

# National Adolescent Sexual and Reproductive Health Programme

Mid-Term Evaluation Report



National Adolescent Sexual and Reproductive  
Health Programme

Mid-Term Evaluation Report

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Health Sector Support Programme  
Department of Health Services  
Teku, Kathmandu  
Nepal  
T +977 1 4261404  
F +977 1 4261079  
E hssp@giz.org.np  
I www.giz.de/nepal

Commissioned by:



GFA Consulting Group GmbH



Authors:

Dr. Sushil Chandra Baral  
Rekha Khatri  
Eva Schildbach  
Kathrin Schmitz  
Pushkar Raj Silwal  
Prof Edwin van Teijlingen

Edited by:

Susan Sellars-Shrestha

Photo credits:

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## Acronyms

AFS	adolescent-friendly service
AHW	auxiliary health worker
AIDS	Acquired Immune Deficiency Syndrome
ANC	antenatal care
ANM	auxiliary nurse midwife
ASRH	adolescent sexual and reproductive health
BS	Bikram Sambat (Nepali calendar)
FCHV	female community health volunteer
FPAN	Family Planning Association of Nepal
GFA	GFA Consulting Group GmbH
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ GmbH)
HERD	Health Research and Social Development Forum
HFOMC	health facility operation and management committee
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Sector Support Programme
IEC	information, education and communication
MoHP	Ministry of Health and Population
NHEICC	National Health Education, Information and Communication Centre
NHSP	Nepal Health Sector Programme
NPR	Nepali rupee
OPD	out-patient department
SRH	sexual and reproductive health
STI	sexually transmitted infection
UNICEF	United Nations Children's Fund
WHO	World Health Organization

## EXECUTIVE SUMMARY

### Background and rationale

The Ministry of Health and Population (MoHP) Nepal has endorsed the Nepal Health Sector Programme (NHSP) II (2010–2015), which aims to introduce 1,000 adolescent-friendly services (AFSs) in Nepal by 2015. Towards this, the Government of Nepal is implementing the National Adolescent Sexual and Reproductive Health (ASRH) Programme, which, by November 2012 had covered 516 health facilities in 36 districts.

To assess the implementation of the National ASRH Programme, a mid-term evaluation was conducted by the Health Research and Social Development Forum (HERD) in collaboration with GIZ/GFA in selected health facilities in Doti and Banke. The mid-term evaluation is part of an operational research to determine the effectiveness of the National ASRH Programme and explored the understanding, perceptions and experiences of service providers and adolescents related to the implementation of the National ASRH Programme. The main aims of the mid-term evaluation were to:

- understand the implementation processes and the wider context as it affects the National ASRH Programme in order to provide detailed explanations for the results of the final evaluation; and
- identify improvements that can be made to the intervention to increase access by adolescents to SRH services in the remaining period of the programme and ways of improving the likelihood of scaling up the intervention across Nepal.

Data was collected for the evaluation in March 2013 in semi-structured interviews and focus groups discussions, mainly with health workers and adolescents, supplemented by peer ethnography interviews and observation by the researchers. As the study was conducted in selected health facilities in only two districts, the findings may not be generalised to other GIZ-supported districts or to the many other intervention districts of the ASRH Programme that are supported by the Family Health Division or other donors.

This report presents the findings of this research.

### Implementation of the ASRH Programme

The evaluation looked at the understanding of health workers about the National ASRH Programme and the extent of conforming with the programme guidelines. The National ARSH Health Programme was introduced in 2011 in 14 health facilities in Doti and 13 health facilities in Banke districts. Under the programme, health workers from selected facilities were provided with a two-day orientation about the programme; a display board with the AFS logo; information, education and communication (IEC) materials; and a small flexible amount of financial support for benches, curtains, and shelves to make the facility more adolescent friendly.

Health workers in both of the study districts had attended orientations and understood that the programme is for young people (aged 10–19) undergoing changes associated with adolescence. They said that the programme aims to create an environment that is conducive for adolescents to visit health facilities and receive services including by providing adolescent-friendly services and maintaining privacy. They also understood that the programme is about providing counselling and services to adolescents related to SRH. Although most of the health workers understood that the programme is designed to address the specific needs of adolescents, some said that the programme is only about delivering family planning services and safe motherhood services.

Although the School Health Programme and the training of peer educators do not form part of the ASRH Programme, health workers mentioned these activities as part of it. They said that these activities have created awareness about ASRH services, which suggests that there should be more coordination between the ASRH Programme and programmes at the school level to create demand for ASRH services among adolescents.

**Key finding 1: All health workers are aware of the National ASRH Programme and its components, except for a few who said that the programme is only about delivering family planning and maternal health services. While the School Health Programme and the training**

**of peer educators are not part of the National ASRH Programme, health workers stressed that these are effective ways to share about the ASRH services available at health facilities.**

Health workers were asked what activities have been undertaken to implement the ASRH Programme in their health facilities. In all facilities, health workers reported attending orientations, distributing IEC materials and making physical changes to the facilities, such as erecting curtains for privacy. Facilities had also organised orientations for the members of the health facility operation and management committee (HFOMC), female community health volunteers (FCHVs), students, teachers and members of the village development committee. Researchers observed that all of the health facilities had AFS boards displayed in visible places, except for Doti Hospital. Most HFOMCs did not have any adolescent members although some health workers remembered that adolescents had been members on previous committees. Some health workers mentioned schools, the community and peer educators as important in reaching out to adolescents and imparting SRH messages.

**Key finding 2: Health facilities have oriented selected FCHVs, teachers and other people in the village development committee about the National ASRH programme and health workers perceive community awareness to be a key factor in facilitating adolescents' access to SRH services.**

The study also looked at how health workers are recording and reporting data on the ASRH Programme and what difficulties they face in doing so. Health workers stated that they complete the monthly reporting form for the ASRH Programme by referring to different registers and send the data along with the HMIS 32 form. Some health workers said that it is difficult for them to keep records because they have to look through several registers and suggested a separate recording format for the ASRH Programme. Irregular reporting appeared to be an issue, as was lack of follow-up or refresher training.

In relation to monitoring, health workers reported that GIZ/GFA staff visited the facilities along with the focal person from the District (Public) Health Office. The issue of limited resources was raised in the interviews – there is no budget to visit health facilities under the programme. An annual review

at the district level was suggested by health workers to enable them to address the difficulties and challenges in implementing the ASRH Programme.

**Key finding 3: The recording and reporting of the ASRH Programme has not been regular and consistent. Health workers mentioned not having a separate recording register for the programme and suggested that the programme be included in the HMIS 32 (monthly reporting format).**

### Interaction between health workers and adolescent users

The study examined adolescents' access to health services and the behaviour of health workers in delivering AFSs. In relation to access to health services, health workers said that adolescents visit health facilities mostly for contraceptives, as well as for other SRH problems. They also mentioned that a few adolescents presented with concerns about physical changes and their appearance. Health workers agreed that unmarried adolescents visit health facilities more than married adolescents and adolescent boys more than girls. However, the demand side of the programme is weak, with only a few adolescents reporting that they had visited a health facility for SRH services.

Among the focus group discussion participants who had visited a health facility, most said that they visited the facility to take condoms; a few had gone with friends who had sought services for erection problems and rashes around the sexual organs. Other participants said they buy condoms from the nearby medical store instead of visiting the health facility.

Most adolescent girls in Doti had not visited a health facility, but in Banke adolescent girls had been to a facility, either for themselves or accompanying their friends or sisters-in-law. Adolescent girls visited health facilities for menstrual problems, the oral contraceptive pill and condoms; some had friends who had been to a health facility for an abortion. Married adolescents reported visiting health facilities for antenatal checkups and vaccinations. Health workers said that sometimes adolescent girls come to ask about pimples or for a remedy for pain during sexual intercourse.

In relation to the behaviour of health workers towards adolescents, all health workers interviewed emphasised that there have been significant

changes in their behaviour since the introduction of the ASRH Programme. They said that they used to think that giving young people access to contraceptives would 'spoil' or corrupt them and that adolescents should not be talking about SRH or using contraceptives. Now, some even stated that adolescents have the right to know about and use modern family planning methods. All health workers stressed that they do not ask the marital status of adolescents seeking family planning services. The study found an increased realisation of the importance of SRH among health workers and of the need to deal with SRH issues in privacy. There is an evident awareness among health workers of how they need to respond to adolescents' SRH needs. Some of the health workers mentioned that high patient flows mean that they cannot give as much time to adolescents as they should. Some health workers pointed to a knowledge gap regarding specific aspects of ASRH (e.g. emergency contraception, sexually transmitted infections) and suggested that a training would be helpful on technical aspects of the programme as well as refresher training on other aspects. These comments and the concerns of the focal person at the central level indicate that health workers require better skills to deal with adolescents and further training could be of use to them.

