy was developed, and strategy which includes family planning, safe abortion services, adolescent RH, RH of elderly etc was formulated (66). Later in 2000 National Adolescent Reproductive Health Development (NARHD) strategy was developed

specifically for the adolescents. The ARH policy addresses all adolescents irrespective of marriage, physical ability and gender and has adopted the component of friendly services recommended by WHO. Whereas, policies are not often translated into practice (46) as mentioned earlier.

There is no legal objection for unmarried adolescents in Nepal for the access to contraceptives, abortion and other SRH services (67). Likewise, age is also not a legal barrier to seek contraceptives whereas for abortion services there is provision of informed consent for adolescents less than 16 years of age, which could be a barrier for accessing abortion services (68). The consent for minors for abortion services is required in many countries as well as in Nepal (69) which could be a major constraint for adolescents less than 16 years to seek services because of fear and embarrassment that their need for SRH services will be disclosed to their family members.

CHAPTER 4: NATIONAL AND INTERNATIONAL INTERVENTIONS TO IMPROVE ACCESS TO SRH SERVICES AMONG ADOLESCENTS

In this chapter, evidence based national and international interventions which enhance access to ASRH will be described in detail. The selected interventions are found to be effective within Nepal and the other countries outside Nepal which are similar in cultural norms and values and have similar factors influencing SRH services among adolescents.

Tanzania has similar proportion of youth population as in Nepal, unmet need of family planning among married youth in Nepal is very high and almost similar to Tanzania (Nepal: 42% adolescent between 15-19 year; Tanzania: 41% between age groups of 15-24 years), similar belief that provision of SRH information will encourage sexual activity existed in both the countries. In addition, both countries have the similar economical background. Likewise, Bangladesh and Nepal have most of the traditional norms regarding SRH alike and furthermore influencing factors in accessing SRH by adolescents are also found to be similar.

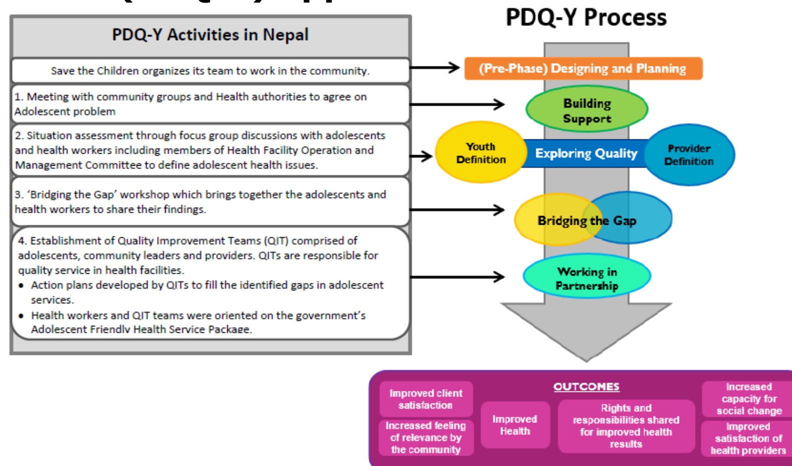
4.1 Nepal

Save the Children US has developed Partnership Defined Quality for Youth (PDQ-Y) (70) approach to get progress in quality and accessibility of the sexual and reproductive health program among adolescents and youth by engaging them throughout the program. This participatory method involve youths actively in identifying the ASRH related problems from problem identifying to program monitoring step with the help of formal and informal community leaders and health workers. PDQ-Y stimulates to hear youth voices from the public which supports to make sure the accountability of services. In Nepal, Save the Children has facilitated major four activities under PDQ-Y approach (70).

Firstly, this process organized a formal gathering between community groups and health authorities to develop conscience to work on adolescents'

problems. Then, it conducted Focus Group Discussion (FGD) to assess the existing situation or perform situation analysis. After FGD workshop called “Bridging the gap” was held by the adolescents and health workers to disseminate assessment’s findings. Final step of Partnership Defined for Youth Approach is the formation of Quality Improvement Team (QIT) among adolescents, formal and informal leaders and service providers as shown in figure 3. This team takes the responsibility to ensure that health facilities provide quality services and before initiating their role, QIT team developed action plans to fulfil identified gap of adolescents health services. This team and health workforces also oriented on Government of Nepal’s adolescents friendly health service package (70).

