Original Article

Adolescent Friendly Sexual and Reproductive Health Service Delivery in Kaski District, Nepal

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Abstract: Adolescents (10-19 years old) account for nearly a quarter (approximately 6.4 million or 24.2%) of Nepal's population. The Government of Nepal had identified adolescents as an important and underserved population, and critical to achieving national health and development goals. This study aimed to add up the insights whether the sexual and reproductive health services provided to adolescents are friendly as par the national standards and in the adolescent's perspectives as well. A descriptive cross sectional study using both quantitative and qualitative approaches was conducted in Kaski district where eight Adolescent Friendly Health Facilities (AFHFs) were selected randomly and the schools in the proximity of the selected health facilities were selected to collect adolescents' perspectives. Structured questionnaire was used to collect data from school adolescents between the ages 15-19 years. Descriptive analysis was carried out to summarize the socio-demographic characteristics, health facility related characteristics, and observation findings of the health facility. The study found that among the total adolescents participated in the study 69% had utilized the health service in last six month of which 82.9% had visited to AFHFs, 35% of them had to travel more than 30 minute distance to reach nearby AFHFs, 67.7% school adolescents had knowledge on the availability of AFHS in the health facility. This study found the status of adolescent friendly health service delivery in Kaski district was below the certification criteria of adolescent friendliness.

Keywords: reproductive Health, Service Delivery, sexually transmitted infections, Nepal

1. INTRODUCTION

Adolescents (10-19 years old) account for nearly a quarter (approximately 6.4 million or 24.2%) of Nepal's population. This developmental stage marks the critical transition from childhood to adulthood, during which physical, emotional, cognitive and social changes expose adolescents to new health needs and risks [1]. It is also a period when opportunities to modify health risks and behaviours are great, with implications for health and wellbeing in later life as well as for health of future generations [2]. Addressing the needs of adolescents is a challenge that goes well beyond the role of health services alone. However, within an integrated approach, health services can play an important role in helping adolescents to stay healthy and to complete their journey to adulthood; supporting young people who are looking for a route to good health, treating those who are ill, injured or troubled and reaching out to those who are at risk [3]. Health services play an important role in reducing preventable ill health among adolescents and

supporting a healthy transition into adulthood. In addition to providing essential curative care for common adolescent health complaints, health services are also a crucial source of preventive services related to sexual and reproductive health (SRH), nutrition, substance use, mental health and other risk factors for poor health later in life [4]. The Government of Nepal had identified adolescents as an important and underserved population, and critical to achieving national health and development goals. Following commitments made at the 1994 International Conference on Population and Development, ASRH was identified as an integral part of the 1998 National Reproductive Health Strategy and included as a core component of the essential reproductive health services package [5]. To support implementation, the Family Health Division (FHD) developed the National Adolescent Health and Development (AHD) Strategy in 2000, which included AFHS as a key objective and detailed activities required to improve access to and utilization of counselling and services [6]. Subsequently, the 2007 Implementation Guideline for ASRH was developed to implement the National AHD Strategy, emphasizing youth participation, equity, and linkages with other youth health and development initiatives [7]. These guidelines provided the detailed comprehensive sexual and reproductive health (SRH) services to be provided at each health facility level and specific actions, roles and responsibilities to effectively organize services to ensure quality, acceptability and accessibility [8]. Youth friendly sexual and reproductive health services (YFSRHS) had been recognized as an appropriate and effective strategy to addressing the sexual and reproductive health (SRH) needs of the youth following the international Conference on Population and Development in Cairo; Egypt, 1994. Senderowitz, Hainsworth admit that the essence of the friendliness of sexual and reproductive health services for the youth are because of the specific biological and psychological needs of the youth, the high risks of sexually transmitted infections (STIs) and HIV, and pregnancy, disproportionately high risk of sexual abuse [9]. The Nepal Health Sector Program II Implementation Plan 2010–2015 included the target of introducing 1000 FHS in the public health system by 2015, hence 25% of the government health facilities would be covered Currently the AFS are provided by 1144 health facilities covering 63 out of 75 districts in Nepal [10]. However the facilities that were selected for scale-up of AFS were the ones which had proper infrastructures according to stringent criteria, laid down by ASRH implementation guideline [11]. This requirement had led to AFS centres being established in urban and semi-urban areas depriving rural hard-to- reach adolescents of adolescent-friendly services [12]. Studies had indicated that the barriers faced by the youth in the utilization of services is attributed to the quality of the sexual reproductive health care offered, cultural norms as a critical component that continues to influence youths' behaviors and actions with regards to sexual and reproductive matters and availability of health services to adolescents and youths [13]. This stems from the absence of a proper appreciation for the importance of sexual health care complemented with the current rapid social, political and economic transformations which had profound impacts on the social norms affecting the youths. Limited access to information and services, cultural restrictions, unwelcoming services, provider's attitude, high cost, lack of confidentiality and privacy and gender barrier are the reasons of poor utilization of health services. Adolescents are neither able nor willing to obtain health services because they are not friendly. Significant numbers of adolescents are not adequately reached by the interventions intended for them. This is due to the fact that adolescent friendliness as a concept is beginning to gain grounds in with myriad challenges, hence the need for research to evaluate the intervention and improve upon it is essential. The knowledge gap exists whether the adolescent friendly health services is friendly to the adolescents or not. Hence, this study examines the friendliness of adolescent sexual and reproductive health service delivery in the Kaski district of Nepal.