Adolescents were asked how health workers responded when they visited the health facility for SRH services. Adolescent boys had mixed experiences, but most gave positive feedback and said that the health workers counselled them well and answered their queries. They also shared that they could take condoms easily from health facilities. Many participants shared that the health workers taught them how to use condoms properly and advised them not to have unprotected sex with multiple partners. Adolescents said that the health workers assured them that they would maintain confidentiality and privacy. The findings of peer ethnography also suggest that confidentiality is maintained.

While most adolescents were pleased with the health workers' behaviour and said that they would happily go back to the health facility again, some did not have good experiences. Some adolescents shared that the health workers asked whether or not they were married when they went to take condoms. Some of the adolescent boys mentioned that the health workers asked the question in a teasing way or made 'fun' of them.

Similarly, adolescent girls, with few exceptions, said that they found the behaviour of health workers good and that the health workers talk to them in a friendly manner. These girls also shared that there are separate toilets for males and females. They mentioned that the 'sisters' maintain privacy by taking them into a separate room. However, some adolescent girls in Doti were discouraged by health workers' behaviour. In some cases, health workers were judgmental. Such behaviour from health workers creates a sense of mistrust among adolescents and discourages them from visiting health facilities and discussing problems with health workers.

**Key finding 4: All health workers stated that there have been significant changes in their behaviour as a result of the programme. They shared their previous reluctance to provide contraceptives to adolescents as they thought it would 'spoil' them and their previous belief that adolescents should not talk about SRH or use contraceptives. Now, when asked about changes in their behaviour towards adolescents seeking SRH services, almost all health workers expressed adolescent-friendly attitudes. However, one health worker mentioned a gap in the training of health workers, which was also stressed by the focal person at the central level, namely, that, in addition to managerial aspects, such training should also cover more technical knowledge and skills on SRH topics and on the counselling of adolescents in SRH.**

**Key finding 5: Health workers were aware of the importance of maintaining privacy and ensuring confidentiality while providing services to adolescents. They mentioned using curtains or meeting adolescents in ANC clinics, but that high patient flow sometimes does not allow them to give much separate time to adolescents.**

**Key finding 6: Few adolescents stated that they had visited health facilities for SRH services. Most of those who had visited related positive experiences, while a few had bad experiences regarding the attitude of health workers. According to health workers, unmarried adolescents visit health facilities to access services related to the ASRH Programme more than married adolescents. Furthermore, adolescent boys visited health facilities more than adolescent girls. At the same time, adolescent girls tended to have detailed knowledge about the specific**

**health services offered, e.g., for STIs, menstrual problems, acne, pain during sexual intercourse and even abortions. Most adolescents who visited health facilities shared that they were happy with the health workers' behaviour and that health workers treated them in a friendly and helpful way, did not ask for their marital status and maintained confidentiality while providing information and services.**

Adolescents who said that they had never visited a health facility for SRH services were asked their reasons for not visiting. They said that they feared that their issues would be talked about and that they would feel embarrassed. These adolescents were often not aware that health facilities offer confidential services in private. Boys in particular said that they feel uncomfortable because the health workers are senior to them. Adolescents also shared that in some cases the health workers are relatives, which adds to their discomfort as they feel shy and fear that the health worker might tell their parents. They also said that they fear running into neighbours or people they know at the health facility. Some adolescents said that they could not find the time to visit a health facility because of the long distance to school and the need to do household chores. Instead they shared their problems with friends or their mother and, hence, did not feel the need to visit a health facility.

**Key finding 7: Those adolescents who had not used SRH services were concerned about confidentiality, which seems to be one of the main reasons for adolescents not visiting health facilities for SRH services, in addition to feeling embarrassed to talk to health workers who are older than them or acquaintances.**

A set of eight adolescent-friendly IEC booklets on issues related to adolescents' SRH and rights have been produced and distributed to all public health facilities that provide AFSs and to schools in the catchment area of these facilities as part of the National ASRH Programme. Both the health workers and adolescents who have read the booklets found these materials to be very helpful. Health workers have said that adolescents visit health facilities to read these booklets. The health workers maintain that the materials are adequate in quantity for adolescents to come and read, but not for wider distribution, except for in Bajapur where the health workers said that they have been distributing the

booklets. Health workers also said that they had distributed the booklets to school libraries and community libraries. In addition to the booklets, health facilities that provide AFSs are provided with ASRH posters, an ASRH flipchart and comic book.

**Key finding 8: Most boys interviewed were aware of the IEC materials available in the health facilities, but only a few boys and girls said that they had actually read the booklets. Both health workers and adolescents who had read the booklets found these materials to be very helpful. Health workers shared that the quantity of materials is adequate for adolescents to come and read, but not for distribution.**

### Facilitators and barriers to the implementation of the programme

The study looked at the facilitators and barriers in implementing the National ASRH Programme. The main reasons for adolescents not using SRH services were concerns about confidentiality and embarrassment. Other barriers to implementation of the programme included lack of separate space for consultations, hesitation on the part of adolescents to visit the health facility, negative social perceptions towards seeking information and services to do with SRH, and inconvenient opening hours. The health workers also identified lack of refresher training (since the once-off programme orientation) and high workload as other barriers to implementation of the programme.

Facilitators to implementation included the physical changes made to the facility as part of the programme, such as the signboard displaying the AFS logo, curtains for privacy and provision for seating. Other facilitators were the emphasis by the programme on confidentiality and provision of a private consultation area; the orientation given to the programme; availability of health workers of both genders; and familiarity and trust in health workers, although this last factor could also be perceived as a barrier by some adolescents who preferred the health worker not to be a relative or someone they know.

The fact that the programme did not have district coverage was raised by focal persons as an issue in terms of the priority given to the programme. The central focal person referred to the programme as "is a forgotten agenda". He said that, at this stage,

the biggest problem is that the programme has not covered entire districts, but just 13 facilities in a district, which affects the value placed on the programme at the policy level. It also poses problems with reporting at district level. As not all health facilities are covered, not all health workers are trained, which creates problems when health workers are transferred in or out of AFS facilities. He pointed out that the ASRH Programme has just started and it will take time to mature. When it starts covering entire districts, it will gradually obtain space in review meetings and everybody will be involved, which will be beneficial to the programme. He added that the national level strengthening will take time.

**Key finding 9: The National ASRH Programme does not cover all health facilities in each district, but is limited to 13 facilities. This limited coverage has implications for the priority given to the programme at all policy levels. It also poses problems with reporting, as the reporting of AFS is not part of the HMIS 32. In addition, there is a problem when health workers who have been oriented on the programme are transferred out and replaced by health workers who have not been oriented.**

### Recommendations

The following recommendations can be drawn from the key findings:

- While in all orientations on the National ASRH Programme there is a section on cooperating with other actors in the field of SRH (including schools), the ASRH Programme should coordinate more closely with schools to effectively impart information about ASRH issues and sensitise adolescents about the availability of adolescent-friendly services at health facilities.
- As community awareness is seen as a key factor in facilitating adolescents' access to SRH services, community-based activities should be undertaken to increase awareness of the importance of adolescents' access to SRH services.
- During supervision visits, the district focal persons should pro-actively check the quality of data being recorded by health workers for the ASRH Programme, address any issues and encourage regular reporting to allow the monitoring of progress.
- Conduct refresher trainings and technical trainings for health workers as behaviour change needs reinforcement and must be supported with knowledge and skills.
- A district level review could be organised for all health facilities providing ASRH services to provide health workers with refresher training about the reporting format and to address any confusion regarding recording and reporting for the ASRH Programme.
- The provision of services to adolescents should be promoted as a routine service and treated as equally as important as other health services. The provision of services to every patient or client in a health facility should be confidential; this builds a patient-friendly approach in health service delivery in the long term.
- As many adolescents did not seem to be aware of the availability of confidential counselling services in the facilities, awareness raising activities should be targeted at adolescents to impart information about AFS. In addition to closer coordination with schools, there should also be coordination with local clubs and other organisations working in SRH to encourage adolescents to use SRH services.
- The 8 IEC booklets on ARSH should be distributed to health facilities in greater quantities, as well as to schools and clubs, and adolescents should be encouraged to read them.
- Introduce the National ASRH Programme in all health facilities in a district so that, eventually, the programme is scaled up nationwide.

## 1. INTRODUCTION

The Ministry of Health and Population (MoHP) Nepal has endorsed the Nepal Health Sector Programme (NHSP) II (2010-2015), which aims to introduce 1,000 adolescent-friendly services (AFSs) in Nepal by 2015. Towards this, the Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (GIZ, previously GTZ) is supporting the Family Health Division of the Department of Health Services, Ministry of Health and Population (MoHP) in the field of sexual and reproductive health and rights for young people. GIZ subcontracted this component of the Nepali-German Health Sector Support Programme (HSSP) which is supported by GIZ on behalf of the German Federal Ministry of Economic Cooperation and Development to GFA Consulting Group GmbH (GFA) from November 2010 to June 2014.