Figure 3: Partnership defined quality for youths (PDQ-Y) approach and its outcome



Source: Save the Children, 2014 (70).

To increase access to reproductive health services, PDQ approach is integrated in Adolescents Development Program in 63 health facilities within two districts of Western Nepal. The utilization of RH services by adolescents has increased in PDQ integrated health facilities. For example, 4,193 adolescents has taken services from health facilities in 2012 and this number climbed to 23,641 (463% increased) in 2013 and majority of them (One-Third) are for reproductive health services in PDQ-Y adopted health facilities. In addition, there is an increment of couple year

protection by 250 percent from 307 couples in the year 2012 to 1,077 couples in the year 2013 (70).

A female in case study said,"I was so uncomfortable and hesitant when I face elders and friends and converse with them although I was married. I hardly went out of the house. Now, I am in Quality Control Team and I advocate and manage separate room for a specific day to focus on adolescents' health needs. At present, adolescent friendly health services are in action in my surrounding health facilities. I am happy that my effort can make other adolescents happier" (70).

4.2 Tanzania:

The African Youth Alliance (AYA), from 2000 to 2006 in Tanzania target adolescents between the age group of 10-24 years. It focuses on the comprehensive approach in prevention of SRH problems. The project collaborates with the government and NGOs, community groups and youth serving group. Resources and technical interventions that have positive impact on ASRH behaviour are provided. The project implemented the intervention on pre-existing institutions, where six components of comprehensive ASRH was implemented namely "Policy and Advocacy Coordination, Institution Capacity Building, Coordination and Dissemination, Behaviour Change Communication (BCC) including Life Planning Skills (LPS) and Enter- Education Activities, Youth Friendly Services (YFS) and integration of ASRH with livelihood skill training" (71).

The impact was measured among 17-22 years old male and female youths, which was found to have significant impact in most of the desirable outcomes like knowledge, attitude and even behaviour change on HIV and contraceptive use. Among both males and females the knowledge and attitude regarding condom use, consistent condom use (as shown in the table below),

confidence in using and asking partner for condom use had increased significantly (71). Likewise, a positive impact was also seen on partner reduction among females whereas a little visible impact was seen on delaying sexual debut and abstinence.

Table 3: Impact of African Youth Alliance intervention on knowledge, attitude and behaviour of youths

	Female	Male
Antecedents		
HIV/AIDS knowledge (spontaneous response)	+	
HIV/AIDS knowledge (prompted response)		
Believes condom is protective against HIV		
Positive attitude toward condom users	+	+
Very confident in obtaining condom when needed		
Confident could put on condom correctly	+	
Believes he or she could insist that partner use a condom	+	+
ASRH behaviors		
Delay of sexual debut		
Abstaining from sex during past 12 months	–	
Fewer than two sex partners during past 12 months	+	
Condom use at first sex	+	+
Condom use at last sex	+	
Ever used condom with current partner	+	
Consistently uses condom with current partner	+	+
Modern contraceptive used at first sex	+	+
Modern contraceptive used at last sex	+	

Source: JSI,2007 (71)

Hence, the AYA project launched holistic interventions involving communities, youths, community members, health facility, policies which as a result gave a significant positive impact as a whole.

4.3 Bangladesh:

Evidences from Nepal showed that curriculum for SRH at school has not included all aspect and teachers are reluctant in providing information as described in Chapter 3. Therefore, development and distribution of RH curriculum, conducted in NorthWestern region of Bangladesh (72) could be adapted in Nepal as well for the effective transformation of information without restriction in a friendly manner. The intervention is carried out by population council in coordination with Urban Family Health Partnership along with three non-government service delivery partners in urban area from 2000 to 2002.