2. MATERIALS & METHODS

A descriptive cross sectional study was conducted to describe the friendliness status and adolescent's perception towards adolescent friendly sexual and reproductive health service delivery in Kaski district. Focal person for adolescent friendly services in district public health office, health facility in-charge, and adolescent sexual and reproductive health service providers of selected health facilities were the study population. Similarly, the school adolescents were also the study population for the users' perspectives regarding the adolescent friendliness of the available sexual and reproductive health services. The study was conducted in health posts and primary health care centers of Kaski districts and higher secondary schools located in the proximity of the selected health facility run by government of Nepal in Kaski district. Among 26 adolescent friendly health facilities in Kaski district, the simple random sampling technique for selecting the health facilities was done to collect qualitative data and for the observation of the health facilities. Purposive sampling was carried out to collect the data from the adolescence studying in higher secondary schools in the vicinity of the selected health facility less than 15 years of age. All the students studying in class 11 and 12 were selected to collect the users' perspectives. Thirty percent of the health facilities were selected for the study. Out of 26 adolescent friendly health facilities 8 facilities were selected randomly. Total N=461 samples were collected from which 12 sample were excluded due to their age above 20 years and 449 data were included for the analysis. Structured self-administered questionnaire was used for data collection regarding the users' perspectives. Key informant interview was conducted with health facility in-charge, service providers and ASRH focal person at DPHO using interview guideline. Data was entered in Epi data version 3.1 and analyzed in IBM SPSS version 20.

3. RESULTS & DISCUSSION

3.1 Socio-demographic characteristics of the respondents

In this heading the socio-demographic characteristics had been described. It includes age, sex, marital status, religion and ethnicity of respondents.

Table 01: Socio-demographic characteristics of respondents

Characteristics	Number	Percentage
Sex of Respondents		
Male	179	39.9
Female	270	60.1
Religion		
Hindu	395	88.0
Buddhist	47	10.5
Muslim	2	0.40
Christian	5	1.10
Marital Status		
Married	18	4.00
Unmarried	431	96.0
Ethnicity		
Dalit	100	22.3
Janajati	104	23.2
Madhesi	1	0.20
Brahmin/Chhetri	244	54.3

Adolescents between the ages of 15-19 years old were included in the study. The mean age of respondents was 17.05 years with standard deviation ± 1.077. Table 01 showed that 39.5% were male and 60.1% were female. The respondents were from different religion. The majority of the respondents (88%) were Hindu followed by Buddhist (10.5%). The remaining were Christian and Muslim. The majority of the respondents (96%) were unmarried while remaining 4% had already got married in their teenage. The respondents were from different ethnic community. More than half of them were from Brahmin/Chhetri (54.3%) whereas, 23.2% and 22.3% were from Janajati and dalit ethnic community respectively.