In 2008, the Family Health Division and GIZ started to discuss possible government interventions to improve the ability of adolescents to protect their sexual and reproductive health (SRH). Up until then, adolescent-specific health services and information had been mainly provided by non-government and private health care providers. The Family Health Division conducted a pilot for the introduction of AFSs into the existing network of public health facilities in line with a rights-based approach to health.

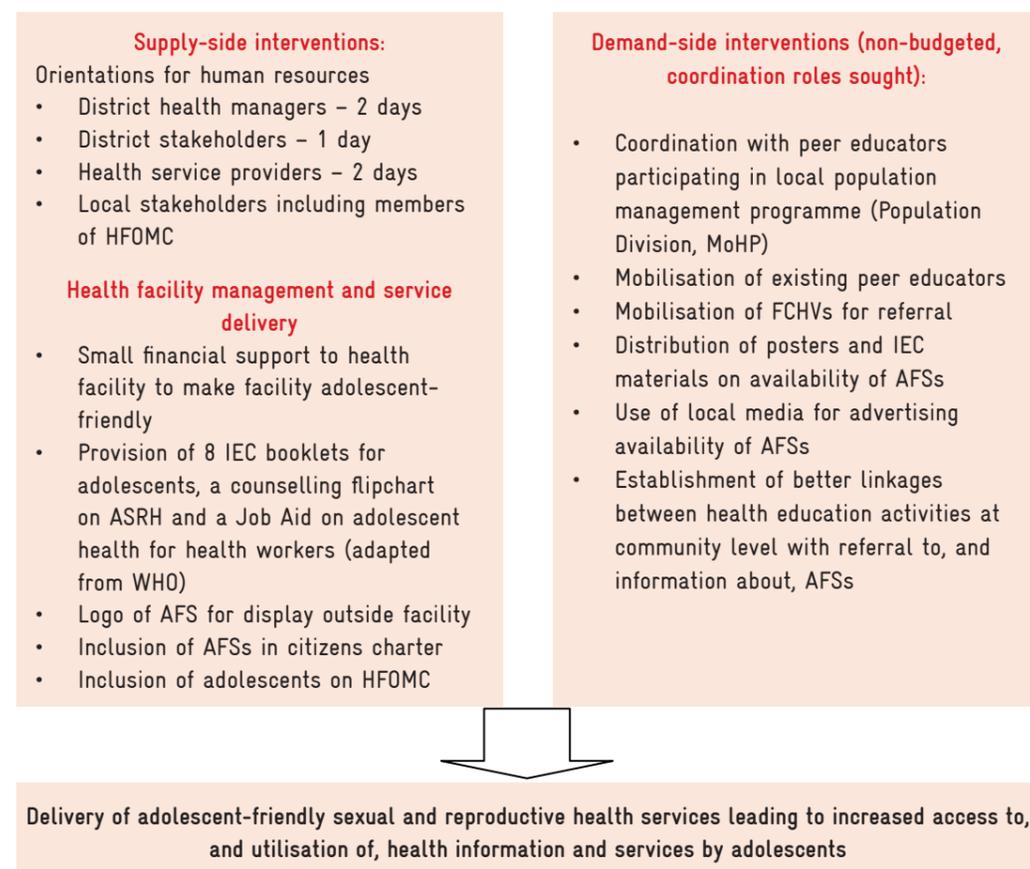
The National Adolescent Sexual and Reproductive Health (ASRH) Programme was subsequently designed based on the findings of the pilot in order to contribute to Nepal's commitment to achieving Millennium Development Goal (MDG) 5 B:

Universal Access to Reproductive Health, which is measured by the reduction in the adolescent fertility rate and increase in the contraceptive prevalence rate among women of reproductive age. The National ASRH Programme was conceptualised in line with the objectives of the National Adolescent Health and Development Strategy 2000, which are to:

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

The scaling-up process was funded directly by the Government of Nepal and different partner organisations working in the ASRH sector such as GIZ, the United Nations Population Fund, Save the Children, the World Health Organization (WHO), and UNICEF. By November 2012, the National ASRH Programme had been scaled up to 516 health facilities in 36 districts. GIZ/ GFA supported the implementation of the programme in 10 districts in the Mid Western and Far Western development regions until 2012 and is currently supporting its implementation in 5 additional districts in the same regions. GIZ/ GFA has committed to supporting the scaling-

Figure 1. Key components of the National ASRH Programme



up of the programme in up to 15 districts (up to 204 Health Facilities) using the National ASRH Program Implementation Guide 2011 (Family Health Division 2011). If the target of introducing 1,000 AFSs in the public health system by 2015 is achieved, coverage will reach about 25% of the current total number of government health facilities.

So far, there has been no systematic gathering of data to document the implementation of this recently introduced intervention to deliver sexual and reproductive health care services to adolescents. To address this, GIZ/GFA was asked by the Family Health Division to ensure that evidence on the effectiveness of the programme in terms of an increase in utilisation of SRH services as well as satisfaction with health services among adolescents

and youth is produced. Accordingly, GIZ/GFA and the Family Health Division jointly designed an operational research concept consisting of a baseline survey (conducted in 2011) and a mid-term evaluation (conducted in 2013) and an end line evaluation (to be conducted in 2015). The operational research comprises a controlled before-and-after-study using a mixed-methods approach (Simkhada et al. 2012). This report presents the findings of the qualitative research conducted for the mid-term evaluation.

### Mid-term evaluation

The mid-term evaluation was conducted as a qualitative process evaluation to explore the understanding, perceptions and experiences of service providers and adolescents related to the

implementation of the National ASRH Programme. The evaluation was conducted by the Health Research and Social Development Forum (HERD) in collaboration with GIZ/GFA in March 2013. It assessed the implementation of the National ASRH Programme in selected health facilities in Doti and Banke districts, 2 of the 10 districts where the programme has been implemented with GIZ/GFA support and where baseline data was collected in 2011. The evaluation aims to understand what activities were carried out by health service providers subsequent to the introduction of the programme for implementation; to what extent these activities conform with the ASRH Program Implementation Guide (Family Health Division 2011); and how health workers have understood the programme and have changed their delivery of SRH services to adolescents. It explored the experiences of both adolescent users and non-users of SRH services at health facilities. The evaluation also sought to identify areas for improvement to make the National ASRH Programme more effective.

The main aims of the mid-term evaluation were to:

- understand the implementation processes and the wider context as it affects the National ASRH Programme in order to provide detailed explanations for the results of the final evaluation; and
- identify improvements that can be made to the intervention to increase access by adolescents to SRH services in the remaining period of the programme and ways of improving the likelihood of scaling up the intervention across Nepal.

The mid-term evaluation aimed to answer the following research questions:

1. What is the understanding of the National ASRH intervention by health sector staff at the health facility, district and central levels?
2. What actions have been taken to implement and monitor National ASRH interventions at the centre, district, health facilities and communities?
3. What are the facilitators and barriers to the implementation of the National ASRH Programme?
4. Are the services in health facilities accessible to adolescents? What are the facilitators or barriers for adolescents in accessing services in health facilities? Have there been any changes in accessibility since 2011?
5. Have health workers noticed any changes in their own attitudes or behaviour towards adolescents or that of other health service providers?
6. Have adolescents noticed any changes in the attitudes or behaviour of health workers towards them?
7. What contextual issues, at community, regional or national levels, may have influenced attitudes and practices related to adolescent sexual and reproductive health?
8. How could the intervention be improved from the perspective of adolescents and health workers?

## 2. METHODOLOGY

The methodology used for the mid-term evaluation was a qualitative mixed method approach (Simkhada et al. 2012) and combined interviews, focus group discussions, peer ethnography and observations. The fieldwork was conducted in March 2013.

### Study area

The research was conducted in Doti and Banke districts given their regional and geographic variation and their inclusion in the baseline study in 2011 (Simkhada et al. 2012). Four health facilities in each district were selected by the GFA team based on their knowledge of compliance\* from regular supervision visits. Examples of all types of health facilities ranging from those performing well, medium and poor were included (Table 1).

### Research team

Eight field researchers, mostly from public health and social science backgrounds, were trained in conducting semi-structured interviews (van Teijlingen and Ireland 2003), focus-group discussions (van Teijlingen and Pitchforth 2006), peer ethnography (Price and Hawkins 2002), and observation and note-taking (Mulhall 2003). These field researchers were asked to write their observation notes at the end of the training day and

their notes were discussed later with the facilitator to improve the writing of effective notes and avoid making judgments. They were also taught how to maintain a field diary to record their observations and experiences to provide context to the data collection process.

Prior to this orientation, the eight field researchers attended a two-day research skills workshop to introduce them to qualitative research. They were also trained in how to apply the research tools.