In the intervention, teachers, adolescents and program managers were actively involved in the development of curriculum. Focus Group Discussions (FGDs) among teachers, community leaders, religious leaders and parents was conducted. Likewise, baseline survey was done among parents of adolescents and adolescents themselves. On the basis of the findings from FGD and baseline survey, various topics were chosen. The existing curriculum was also reviewed and a draft curriculum was developed. Curriculum was developed considering the social norms and values in order to make socially acceptable. Risky behaviour, their consequences like STI/HIV and necessity of appropriate health care was explained in a agreeable manner by the society (72).

Curriculum was made lively with poems, stories, quizzes so that the adolescent's attention gets attracted towards sensitive issues. The text is designed in a way to capture the attention and keep the interest of students consistently. It addresses the SRH issues and RH needs of both males and females. The techniques of teaching are also included that helps the teachers to make the sessions more participatory, interesting and lively. All the topics of comprehensive SRH are included in the curriculum including gender issues and drug abuse as well. The draft curriculum was then reviewed by the experts, teachers, community members and the adolescents to ensure adequacy and acceptability. The final developed curriculum was implemented in 8 schools after teachers training and 300 curriculums are distributed at different areas (Annex). Along with this, other interventions like RH education to adolescent out of school, supportive community activities and AFHS was also done in one area i.e. site B and in site A all other interventions except school curriculum development and distribution was done and in site C not one interventions was performed. The result showed that in site B where all intervention along with RH curriculum was implemented has the most effective significant improvement in knowledge on RH issues. Similarly, there was a

change in attitude towards use of contraceptive methods by unmarried adolescents. Likewise, the education has not shown any impact on increment of pre-marital sexual intercourse. In addition, the utilization of services in site B remarkably increased by 10 folds than the other sites for instance utilization of service in site A increased by 2 folds compared to change in utilization in site C (72).

Hence, it proves the fact that appropriate and adequate RH curriculum to adolescent have a significant positive impact on utilization of services. Similar curriculum, if adapted, in Nepal could prove to be effective.

CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATION:

In this chapter, the findings from the literature review will be discussed and critically analyzed. Based on the discussion, conclusion will be drawn out and recommendations will be provided accordingly.

5.1 Discussion:

The literature review suggests that access to SRH services among adolescent is low and various interrelated factors influence the access. One of the major factors is the knowledge of adolescents. The literature shows that although adolescents are aware of some of SRH issues, however, they lack comprehensive knowledge regarding the access to SRH services. The rural youths have poor sexual health knowledge and utilization of SRH services when compared to the youths in urban areas; this could be due to the inequitable distribution of health facilities. Most of the health facilities are concentrated in urban areas leaving behind 53 percent of the adolescents residing on rural areas. Males are found to be more aware about SRH than females which could be due to the gender norms or the higher enrolment of boys in secondary school than girls as SRH is initiated only from the secondary level in Nepal. Education has a significant impact on the knowledge and service utilization. Lack of education also imposes adolescents to various misconceptions which increases the risk of sexual health problems.

Pre-marital intercourse is present in Nepal although according to cultural norms it is highly restricted. This strong belief has caused unmarried adolescents to avoid contraceptives and other reproductive health related information from the health facilities, teachers and parents. In addition, the belief that SRH issues are the issues required only after marriage also hinders the unmarried adolescents to health seeking as well as utilization of services. However, literature found that the use of facility is poor even for married adolescents as well because of the gender norms and reluctance of health workers to discuss openly about SRH. Hence, an open attitude

towards the need of SRH services among the parents, teachers and health workers are required which could be developed by providing training, community participation and behaviour change communication as the intervention was done in Tanzania by African Youth Alliance using the comprehensive approach in the prevention of SRH problems. At the same time, sensitization of community members and of the adolescents about the influence of gender norms is required.