Table 02: Health facility access and utilization

Characteristics	Number	Percentage
Accessibility **Distance to nearby Public health facility**		
≤ 30 min travel distance	295	65.70
> 30 min travel distance	154	34.30
Utilization **Health Facility visited for health service**		
Yes	310	69.0
No	139	31.0
Type of health facility visited (n=310)		
Public health facility	257	82.9
Private health facility	53	17.1
Received health service went for (n=257)		
Received	201	78.2
Not received	56	21.8
Total	257	100

Table 02 showed that out of 449 adolescents, around one third (34.30%) of them need to travel more than 30 minutes to reach nearby health facility. Regarding the utilization of health facility 69% had visited to any of the health facility for health services in last six month. Among them 82.9% had visited to the adolescent friendly health facility within last six month. Out of the total adolescents who had visited adolescent friendly health facility for service, 21.8% did not get the service they need.

Table 03: Respondent's observation regarding basic amenities and opening hours

Characteristics	Number	Percentage
Availability of drinking water		
Yes	223	86.8
No	34	13.2
Availability of functional toilets		
Yes	225	87.5
No	32	12.5
Surrounding of health facility		
Clean	226	87.6
Not clean	31	12.1

Comfortable waiting space		
Yes	177	68.9
No	80	31.1
Health facility opening hours		
Convenient	147	57.2
Not convenient	110	42.8
Total	257	100

Table 03 showed that 86.8% had found that the health facility they visited had drinking water facility; 87.5% had found availability of functional toilets, 87.6% had found clean surrounding of the health facility and 68.9% had found comfortable waiting space. The above table showed that 57.2% of the respondents found the health facility opening hours as convenient to them while 42.8 % responded as inconvenient.

3.2 Access to information on AFSRH service availability

Table 04: Awareness of AFSRH service availability in nearby health facility.

Sex of respondents	Known about service availability of ASRH	
	Yes (%)	No (%)
Male	80 (72.1)	31 (27.9)
Female	94 (64.4)	52 (35.6)
Total	174 (67.7)	83 (32.3)

The majority of respondents (67.7%) were aware that AFSRH services is available in the nearby public health facility. Still more than one third adolescents did not know about the availability of AFSHR services in the nearby health facility among which females were higher 35.6% than males 27.9%.

Table 05: Respondent's knowledge on ASRH services availability

Services available in the health facility*	Number	Percentage
Problems during menstruation	186	78.5
Treatment of STIs	71	30.0
Counseling and testing of HIV	52	21.9
Counseling of reproductive health	111	46.8
Counseling of Contraceptives	164	69.2
Contraceptive device	204	86.1
Emergency contraceptive pills	112	47.3
Antenatal care	176	74.3
Safe delivery	142	59.9
Postpartum care	125	52.7
Safe abortion	114	48.1
Mean knowledge score 5.67 and ±3.37 SD within minimum 0 and maximum 11		

*Multiple Response

Majority of the respondents were aware that nearby health facility provides ASRH services like contraceptive devices, ANC/PNC services, and management of problems during menstruation, delivery services. Still the awareness regarding the availability of services like counseling on HIV, reproductive health, treatment of STIs, emergency contraceptives, abortion services is low. The mean knowledge score of respondents was 5.67, ±3.329 SD with minimum 0 and maximum 11.

3.3 Respondent's knowledge on ASRH rights

Table 06 showed that majority of the respondents knew that clear and adequate information, non-discrimination, participation in decision making during treatment procedure are the ASRH rights of adolescents. Small number of the respondents were known about the ASRH rights like respectful and non-judgmental attitude of service providers, respect for their privacy, anonymity of the information. The mean score of respondent's knowledge on ASRH rights was 3.22, ± 1.87 SD with minimum 0 and maximum 7.