Data collection took place over a period of ten days in March 2013. The researchers contacted the respective district (public) health office with a letter from Family Health Division to co-ordinate the research. The district health officer or deputy prepared a letter directing the selected health facilities to provide support to the research team. The focal persons for the ASRH Programme in the district also made telephone calls to the respective facilities informing them about the research and requesting their cooperation.

**Table 1: Selected health facilities**

Doti	Level of compliance*	Banke	Level compliance
District Hospital	High (7/7)	Sonpur Health Post	High (7/7)
Mudvara Health Post	Medium (6/7)	Samshergunj Health Post	Medium (6/7)
Bhumirajmandu Health Post	Medium (5/7)	Baijapur Sub Health Post	High (7/7)
Saraswatinagar Primary Health Care Centre	Low (2/7)	Titirihya Sub Health Post	Low (3/7)

\*Note: Compliance level indicates how many indicators out of seven indicators of adolescent-friendliness the health facilities met at the time of supervision.

### Sampling

The research employed purposive sampling (Neuman 2000) to choose study participants to ensure that they would be able to provide insights on the National ASRH Programme that the study was aiming to evaluate. As the research is a process evaluation of the implementation of the National ASRH Programme, the participants in the study comprised service providers and adolescents. The health workers who had received the two-day orientation of the National ASRH Programme were selected, as were members of health facility operation and management committees (HFOMCs) who had received the programme orientation. The district focal persons for the National ASRH Programme were also interviewed in Doti, but not in Banke, because the key person in Banke was not available during the research period. The field researchers also spoke to a few adolescents in the community to gather other adolescents to take part in the study. At some places, the researchers met volunteers from SRH organisations, who helped to gather adolescents for focus group discussions. As peer ethnography was employed only in Banke, the researchers recruited four peer interviewers (adolescent boys and girls) who were trained by the field researchers on specific questions to ask their adolescent friends. Each peer interviewer interviewed two of their friends. In total, eight peer ethnographic interviews were conducted. A total of 74 people participated in 9 focus group discussions (Table 2).

### Sample characteristics

The participants were primarily health workers and adolescents. The health workers comprised health assistants, auxiliary health workers (AHW) and auxiliary nurse midwives (ANM). In order to understand the context, those health workers who had not received the orientation, but were providing SRH services to adolescents, were also interviewed. The research team also interviewed members of the HFOMC whenever possible. The current and previous district focal persons at Doti and the focal person at the central level were also interviewed.

A pharmacy student in Doti Hospital in an informal conversation mentioned that adolescents visit the

**Table 2: Participants in interviews and focus groups**

Participants	Number
Health workers	17
HFOMC members	6
Peer interviews	8
Exit clients	2
Former SRH service users	2
District focal persons	2
Central focal persons	1
Contextual interviews with representatives of SRH organisations and a teacher	3
Total number of interviewees	41
Focus group discussions (nine) with adolescents	74

Family Planning Association of Nepal (FPAN) for SRH services instead of the district hospital. Interviews with health workers revealed that FPAN conducts awareness programmes on SRH in the district and, therefore, the researchers visited FPAN's office in Doti to understand the context in the district. Similarly, the volunteers of the Restless Development Center in Bhumirajmandu were interviewed on issues related to health education in schools.

Both male and female adolescents participated in the study. The boys were aged between 13–19 years and most were school students, with some college students (doing their intermediate level). The girls were aged between 10–19 years and none had been to college. The unmarried girls were still in school and the married ones had discontinued their studies.

In 2011, the Nepal Health Research Council approved the qualitative process evaluation as part of the wider programme evaluation, which consisted of two quantitative surveys and a qualitative process evaluation. A participant information sheet was prepared in Nepali to explain what the research was about. All participants had the study explained to them and verbal consent was taken for the interviews and focus group discussions. The interviews were audio taped with the permission of the participants and, if they declined, recorders were not used. The names of the participants have been removed and to make the data anonymous and confidential.

## Data collection

Data was collected in semi-structured interviews, focus groups discussions, peer ethnography interviews and observation by the researchers.

## Semi-structured in-depth interviews

A total of 27 semi-structured in-depth interviews were conducted with health workers, HFOMC members, district and central level focal persons, and other relevant people to understand how the National ASRH Programme is being implemented and the perceived facilitators and barriers. The researchers also interviewed two exit clients and two former SRH service users. A Semi-structured Interview Guide (see Annex 1) was developed to guide the interviews, but the researchers tried to keep the interviews conversational.

Some difficulties were experienced in conducting the interviews as the health workers and focal persons were very busy. At the time of the interview, family planning training was being conducted in Doti and, therefore, it was difficult to meet the focal person. Two health workers from Bhumirajmandu Health Post also participated in this training, so the interviews had to be conducted during the breaks in the training. Most of the other interviews were conducted at the health facilities. A health worker from Dhangadi working in Saraswatinagar was interviewed at a hotel. The researchers met the AHW of Mudvara at the Doti District Hospital and walked with him to the facility as there was a general strike on at that time; however, when they reached the facility the health workers became engaged in a meeting and researchers could only interview them afterwards. Occasionally, interviews with health workers in facilities were interrupted by patients or someone else. It was very difficult to interview the focal person at the central level because he was busy with programmes and out of Kathmandu for much of the time. However, he was finally interviewed late in the day at his office.

## Focus group discussions

Focus group discussions were carried out with adolescent boys and girls in both districts to

understand their perceptions of the SRH services provided by health facilities and of health workers' behaviour using a Focus Group Discussion Guide (see Annex 2). Of the 9 focus group discussions, 4 were conducted with boys and 5 with girls, with 7 to 11 participants in each group (Wilkinson 1988). Focus group discussions took place at schools, outside health facilities, at a hostel and in an open space. The female researchers found it difficult to get the girls to speak, partly due to shyness. At one place where the focus group discussion was conducted in open space, they were frequently interrupted by small kids. The researchers tried to send them away by giving them sweets, but were unsuccessful.

## Peer interviews

Peer ethnography is a qualitative research method derived from anthropological approaches to ethnographic fieldwork (Price and Hawkins 2002). Peer ethnography is used in research areas that are sensitive in nature (e.g., Collumbien et al. 2009). It is based on the premise that there is an established familiarity and trust among the members of a community, which allows them to engage in in-depth conversational interviews (Collumbien et al. 2009). In this method, peer researchers/interviewers are trained to conduct in-depth interviews with individuals from their network. This generally involves interviewing over a period of time to obtain in-depth information. However, due to the limited time in which the study was conducted, the research team did a rapid peer study consisting of one-off interviews by the peer interviewer with his/her friends.

As peer ethnography is a relatively new method, it was used only in Banke and a separate guide was prepared for this (see Annex 3, Peer Ethnography Guide). One male and one female peer interviewer were identified among the community and trained by the researchers. These peer interviewers spoke to two of their friends and shared the information with the researchers.

## Observation

The field researchers used an observation checklist (see Annex 4) to collect data regarding implementation of the ASRH Programme from the facilities (Pretzlik 1994).

**Table 3: Overview of key research questions, participants and methods**

SN	Research question	Participants	Methods
1.	What is the understanding of the National ASRH intervention by health sector staff at health facility, district and central levels?	Focal person for ASRH at the district and central level; AHWs; ANMs	Interviews
2.	What actions have been taken to implement and monitor ASRH interventions at the centre, district, health facilities and communities?	Focal person for ASRH; AHWs; ANMs; members of HFOMC	Interviews Observation at health facilities
3.	What are the facilitators and barriers to the implementation of the National ASRH Programme?	Focal person for ASRH; AHWs; ANMs; members of HFOMC	Interviews Observation at health facilities
4.	Are the services in health facilities accessible to adolescents? What are the facilitators or barriers for adolescents in accessing services in health facilities? Have there been any changes in accessibility since 2011?	Adolescents: (non) service users; male/female; married/unmarried; different ages	Peer ethnography Interviews Observation at health facilities
5.	Have health workers noticed any changes in their own attitudes or behaviour towards adolescents or that of other health service providers?	Focal person for ASRH; AHWs; ANMs	Interviews
6.	Have adolescents noticed any changes in the attitude or behaviour of health workers towards them?	Adolescents: (non) service users; male/female; married/unmarried; different ages	Peer ethnography Interviews Focus group discussions
7.	What contextual issues at the community, regional or national level may have influenced attitudes and practices related to ASRH?	Focal person for ASRH; AHWs; ANMs; members of HFOMC Adolescents: (non) service users; male/female; married/unmarried; different ages	Interviews Peer ethnography Focus group discussions
8.	How could the intervention be improved from the perspective of adolescents or health workers?	Health workers and adolescents	Interviews Peer ethnography Focus group discussions

Note: AHW= auxiliary health worker; ANM= auxiliary nurse midwife; HFOMC = health facility operation and management committee

## Data analysis

Creswell (2009) pointed out that data analysis involves making sense out of text and image data, which involves moving deeper into the data to represent and interpret its larger meaning. Most of the interviews and focus group discussions were recorded and the field researchers transcribed the data in Nepali when in the field, based on their notes and the recordings. The handwritten transcripts were translated in English by translators when the researchers returned to Kathmandu. The English transcripts were coded using the ATLAS.ti software and were then thematically analysed (Forrest Keenan et al. 2005).