Communication of the parents with adolescents about sexual and reproductive health is found to be poor in Nepal. Parents have strong belief that adolescents are too young to discuss about sex and sexuality, and sex education will promote young people to be involved in sexual activity. However, a significant number of literatures found that open communication between parents and adolescents have a positive impact on delaying sexual debut and adapting safer sexual practices. This signifies that a good communication is required and parents should be open with their children in order to develop a positive attitude towards SRH and follow healthy practices. Parents' involvement in educating adolescents could prove to be an effective intervention.

In Nepal, peer is found to be the most common source of information for adolescents as sexual and reproductive health topic is considered to be private. However, peer themselves are not adequately informed which sometimes leads to the provision of wrong information to their friends. Hence, making adolescents well equipped with knowledge and skills and mobilizing the adolescents as peer educator might be a very effective sexual and reproductive health promotion intervention as the intervention carried out by Save the Children in Nepal. The partnership defined quality for youth project of Save the Children in Nepal has a remarkable impact on the utilization of RH services. The participation of adolescents from the assessment, planning, implementation and even evaluation have significantly increased the quality of services

provided in health facilities which ultimately promote access to youth SRH services. In my opinion, the success of this participation is because no one else can understand the adolescent better than the people of their age. In addition, the support of the family members, community members and the health workers is equally important which were also considered in the project. In Nepal, this sort of participation of youths in every aspect is lacking although it is written in policy. Hence, the lesson learned from this project can be replicated in other areas of Nepal so that the quality of health facility which is poor in Nepal can improve and the services will be more youth friendly. Furthermore, health facilities could be linked with schools, youth clubs and work places to reach out to adolescents in schools and out of school. Media could also be used for awareness raising program involving the youths so that the youth feels free to exchange their issues and problems with other youth of their age like the mass media program done by an NGO as discussed in findings. Such kind of program should be expanded and ensured for adequate coverage among all adolescents.

Although adolescent friendly services, are initiated in Nepal, are in ongoing process of expansion, however, adolescent lack awareness about the availability of adolescent friendly services (AFS) even in areas where such services are already initiated, which leads to limited utilization to services. National Adolescent Reproductive Health Development Strategy has adopted all the criteria of WHO, but the written policies and programs are needed to be implemented as they are intended to. The inconvenient opening hours of the health facilities, lack of confidentiality and privacy and lack of health providers of both sexes are the barriers of adolescents in seeking services. Not only these, the incompetence of health workers, judgmental attitude and reluctance of health workforce also had a predominant effect on limited access to SRH services by adolescents in Nepal. It is, therefore, required that the written policies are translated in action. Similarly, health

workers should be well-trained so that they could identify the need of adolescents and create an enabling environment to use the services. A coordinated approach of Ministry of Health (MOH) with other stakeholders (like: Ministry of Education, Ministry of Women and Children Welfare, Ministry of Local Development, UN agencies, Media, youth networks, faith based organizations, NGOs and INGOs) is required for the awareness of availability of services and policy implementation in making SRH services youth friendly. As the intervention done in Tanzania which includes the interventions like policy and advocacy coordination, youth friendly services, institutional capacity building, behaviour change communication were found to be effective, which could be adopted and promoted in Nepal as well.

In Nepal, literature suggests that curriculum regarding sexual and reproductive health is not comprehensive. Many of the important social issues relating to SRH like gender inequality, stigma and discrimination are missing in the curriculum. Within the included portions also, the quality of teaching method is poor. Teachers are unwilling to provide detail information. The subject of feelings are often neglected which might create a gap between teacher and students. The resistance of the teachers might be due to the influence of the societal norms as they are also from the same society where sex and sexuality are considered a taboo. More importantly, the SRH education was initiated late after the adolescents become sexually active or exposed to various misleading information. This signals that curriculum in Nepal should be revised and provide a general information on sex and sexuality, and reproductive health should be initiated early. Thus, it paves the way for the adolescents to seek SRH services. Similarly, the intervention carried out in Bangladesh regarding curriculum development could be adopted in Nepal. The involvement of teachers and adolescents in curriculum development at the same time the participation of community members, religious leaders, parents along with teachers and