Table 06: Respondent's knowledge on ASRH rights

Adolescents' SRH Rights*	Number	Percentage
Considerate, respectful and non-judgmental attitude	60	23.9
Respect for privacy during consultations, examinations and treatments	102	40.6
Non-discrimination	142	56.6
Participation in decision making of treatment procedure	149	59.4
clear information	148	59.0
Adequate information	115	45.8
Anonymity of information	124	49.4
Mean knowledge score 3.27 and ± 1.90 SD within minimum 0 and maximum 7		

*Multiple response

3.4 Promotional activities of AFSRH service

Table 07 showed that 67.7% of adolescents had seen the display of list of available ASRH services while 32.3% did not see. Regarding the provider adolescent interaction, 62.3% of the respondents had never experienced that provider had discussed on the availability and importance of AFSRH services. Only 27.6% of respondents were provided with IEC materials related to adolescent sexual and reproductive health services of which 76.1% found those materials were useful to gain knowledge on ASRH. The KII findings showed that the outreach activities regarding the AFHS were conducted very rarely during school health program (classes on SRH, Nutrition, Drug abuse etc). But these activities have not been conducted in last six month except in two health facilities. Being busy in the health facility; thoughts like adolescents have access to information from social media, they get information from HFs; lack of budget, and instructions from DPHO were the reported reasons for not conducting such activities.

Table 07: Promotional activities of AFSRH service

Characteristics	Number	Percentage
Display list of available services (n=257)		
Yes	174	67.7
No	83	32.3

Provider-adolescents interaction regarding AFSRH (n=257)		
Yes	97	37.7
No	160	62.3
Provided IEC materials related to ASRH (n=257)		
IEC materials Provided	71	27.6
IEC materials not provided	186	72.4
Usefulness of IEC materials for ASRH Knowledge (n=71)		
Useful	54	76.1
Not useful	17	23.9
Total	257	100

3.5 Privacy and confidentiality

Respondent's Experience on privacy and confidentiality during last visit Table showed that 87.58% of the respondents did not see the confidentiality policy displayed in the public health facility that they had visited in last six month. Regarding the respondent's experience on privacy and confidentiality, 18.3% of them had experienced that someone other than health worker had enter the room during consultation or treatment and 81.7% respondents found curtains on doors and windows in examination rooms. But, 73.9% respondents were not assured that the information provided won't be shared to anyone else by the service provider. Similarly, out of 257 respondents 70.4% of them do not had trust that the providers will not share information to anyone else.

Table 08: Respondent's Experience on privacy and confidentiality.

Characteristics	Number	Percentage
Display of Confidentiality policy		
Yes	32	12.5
No	225	87.5
Privacy (anyone entered the room during counseling or treatment)		
Yes	47	18.3
No	210	81.7
Curtains in doors and windows		
Yes	210	81.7
No	47	18.3
Confidentiality (provider assurance for not sharing the information)		
Yes	190	73.9
No	67	26.1
Trust (felt confident that providers do not share information to anyone)		
Yes	76	29.6
No	181	70.4
Total	257	100

3.6 User's perspectives

Regarding the users perception towards provider's attitude during service delivery, 67.7% respondents found that service providers were respectful towards them while 32.3% did not. Out of 257

respondents who had visited to the nearby public health facility, 64.2% of them perceived that the service providers were friendly to them. Similarly, only 52.5% of the adolescents who had visited to the nearby public health facility were asked for consent during the treatment process.

Table 09: Respondent's perception on service provider's attitude

Characteristics (n=257)	Number	Percentage
Respectful service provider		
Yes	174	67.7
No	83	32.3
Informed Consent		
Yes	135	52.5
No	122	47.5
Friendly service provider		
Yes	165	64.2
No	92	35.8
Total	257	100

Out of 257 respondents who had visited to nearby public health facility for ASRH services, 17.5% of the respondents were denied for the service they went for. The findings of KII and observation showed that health service to adolescents was not denied for anyone just for being adolescent or unmarried but if the case was unmanageable in the health facility referral used to be done. Sometimes stock out of drugs commodities and absence of health worker were reasons to turn back adolescents.