## Limitations

The study was conducted in selected health facilities in only two districts; therefore, the findings may not be generalised to other GIZ-supported districts or to the many other intervention districts of the ASRH Programme that are supported by the Family Health Division or other donors. As the study was conducted over a short time period, only one focus group discussion was conducted per facility, which may not have been representative of all the adolescents.

# 3. Findings: Implementation of the ASRH Programme

This chapter discusses health workers' understanding of the ASRH Programme, what they have done to implement it and how they have reported the programme.

## Key components of the programme

The National ASRH Health Programme was introduced in 2011 in 14 health facilities in Doti and 13 in Banke districts. Under the programme, health workers from selected facilities were provided with a two-day orientation about the programme; a display board with the AFS logo; information, education and communication (IEC) materials; and a small flexible amount of financial support (of approximately NPR 10,000, equivalent to approximately EUR 80) to purchase equipment to make the health facility adolescent-friendly (e.g., curtains to create a private counselling area for adolescents, benches for a waiting area and wooden shelves for IEC materials). Some of the interviewed health workers said they used the money to buy curtains, water filters and benches. In Banke, health workers showed a cupboard that was purchased using financial support provided by GFA/GIZ.

## Understanding of programme by health workers

When reflecting upon the programme, health workers in both of the study districts referred to the orientations they attended as *taalim* (training). They said that the programme is intended for young people aged 10–19 who are undergoing changes associated with adolescence and become curious about SRH. They said that the programme is to help adolescents by creating an environment that is conducive for them to visit health facilities to receive services.

*Adolescent are people aged 10–19 years old. The National ASRH Programme covers understanding their problems and giving counselling, advice and suggestions to them [...]. It also deals with sexual and reproductive health problems and makes us [health workers] and adolescents comfortable to talk freely about such problems and addresses how to give adolescents proper advice, counselling, medicine and services.*

Health worker, Banke

*The ASRH Programme has been introduced for the 10 to 19 age group. They undergo different physical and mental changes and this programme is to provide information to answer any questions that arise from these changes. This programme provides the knowledge to distinguish right activities from wrong and provides information to adolescents about sexual diseases, their causes and prevention and control measures. This programme also provides knowledge about safe sexual intercourse, the appropriate age for sex and the age for physical development and changes.*

Health worker, Doti

*I received a one-day orientation on ASRH and I learned a lot from it. I learned how to run a programme in an effective way, how to maintain their privacy, (for example, by closing curtains during checkups) [and] how to counsel them [adolescents] [...].*

Health worker, Banke

Most staff in health posts had an understanding of which aspects characterise adolescent-friendly services; however, one staff member said that he didn't "know exactly what the programme has been doing".

*The adolescent programme means that we give adolescent-friendly services in this facility, such as family planning. Adolescents may be married or unmarried. We give counselling and friendly services to them [...], but I don't know exactly what the programme has been doing. It has given safe motherhood services, abortion services and family planning service, as usual.*

Health worker, Doti

As illustrated by these quotes, health workers understand that adolescents undergo various changes and that this programme is about providing counselling and services to adolescents related to SRH. Some health workers said that the programme emphasised the need to maintain privacy when dealing with adolescents and to be friendly with them. Although most of the health workers mentioned that the programme is designed to address the specific needs of adolescents due to their age, some of the health workers said that the programme is only about delivering family planning services and safe motherhood services. All of the health workers who participated in the study noted that they need to be adolescent-friendly in the provision of services.

## Programme activities

Health workers were asked what activities have been undertaken to implement the ASRH Programme in their health facilities. They mentioned the orientations, the distribution of IEC materials and physical changes to the facilities.

*We have conducted an [...] orientation for the management committee; given training to 2–4 adolescents; constructed a counselling room for adolescents; provided books for them to read and asked them what they have learnt. We have displayed the logo and distributed IEC materials.*

Health worker, Banke

*To implement this programme, our facility has given training to the members of the management committee, students, [and] volunteers [...]. [T] here was a set of educational materials focusing on adolescent people in which there were 7–9 different books on things like the menstruation cycle, adolescent changes and other subjects. We have distributed those books [...].*

Health worker, Banke

*There is a concept of [peer education] [...]. First, we provide training to students on the ASRH Programme [...]. After training, according to their eligibility and ability, we choose students [to be peer educators]. We choose students from class 9 and 10. One boy and one girl are chosen. After that we give an orientation on the ASRH Programme using our manual. The orientation manual contains information on sexually transmitted diseases, HIV/AIDS, scabies, the physical changes that take place during adolescence, negative and unusual behaviour among adolescents, and adolescents involved in drug addiction. We train them on these topics. We also provided them with books on adolescence for their further study.*

Health worker, Banke

*We organised a one-day orientation programme about the commencement of the ASRH Programme for all of the members of the health facility operation and management committee, female community health volunteers and adolescents in the local area. This programme was conducted by the Health Post itself and the budget for this was provided to us by GTZ [GIZ]. Adolescents also participated. As adolescents are very inquisitive and curious, we have made a sort of IEC corner where we have placed different kinds of IEC materials related to family planning and on matters relating to the changes seen in adolescents, so that whatever and whenever they desire for anything they can read it. We have even distributed [these brochures] to them.*

Health worker, Doti

In all facilities, health workers reported that they had conducted activities to implement the ASRH Programme. As evidenced by the quotes above, health workers said that their facilities had organised an orientation for the members of the HFOMC, female community health volunteers (FCHVs), students, teachers and members of the village development committee. Some also mentioned that they have put up the board with the AFS logo in their health facility and established an IEC corner.

The observation data collected by the researchers (using the Observation Checklist in Annex 4) shows that all of the health facilities had AFS boards displayed in visible places, except for Doti Hospital. The AFS board in Doti Hospital was inside the antenatal care (ANC) clinic and could not be easily seen from outside. The Doti ANMs explained that the board used to be outside the ticket counter, but they had to shift it inside because of the wind.

One ANM mentioned that, as they had no separate space, they used small curtains while talking to adolescents. Health workers in all facilities, except for Saraswatinagar, provided services to adolescents through their out-patient department (OPD) and ANC clinics. They said that curtains are available, but the researchers did not see the curtains being used as hardly any adolescents visited the facilities for ASRH services during their visits.

The researchers asked health workers and HFOMC members whether there were any adolescents on the committee. According to the participants, most HFOMCs did not have any adolescent members. Some health workers remembered that adolescents had been HFOMC members, but reported that this was no longer the case.

*One adolescent girl and one adolescent boy were included as representatives on the health facility operation and management committee, but that management committee collapsed and there are not any adolescent representatives on the newly formed management committee.*

Health worker, Doti

One HFOMC member pointed out that numerous programmes come to the health facilities and

suggested that they need to be reminded of the ASRH Programme.

*Earlier, we used to have discussions about the ASRH Programme, but nowadays we are not discussing it because many new programmes have come along and we have forgotten this programme. If employees from GIZ came regularly, like you have, and made suggestions, then we would remember this programme. Earlier, adolescents were involved in the programme and in the meetings, but not now. Nowadays, adolescents only come to the facility for services, not for committee meetings.*

HFOMC member, Banke

In other facilities, health workers did not refer to the inclusion of adolescents in the HFOMC. Only some of the interviewed HFOMC members said that the ASRH Programme is to provide services and counselling related to the physical changes that take place in adolescence. HFOMC members also spoke of the need to maintain privacy and confidentiality while providing services to adolescents.

## Other activities

Although the School Health Programme and the training of peer educators do not form part of the ASRH Programme, health workers mentioned these activities as part of it. This suggests that they are not entirely clear about the components of the ASRH Programme. Nevertheless, these activities have aided in creating awareness about ASRH services. This observation suggests that there should be more coordination between the ASRH Programme and programmes at the school level to create demand for ASRH services among adolescents.

In Banke, health workers stated that they had distributed IEC booklets to libraries in schools and the community as part of the regular programme implementation. These health workers said that they believe that the School Health Programme is crucial in delivering information on the ASRH Programme and in reaching out to adolescents. They mentioned the role of peer educators

in schools in imparting SRH messages. One health worker shared that, although there are no designated activities at schools under the National ASRH Programme, they give information about ASRH in schools and in communities when they conduct other programmes.

An AHW in Banke mentioned that there is no financial provision for activities in schools under the National ASRH Programme and running the School Health Programme is not compulsory; consequently, the programme has not been prioritised. In Doti District Hospital, an ANM said they have not been able to reach out to adolescents as much as they should have. This ANM said that they visited some schools in the beginning, but did not continue because their workload did not allow. Some of the health workers also shared that when the 'selected peers' had finished school, another group of peers had not been selected to replace them.