adolescents in identifying the most appropriate topic to be included addresses the need of the adolescents in a socially acceptable environment. This also prevents the gap between the content and display of information as teachers might feel comfortable to discuss the topic which is approved by community members and by themselves. Lively nature of the curriculum through poems, stories and quizzes make the curriculum more interesting as it attracts the attention of adolescents and they will be able to capture the information as practical learning not only as a course content which they need to learn for passing exams. This might have brought significant impact on the behaviour of adolescents as an evidenced by more positive result in the area where this intervention was carried out than in other area where new curriculum was not formulated. Hence, revision of the curriculum, inclusion of all aspect of SRH and its access to its services in a socially acceptable and in a lively way is a high requirement in Nepal. In addition, out of school adolescent should also be addressed through youth clubs, work places, health facilities and community groups.

Relevance of Conceptual Framework: The modified socio-ecological model is very relevant for my thesis as of to answering my questions in accordance to the objectives. The model helped to explore the multiple level factors influencing access to SRH services by the adolescents and it also helped to understand the close link between the levels. The use of the model also helped to identify the linkage between the factors and the interventions as the proved evidences were taken into consideration – the individual and his/her environment. Hence, I found that the socio-ecological model to be the most suitable model for my thesis.

5.2 Conclusion:

In conclusion, the literature review shows that the access to sexual and reproductive health services is very low in Nepal. Although, marriage provide sexual recognition and SRH are thought to be only

for married couples, however, access of services are poor for married adolescents as well. The reason behind the low use of sexual and reproductive health varies from one individual to the other i.e. adolescent's knowledge as well as his/her environment such as support system from parents, community members, HWs also affect the adolescents. Lack of awareness of the adolescent about the comprehensive SRH and the availability of facilities has a profound effect on the access. Reluctance of parents, teachers and even health workers to discuss about SRH with adolescents resulting from the strong cultural norms is another major barrier realized in accessing sexual and reproductive health information and services. Similarly, incompetent teachers and health workers dealing with the adolescents need to know well about SRH, inadequate curriculum, late initiation of sex education and lack of friendly services also have a major influential role.

Government of Nepal has shown commitment in promoting sexual and reproductive health of adolescents through the initiation and expansion of AFS in almost all districts of Nepal, inclusion of SRH curriculum in the secondary level education. Similarly, various NGOs have taken a good initiative like mass media campaign and program, however, significant gap exists during the implementation of well designed and written SRH program and policies. As the factors are multilayered and interlinked with each other as one factor affects the other, a multilevel approach as well as the approaches done in Tanzania and Bangladesh is required to address the problem effectively. Making the adolescent aware through mass media, a comprehensive and age appropriate curriculum, early sex education at school, training the teachers and health workers, fulfilment of all adolescent friendly services criteria and involving all the supporting members for adolescents like parents, community members and making them aware is required. Out of school adolescents should be addressed through youth

clubs, work places, community groups and media as well.

5.3 Recommendations:

For Ministry of Health and Population (MoHP), NGOs, INGOs and other stakeholders:

- MoHP should ensure implementation of AFS as per the written policy and strategy such as convenient opening hours, confidentiality and privacy. Task force consisting of adolescents and youth, health workers, community leaders, media people should be established and mobilized to create supportive environment in health facilities in delivery of adolescent friendly RH services.
- MoHP in coordination with other stakeholders should provide training to the health workforce in order to deliver the services for adolescent in a non-judgmental manner.
- MoHP in collaboration with NGOs and INGOs should provide support to the health facilities to provide awareness of the comprehensive SRH among adolescents.
- Community sensitization and Behaviour Change Communication should be provided so that parents and the community members become comfortable to discuss SRH issues.
- Parents, community leaders and religious leaders should be involved in awareness raising so that an enabling environment is created.
- MoHP in coordination with Ministry of Information and Communication should do partnership with media to increase coverage of SRH awareness initiatives for adolescents.