Table 10: experience of service denial by respondents

Service denied by service provider		
Respondents	Yes (%)	No (%)
Male	24(21.6)	87 (78.4)
Female	21 (14.4)	125 (85.6)
Total	45 (17.5)	212(82.5)

Among the respondents who were denied for providing the services most of them perceived the reasons for service denial were service unavailable in the facility, lack of medicine and equipment, being age below 18 years and unmarried.

Table 11: Respondent's perception for service denial by provider

Perceived reasons for service denial*	Number	Percentage
Age below 18	11	24.4
Unmarried	14	31.1
Unable to pay	4	8.9
Lack medicine and equipment	15	33.3
Unavailable in the facility	17	37.8

*Multiple response

Out of the 257 respondents who had visited to public health facility for ASRH services in last six month, 66.9% of the respondents told that they will visit the same health facility for required health services while 20.6% of respondent's do not want to visit the same health facility again for the ASRH services. Similarly, 12.5% of the adolescents were not sure that whether they will revisit the same health facility for health services.

Table 12: Respondent's willingness to revisit the same health facility

Response	Number	Percentage
Yes	172	66.9
No	53	20.6
Don't Know	32	12.5
Total	257	100

3.7 Findings of observation of Adolescent Friendly Health Facilities

Out of the 26 adolescent friendly health facilities in Kaski district 8 AFHS were observed, the findings of observation of the adolescent friendly health facilities showed that all the health facilities had provision of general ASRH services like treatment of general health problems, management of menstrual problems, TT immunization, delivery, safe abortion services, ANC, PNC, health education and counseling on family planning, pregnancy and abortion, STI/HIV, GBV etc. Seven out of 8 health facilities are located in the accessible location to adolescents (nearby the school and public gathering places. All the health facilities except one had separate examination room with curtains on the doors and windows. All the facilities observed had availability of drinking water, functional toilets, clean surroundings, waiting space and short waiting time. All the health facilities except one had displayed AFHS logo and board indicating separate clinic hours for adolescents but only one health facility had mentioned opening hours other than school opening time and had been practicing accordingly. The IEC corner is set up in seven health facilities but none of them had availability of 8 ASRH booklets provided by NHEICC in the waiting space or IEC corner as provisioned by ASRH Implementation Guide 2011. All the health facilities had age, sex disintegrated records in the HMIS OPD register but none of the health facilities had been reporting AFHS in separate format along with HMIS report to DPHO. None of the health facilities had self-assessment chart available in the facility.