## Reporting

### Monthly reporting system

According to the ASRH Programme Implementation Guide (Family Health Division 2011), the total number of adolescents who come for health services needs to be recorded in the miscellaneous column of the Health Management Information System (HMIS) register for OPD. A separate monthly reporting form should be used to report the overall use of AFSs and sent with the HMIS 32 (monthly reporting form for health facilities) to the district, region and centre. In this section, we discuss how health workers are recording and reporting the data and what difficulties they face in doing so.

Health workers stated that they complete the monthly reporting form for the ASRH Programme by referring to different registers and send it along with the HMIS 32.

*"We have done the reporting every month [...]. We record how many adolescents came [and] what services they used [...]. We are four staff members here [...]. Anyone can record and all of us are doing that. To date, we haven't faced any problem in relation to recording and reporting."*

Health worker, Banke

*"We don't have many difficulties in recording and reporting. We separate those of adolescent age from the master register and from the OPD register. We record the problem they presented with and the services provided from the OPD register. In this way, we maintain recording and reporting. All staff do recording and reporting. Sometimes difficulties occur because there are many other programmes."*

Health worker, Banke

While the health workers in some facilities stated that they don't face any difficulties in either recording or reporting, in other facilities in Banke and Doti health workers said that it is difficult for them to keep records because they have to look through several registers. These health workers said that it is necessary to have a separate recording format for the ASRH Programme.

*"We don't have any problem in reporting, but have a problem in recording. The ASRH Programme doesn't have its own recording format, so there are difficulties. We record the age of the adolescent from the OPD register, maternal and child register, nutritional register and family planning register (especially for contraceptives)."*

Health worker, Banke

*"The challenge is in turning over all the files. It is very difficult to search for records of adolescents aged 10–15 years and 15–19 years. We don't have a separate register. It would be easy, if there was a separate register for this programme."*

Health worker, Doti

The current and the previous focal persons for the ASRH Programme in Doti district did not suggest the need for a separate register, but discussed the problem of irregular reporting. As the focal persons were interviewed before the health workers, they could not be probed on this issue. However, the national focal person in charge of the National ASRH Programme said, "ASRH is not a separate service in itself" and, therefore, there is no need for a separate register as the information can be obtained from other registers. He also said that having a separate register might impact on the confidentiality of information given by adolescents. He, however, admitted that there is confusion about the recording and reporting of relevant data, for example:

*"There is no clarity among health workers on recording and reporting for the ASRH programme [...]. It is true that there were not enough exercises during the training [...]. The exercises were inadequate and, therefore, the health workers are confused [...]. Generally, in the training, the recording/reporting section is done last and there is always a rush to complete the session [...]. The trainers say "do it like this", but when the health workers have to do it in practice, they face problems. There definitely has to be more exercises included in the training, which would involve increasing the number of days, so that they [health workers] are familiar with the recording/reporting system."*

Focal person, Family Health Division

The district focal person at Doti, who had received the training, shared similar concerns. He said that the recording pattern was not given during the training and there was no follow-up or refresher training, which caused difficulties in maintaining the records of the programme. In the following excerpt, the in-charge of a health facility in Doti said that they haven't been able to incorporate the information and counselling services into the recording system of the health facility.

*"There are other components of this ASRH Programme, but we haven't been able to address these components in the recording process. For example, we haven't been able to incorporate the use of services related to counselling and IEC materials into the recording system. Our reports*

*only show the services used by OPD patients. In our other records, there are a large number of females of different ages. This could be the reason why the number of adolescent girls receiving services is high."*

Health worker, Doti

As the in-charge said, we did not find the counselling, information and education services being reported in any month from the Bhumirajmandu Health Post. While confusion over how to report this data may not be a problem in every health facility, the fact that one health worker brought up the issue indicates that it could be a problem in other localities.

Most health workers said that the reporting of the programme should be integrated into the HMIS 32 to make it easier for them, which shows that health workers do not know that the programme is not being implemented in all health facilities. The focal person at the central level said that unless the programme is implemented in all health facilities in a district it is not possible to integrate it into the HMIS 32.

### Irregularity in reporting

Both the previous and current focal persons for the ASRH Programme at Doti mentioned that health facilities did not report regularly at the beginning of the ASRH Programme, but said that there had been improvements.

*"[W]e distributed [IEC] materials, put up the board supported by GIZ/GFA, and did other things for the ASRH Programme and asked the health workers to do 'recording' and 'reporting' of the programme [...]. But after the orientation, we could not follow up because of our own workload and, therefore, there was no reporting [...]. After receiving training, the staff of the 13 health facilities who were trained were engaged in other work. So they neglected to do the reporting for this programme. All of the 13 health facilities participating in the programme are far from the district capital, so we have not visited these facilities regularly or kept in contact over the phone [...]. There is network problem, which makes it difficult to keep in contact by phone."*

Former focal person, Doti

The situation, however, has been improving as the current focal person at Doti has been following up with health facilities by phone or in person to collect reports. He said:

*In Doti district there is a problem with the timely reporting for the ASRH Programme. Reporting is done only after 2–3 months. Reporting for Falgun [February/March] has just arrived in the district this month. The focal person himself has to collect reports by visiting the facilities [...]. In the past month, I visited nine facilities and have been able to collect the reports [and] they have started becoming regular.*

Focal person, Doti

The health workers from Mudvara and Bhumirajmandu health posts also said that they only started sending regular reports to the district when the focal person from the district and GIZ staff visited for supervision. One health post in-charge explained:

*Our district focal person and Pushkar Silwal visited our facility [...]. They even shared their experiences of visiting other health facilities and the activities conducted by these facilities; this totally encouraged me to do the same [...]. I hadn't sent reports for many months, so they encouraged me to send the reports in a timely way. Now I do send these reports.*

Health worker, Doti

Health workers at Mudvara and Doti hospitals said that the reporting forms had been misplaced or were unavailable and, hence, they were unable to submit reports on time. The following quotes show that in some cases the reporting system is very much dependent on one person:

*We have to report monthly to the District Health Office, but we have not been able to do so because we do not have the forms. Earlier, we had made photocopies of the form and used it for reporting, but these forms are finished. I was in training for six months and perhaps others did not ask for the forms. Since I returned, I have maintained reporting.*

Health worker, Doti

*[D]idi [senior woman] used to do it; I could not give time because of my OPD duties. I did the reporting for only one or two months about six or seven months ago. Previously, the ASRH Programme was implemented from the building nearby, but later the rooms were shifted and the reporting forms could not be found [...]. The forms were lost when the programme shifted rooms. We usually take the records from the indoor record and from the OPD records. And then we send the reports to [...] 'dai' [senior male/focal person]. It seems like it has been almost four or five months since the reports were prepared.*

Health worker, Doti

In these quotes, the health workers said that they had not undertaken reporting because the forms were not available, but did not mention asking for forms when there were not enough forms or the forms were lost. At a facility in Doti, an AHW said that the forms were misplaced, but the ANM did not seem to agree. She shared that the reporting had been done by the AHW for the first two months only and the ANM did it after that. This reveals a lack of clarity among health workers about who should be doing the reporting of the ASRH Programme in this particular facility. The explanation for this lies partly in the following quote where the same AHW outlined the change in his duties shortly after completing training:

*I took the training, but have not been properly involved in this programme as I am engaged in morning and evening duty rotations in the OPD [...]. I have not worked for this programme since the first few months.*

Health worker, Doti

The explanation may also lie in the lack of ASRH patients, as the AHW said that he did not remember adolescents visiting the OPD with SRH problems.

### Observation of reporting

The field researchers observed the reporting done by health facilities and noted the data available in the forms. In Doti, the team collected the information from the reports at the District Health Office. The reports from all four facilities in Doti

were available, whereas in Banke the reports were checked by the researchers at the facilities. In Doti, the researchers also observed the reports in the facilities (in addition to looking through them at

the District Health Office) where they found recent reports from Falgun, (February/March) (see Table 4).