For Ministry of Education (MoE), MoHP and other stakeholders:

- MoE in collaboration with MoHP, SRH experts and adolescent should review the existing curriculum and a new curriculum including comprehensive SRH should be developed. The curriculum should be made lively and socially acceptable. Adolescents, teachers, parents, faith based and community leaders should be involved in the

planning, development, implementation and evaluation of curriculum. In addition, SRH education should be initiated from the primary level education.

- MoE should provide adequate materials and proper guidelines for the teachers to convey SRH education.
- MoE in coordination of other stakeholders should work together to enhance the capacity of teachers in delivering SRH information in a friendly, nonjudgmental manner without harassment.
- MoHP along with MoE and NGOs should promote peer education program in SRH within and out of school.

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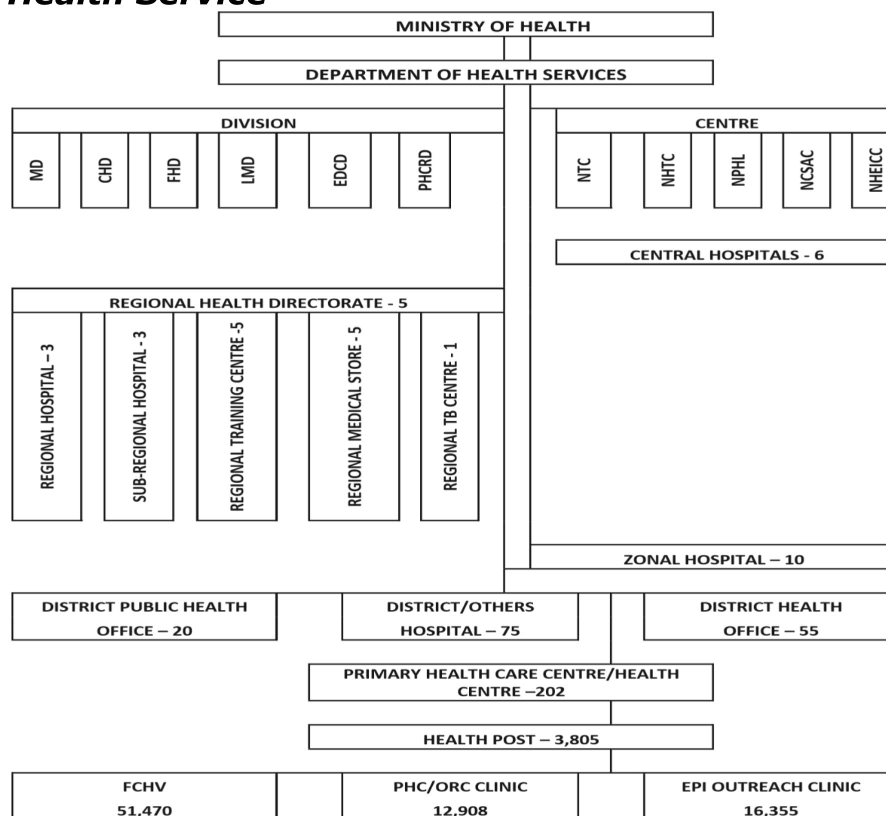
ANNEXES:

Annex 1: Organogram of Department of Health Service



Acronyms

MD	*Management Division*	*NHTC*	*National Health Training Centre*
FHD	*Family Health Division*	*NTC*	*National Tuberculosis Centre*
CHD	*Child Health Division*	*NCASC*	*National Centre for AIDS and STD Control*
EDCD	*Epidemiology and Disease Control Division*	*NPHL*	*National Public Health Laboratory*
LMD	*Logistics Management Division*	*FCHV*	*Female Community Health Volunteer*
LCD	*Leprosy Control Division*	*PHC/ORC*	*Primary Health Care Outreach Clinic*
PHCRD	*Primary Health Care Revitalization Division*	*EPI*	*Expanded Programme on Immunisation*
NHEICC	*National Health Education, Information and Communication Centre*		

Source: Annual Report, 2015

Annex 2: Characteristic of Adolescent Friendly Services

Programmatic:

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

Facility:

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

Health service providers:

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