3.8 Discussion

This study found that all health facilities provided counselling on general ASRH, temporary family planning, STI treatment, menstrual management, ANC, PNC, delivery, abortion, and VCT services. This survey found that 69% of teenagers used health services in the past six months, somewhat higher than Nepal teenagers and Youth Survey (57%) and Dejen district, Ethiopia (45.4%16, 28). Increased information access and other sociocultural variables may explain this. Like the previous survey, 82.9 % of teenagers who used health care used adolescent-friendly services [14]. This study found that 87% of health facilities were near schools and public gathering places, supporting the previous study's finding that 86% of service providers and health facility incharges consider the AFHS accessible1. According to user perspectives, 35% of teenagers said that the health facility is more than 30 minutes away, similar to findings in Kenya (39.5%) and Ethiopia (31%). This survey found that all health institutions except one had separate examination rooms with curtains on the doors and windows [15]. All facilities featured drinking water, working bathrooms, clean environment, waiting area, and quick wait times. The study indicated that 86.8% of teens found drinking water, 87.5% found functional bathrooms, 87.6% found clean surroundings, and 68.9% found comfortable waiting area [16]. This matched the study's findings that 92% of respondents found the facility friendly, 82% found the waiting area comfortable, and 84% found the location convenient [17]. This study aligns with [18] that found all services merged into one location and no separate area for school youth. The NASRHP Implementation Guideline 2011 states that clinic schedule should accommodate adolescents' requirements, including school hours, yet this study found that most facilities offered AFHS during clinic hours [19]. A study found that unfavourable operation hours that conflict with adolescent school schedules, lack of clear directions and services, crowding, and lack of privacy are the main barriers to adolescent reproductive health services [20]. This study found that 67.7% of school adolescents knew about AFHS in the health facility, compared to 74% in Kenya. This may be because most health services in Kaski district are near schools and public meeting areas [21]. Male and female service providers for ASRH services received 2 days orientation and 5 days training under the 2011 national adolescent sexual and reproductive health programme implementation guideline. This study found that none of the service providers obtained 5 days of training as proposed and several did not receive 2 days of AFHS orientation. Central finance suspension for AFHS programme and Kaski district not picked for 5-day training were the reasons. A previous study in Nepal found that only one facility had received AFHS orientation or training, and that both adolescent girls and boys noted the lack of male and female AFHS providers as a barrier and one of the highest priorities for improving AFHS [22]. Only 25% (18 of 72) of Nepalese facilities had adolescent management committee members, this was because the health facility incharge did not want adolescents in HFOMC meetings, and the guideline did not anticipate their inclusion. Lack of training for providers, incharge, and HFOMC members may prevent teenage participation in ASRH programme planning and implementation [23]. This study found that just 2 of 8 facilities taught FCHVs, teachers, HFOMC, and other stakeholders about AFHS. The ASRH Programme Implementation Guideline 2011 requires AFHSs to track success by collecting client data by age and service type in a standardised form. The district ASRH Focal Person or DPHO must also do six monthly monitoring and supervision visits to all AFHS and review the programme quarterly and annually at the district, regional, and central levels1. Most establishments did not keep an AFHS register despite this need. However, many OPD, FP, ANC/PNC, and abortion registers do not extract teenage client data into the AFHS reporting form or any other format that would measure utilisation or progress. This study found that only 66.9% of adolescents said they would return to the facility for similar or related services, 20.6% said they wouldn't, and 12.5% were not sure. A Kenyan study found that 90% of boys and 98.3% of girls

would return. The Quality Improvement and Certification Tool for Adolescent Friendly SRH Services 2016 required 80% aggregate and 60% in each Implementation Guideline criterion to qualify as adolescent friendly31. This study indicated that the aggregate score of adolescent-friendly health service delivery in Kaski district was 53% at 95% significance (CI: 45%-60%), below the certification criteria. Only three of nine benchmarks got over 60%.

4. CONCLUSIONS

This study found the status of adolescent friendly health service delivery in Kaski district was below the certification criteria of adolescent friendliness except indicators of organizing effective services, making conducive environment, addressing the sexual and reproductive health rights of adolescents but other standards set by ASRH implementation guideline were below the set benchmark. Most of the adolescents observed that the health facilities were located in convenient location and had conducive environment. Though adolescents perceived that confidentiality was maintained and privacy was protected by the service providers in the facility majority of the adolescents did not have trust on providers regarding the assurance of confidentiality. The AFHFs in Kaski had conducive environment, friendly and respectful service providers but the service providers were not trained on AFHS. Almost all the health facilities had established IEC corner but community outreach programs regarding the adolescent friendly sexual and reproductive health services had not been conducted by health facilities. There was no specific clinic hours allocated to adolescents in Kaski district and the involvement of adolescents in planning and implementation of AFHS is lacking.

5. RECOMMENDATIONS

Based on the conclusion of the findings following recommendations are made:

1. Training on AFHS to all the health services should be provided. Regular supervision and monitoring of AFHS program from DPHO is recommended.
2. To increase the information regarding AFHS to adolescents and make supportive environment in the community outreach program on AFHS should be done ensuring the involvement of adolescents in planning and implementation of AFHS.

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