**Table 4: Status of reports at health facilities in Doti and Banke**

Health facility	Available reports	Remarks
Doti: District Hospital	3 months: Poush to Falgun (December/January to February/March)	<ul style="list-style-type: none"> <li>Reported only antenatal care, tetanus toxoid (TT) vaccine, abortion, delivery services</li> <li>Date when report sent not written</li> </ul>
Doti: Mudvara Health Post	4 months: Baisakh to Asadh (April/May to June/July) and Falgun (February/March)	<ul style="list-style-type: none"> <li>Reported according to the format</li> <li>Data on information, education and counselling services not reliable because total number of adolescents receiving all SRH services is recorded under general IEC services as well.</li> </ul>
Doti: Bhumirajmandu Health post	10 months: Baisakh to Falgun (April/May to February/March); report for Asadh (June/July) not found	<ul style="list-style-type: none"> <li>Reported only the total number of adolescent clients by age group</li> <li>No disaggregated data according to description of services</li> </ul>
Doti: Saraswatinagar Primary Health Care Centre	8 months: Shrawan to Magh (July/August to January/February) and Falgun (February/March)	<ul style="list-style-type: none"> <li>Reported according to the format</li> </ul>
Banke: Sonpur Health Post	12 months: Chaitra to Falgun (March/April to February/March)	<ul style="list-style-type: none"> <li>Reported according to the format</li> </ul>
Banke: Titirihya Sub Health Post	11 months: Baisakh to Falgun (April/May to February/March)	<ul style="list-style-type: none"> <li>Reported according to the format</li> </ul>
Banke: Shumshergunj Health Post	1 month: Falgun (February/March)	<ul style="list-style-type: none"> <li>Reported according to the format</li> <li>Only reported aggregated data; no details of services used</li> </ul>
Banke: Baijapur Sub Health Post	1 month: Falgun (February/March)	<ul style="list-style-type: none"> <li>Reported according to the format</li> <li>Only reported aggregated data; no details of services used</li> </ul>

Table 4 shows the status of reporting in the health facilities in both Banke and Doti. In one facility, the report showed the same number of male and female clients in all categories of services, which is unusual and may indicate an error. The reports were incomplete in some facilities, only reporting the total number of service users.

#### Possible reasons for non-reporting of data

Health workers commented that some adolescent patients did not wish their service use to be recorded. A health worker said:

*Adolescents don't come with major health problems. They only come for services such as getting condoms. We don't record such activities. Furthermore, unmarried adolescent girls don't want their name and information recorded. They clearly explain that they have come to get the pills to delay their menstruation in order to observe festivals. We try to keep a record of both married and unmarried women, but if they don't want their information recorded, we just provide them with the services. Boys studying in class 8 and 9 come for condoms and silently go after taking them.*

Health worker, Doti

During focus group discussions, adolescents also shared that health workers tell them that they can take condoms from the box kept in the facility, which means that the chances of distribution not being recorded is high. The adolescent boys mentioned that they usually go with their friends, which might make it difficult for health workers to record how many of them actually use the service.

The statements of health workers point to two issues in the recording of services used. Firstly, adolescents are reluctant to be recorded, which is probably because they are concerned about confidentiality. The second point is related to the programme perspective, namely, if the provided services are not recorded, this reflects adversely on the coverage of service delivery under the programme and the actual number of adolescents using the programme services could be much higher than the reported number.

### Monitoring and supervision

Health workers were asked whether or not people from the district or central level conducted monitoring visits for the ASRH Programme. They reported that GIZ/GFA staff visited the facilities along with the focal person from the District (Public) Health Office.

*For the supervision, [...] 'didi' [senior female] came [...]. She is a staff of GIZ. She observed all the materials that were provided by them such as bench, chairs, cupboards [...].*

Health worker, Banke

*[A lady from] GIZ [...] visited this health post for the ASRH Programme [...]. She visited once and asked how the programme is running [and] whether any materials related to programme were required or not.*

Health worker, Banke

The previous focal person at Doti shared that, initially, he did not go for monitoring visits because of his workload and the fact that the facilities are located far from the District Health Office. However, he said that later he joined GIZ staff to visit the facilities for monitoring. The current focal person in Doti, who had recently joined the District Health Office, reported visiting nine health facilities in the past month and was able to collect the reports from health facilities.

The focal persons did not share much about the monitoring visits, but the focal person at the central level, when asked if he goes for monitoring visits or takes information from the district focal person, said, "The ASRH Programme is a forgotten agenda". He said that, at this stage, the biggest problem is that the programme has not covered entire districts, but just 13 facilities in a district, which affects the value placed on the programme at the policy level. He added: "As the programme doesn't have entire district coverage, it does not get given weight in the review meetings at the district, regional and central levels. It is difficult to integrate with the existing review meetings at district, regional and central levels."

He also said that they generally talk about family planning and the Safe Motherhood Programme at the district level. Every programme has a budget for monitoring, but the ASRH budget is very small. There is no money to visit health facilities and the issue of limited resources was raised in the interviews. He pointed out that the ASRH Programme has just started and it will take time to mature. When it starts covering entire districts, it will gradually obtain space in review meetings and everybody will be involved, which will be beneficial to the programme. He added that the national level strengthening might take time as they have been aiming to upgrade 1,000 health facilities as AFS facilities, as per the NHSP II.

*We should have pushed our partners to go beyond the target [...]. We have to make 1,000 health facilities adolescent-friendly by 2015 and we will reach this, but we could have pushed our partners to go towards district coverage, which would have produced a cumulative result. We couldn't do so [...]; we didn't think beyond attaining 1,000 health facilities by 2015.*

Central level focal person

The health workers who took part in the study pointed out that a periodic review at the district level, which could be held once a year, would enable them to address the difficulties and challenges in implementing the ASRH Programme.

## 4. Findings: Interaction between Health Workers and Adolescent Users

This chapter presents the findings on the behaviour of health workers in delivering AFSs under the National ASRH Programme including adolescents' access to health services. Health workers were asked if they have noticed any difference in their response to young people with SRH issues. Similarly, adolescent respondents shared their experiences of interacting with health workers. There is also an element of interaction between health workers and adolescents in the use of information booklets, which is covered in the chapter.

### Adolescents' access to health services

#### Health workers' perspective

Health workers said that adolescents visit health facilities mostly for contraceptives, as well as for other SRH problems. They also mentioned that a few adolescents presented with concerns about physical changes and their appearance.

*Adolescents do visit the health post seeking services under the ASRH Programme. Mostly they come for contraceptives rather than to obtain information on the ASRH Programme. Mostly adolescents of 14–19 years old come with their problems. Adolescent boys visit more than girls. Adolescent boys come to take condoms and adolescent girls come with menstruation problems, breast-related problems and problems with pain during intercourse. They come for services as well as for information.*

Health worker, Banke

*Unmarried [adolescents] visit more. For females, it is mostly with problems related to menstruation, stomach pain and other general problems. A few adolescents visit complaining about acne and other scars on their faces; most of them come for condoms and other contraceptives. Both married and unmarried adolescents come, but mostly unmarried adolescents come to take*

*the condoms, and they even come with problems related to physical changes.*

Health worker, Doti

Health workers agreed that unmarried adolescents visit health facilities more than married adolescents to access services related to the ASRH Programme. One of them said that this is because married adolescents are less free to move about in the community, whereas unmarried adolescents who want to know more about the changes happening to them can move more freely. Health workers noted that adolescent boys visit more often than girls.

#### Adolescents' perspective

Among the adolescents interviewed in focus group discussions, few had visited health facilities for SRH services. Most adolescents were not aware of the specific programmatic aspects of the AFS intervention in nearby facilities, but were aware that general family planning and SRH services were available. The focal person at the central level said that the demand side of the programme is weak. He feared that adolescents do not know that SRH services are available and he emphasised that there should be more information centres for adolescents. The following responses given in a focus group discussion suggest that a few of the adolescents in this focus group had received information and counselling from their local health facility:

**Facilitator:** *Do you know that the nearby health facility provides services on sexual and reproductive health?*

**Participants:** All of the participants said that they knew about the services provided in the health facility.

**Facilitator:** *What services are provided?*

**P7:** *Treatment is done when there are rashes (khatira) around the sexual organs and they also provide contraceptives.*

[Laughing]

**P8:** *Medicine for scabies is also given.*

**P7:** *Education is provided on sexual and reproductive health. Counselling is given when there is curiosity about the physical changes of adolescence.*

**P1:** *Contraceptives are given.*

**P5:** *Pills are provided to females.*

**P6:** *The medicines are also given to girls when they have stomach pain during menstruation.*

Male participants in focus group discussion,  
Banke

Among the few focus group discussion participants who had visited a health facility, most took condoms, while a few had gone with friends who had sought services for erection problems and rashes around the sexual organs. The boys also mentioned that girls go to the facilities for menstrual problems. One of the participants in Shumshergunj, Banke had visited the health worker to ask about pain during menstruation for girls and what should be done and he passed this information on to his friends when their girlfriends had problems. He said, "In the village, if someone has girlfriend and they have menstrual problem, at that time I give advice and suggestions after asking the health personnel and getting advice from them".

The adolescent boys in both Banke and Doti mentioned that they do not visit health facilities if they have unprotected sex to inquire about abortion. However, they did not elaborate on whether or not they had ever gone to a facility to

discuss abortion services. One mentioned, "My friend sent his girlfriend to the health facility when her menstruation stopped. After getting counselling and suggestions from there, she got an abortion at a different place". An ANM in Banke mentioned that a boy had asked about his partner's problem of itching in the sexual organs.

The male focus group discussion participants in Doti shared that, even though they know that condoms are available at the health post, they do not go there because there could be people in the health facility who know them and the condoms in the health facility are past their expiry date. Other participants buy condoms from the nearby medical store.

**Facilitator:** *You said that you go to the health facility. Do your friends also go to the health facility if there is any problem?*

**P4, P3 and P5:** *Not everyone goes.*

**P11:** *Not everyone goes; some hide these things.*

**P10:** *They don't go, sir. I will say freely that if we do have sexual contact, then we don't go to the health post for condoms. Some go to the medical store [private drug store]. A relative works in the health post... Condoms can be bought, so no one goes to health post.*

[P1 and P10 arguing]

**P1:** *Listen here, in fact it is not good in the health post. We steal from the container rather than asking at the health post.*

**P5:** *Condoms are kept in a container, so we take them from there rather than asking the doctor.*

**Facilitator:** *Nobody knows when you take the condoms?*

**P5:** *It is written on the container "Take as you need".*

[Everybody laughed]

**P2:** *Condoms are not good at the health post – they are date expired.*

[Everybody agreed and laughed]

Male participants in focus group discussion,  
Doti

**Facilitator:** Do adolescents go to the health facility to obtain information or services about these subjects?

**P1:** They go...

**P2:** They go, but not all of them...

**Facilitator:** Those who do not visit health facility, where do they go?

**P1:** They go to the medical store [private drug store].

**P2:** It is a disgrace (billa) if you are seen by others visiting a health facility, so they go to their friend's medical to maintain privacy.

Male participants in focus group discussion,  
Banke

The data collected from the records also shows that there are very few regular users of condoms visiting the facilities. This could also be because adolescents can take condoms from the boxes kept in the facilities, which might go unrecorded. The average number of recorded condom users per month in the last 11 months from Baisakh to Falgun 2069 BS (April/May 2012 to February/March 2013) was only 5 in Titirihya Sub Health Post and 8 in Sonpur Health Post. Such numbers fit with the findings of the Nepal Demographic and Health Survey 2011, which found that between 1996 and 2011 there has been a trend among adolescents to obtain contraceptives from non-government sources, mostly private pharmacies (Khatiwada et al. 2013).

As indicated by health workers, adolescent boys visited facilities more than adolescent girls. Most adolescent girls we spoke to in Doti shared that they had not visited a health facility, but in Banke they had been to the facility, either for themselves or accompanying their friends or sisters-in-law. Apart from general problems (fever, colds and coughs), the girls visited health facilities for menstrual problems. The girls said that they had friends who had been to a health facility for an abortion. A focus group discussion participant in Banke said: "I have one friend and she had a boyfriend who is now abroad. My friend was pregnant and was not married. That's why she came to this sub health post for an abortion."

They also mentioned that girls visit health facilities to obtain the oral contraceptive pill and condoms. During the focus group discussions in Saraswatinagar, Doti, adolescent girls said that some go to the health facility to ask about white discharge. The married adolescents visit health facilities for ANC checkups and vaccinations. The health workers shared that sometimes the girls come to ask about pimples on their face and some also ask for a remedy for pain during sexual intercourse.

## Behaviour of health workers towards adolescents

### Health workers' perspective

The health workers (three from each facility) were oriented on the National ASRH Programme almost one-and-a-half years ago. Some recalled being told about the stages of adolescence, the changes and issues faced by adolescents, their curiosity and desire to know more about SRH, and how as health workers it is important to address these changes and needs so that adolescents are better informed and don't make wrong decisions.

*I used to feel shy to provide services and hesitated when males asked for contraceptives. I even felt uncomfortable while counselling [...]. Now we are counselling adolescents by showing them posters and pamphlets [...] demonstrating the use of family planning methods, which was not the practice in the past. These are the differences that we feel.*

Health worker, Banke

Some reported that the training changed their attitude and increased their knowledge about ASRH, for example:

*I have found changes in my own behaviour and opinion. After the programme was introduced in the health post, I felt that adolescents have their own problems [...]. I have learnt how to manage and deal with such problems [...]. They have many questions about things like physical changes, sexual desire, voice changes, etc., which they want to know about. I learnt the proper way to counsel them. I also learnt to solve and deal with sexual diseases and other diseases.*

Health worker, Banke

*Before we [health workers] used to have a negative thinking when they [adolescents] came to take contraceptives. We used to think that it will spoil them, but now after receiving the training we accept it and know that they should be given contraceptives. Before, when we didn't give them contraceptives, they would either steal them or obtain them by lying. So, it is better to give them contraceptives, as they take them anyway. Before, they used to steal and pass the condoms out of the window when we were not looking, but now these students come and take condoms openly.*

Health worker, Doti

All health workers interviewed emphasised that there have been significant changes in their behaviour since the introduction of the ASRH Programme. They shared their previous reluctance to provide contraceptives to adolescents and counsel them. The health workers said that they used to think that giving young people access to contraceptives would 'spoil' them and that they should not be talking about SRH or using contraceptives. Now, some even stated that adolescents have the right to know about and use modern family planning methods.

*There is a difference in our behaviour...earlier we used to ask what they need and whether or not they are married and so on, but after training, I knew they should get [contraceptives] and that is their right.*

Health worker, Banke

Furthermore, when one AHW was asked how he would respond to a 15-year-old boy asking for a condom, he replied, "We give them easily, as it is their human right".

Health workers shared that before they never paid attention to adolescents' specific needs and issues, but now they are aware of the issues that adolescents might be facing. One of the health workers shared that their friendly behaviour is resulting in an increased number of adolescents visiting the health facility. All health workers, in explaining how their behaviour has changed, stressed that they do not ask the marital status of adolescents seeking family

planning services. A health worker in Banke also stated that they give contraceptives to widows without asking anything and keep it confidential as well.

*The behaviour and views of health workers working in this health post are good. They are very active in nature. My colleagues and I treat the adolescents well. We provide contraceptives to both married and unmarried adolescents. We happily give them contraceptives and services at their request. We don't ask them if they are married when they come to take contraceptives such as condoms, the pill, Depo-Provera and IUCDs. We also provide family planning services, both permanent and temporary, to widows and separated people without asking them for reasons.*

Health worker, Banke

*Earlier, when someone came for contraceptives, we used to ask them whether or not they are married, but now we don't ask their marital status. They are receiving services. We live in the same area so we know whether they are married or not, but the difference now is that we don't ask.*

Health worker, Doti

In another instance, a health worker in Doti mentioned hesitating when girls asked for condoms, but suggested that there have been gradual changes in his behaviour: "There was a feeling of hesitation when girls used to ask for condoms, but now there is a slight change."

The study found an increased realisation of the importance of SRH among health workers and of the need to deal with SRH issues in privacy. Another health worker in Doti mentioned that, nowadays, when an adolescent is seen on the periphery of the health facility, health workers have stopped asking, "Why have you come here?" Instead, adolescents are made comfortable by sending them to the adolescents' room and asked to read some booklets and later on counselled.

There is an evident awareness among health workers of how they need to respond to adolescents' SRH needs. Almost all of the health workers who

participated in the study emphasised the desired qualities when asked about whether or not they have experienced any changes in their behaviour since the ARSH Programme commenced.

An in-charge at one of the health facilities raised an issue about the counselling skills that health workers have in dealing with adolescents. He said:

*Let us suppose that even if they [adolescents] do come to us, we don't have the skills on matters concerning, "how to treat them?" and "how to behave with them?" We must have these skills, but we don't possess them. We, the health workers, have not studied how a health worker should treat adolescents. We neither studied these things when studying to become a health assistant, nor did we receive trainings on ARSH later. We were never taught what the sentiments of these adolescents are, what they are curious about or interested in, and how they should be treated. We simply have not studied these things.*

Health worker, Doti

Similarly, the focal person at the central level said that they had made a 'mistake' when formulating the AFS guideline by focusing more on the managerial aspects of the programme, rather than the technical aspects. He said that health workers are not trained well enough in SRH. There is a knowledge gap among health workers regarding family planning, sexually transmitted infections (STIs) and emergency contraception. He also added that there has been a change in the behaviour of health workers compared to the past, although not as much there should have been.

Some health workers said that, as the training was almost two years ago, they had forgotten things and that a refresher training would be helpful. These comments and the concerns of the focal person at the central level indicate that health workers require better skills to deal with adolescents and further training could be of use to them.

#### Adolescents' perspective

The adolescents who participated in the study were asked how health workers responded when they

visited the health facility for SRH services; their experiences included:

*He [the health worker] behaves equally with all. He also talks with those who do not share and asks if there are any problems. He gives us good services and information.*

Male participant in focus group discussion,  
Banke

*They [health workers] guide us properly and tell us how to use a condom [...], advise us to use condoms from next time, and not to have unprotected sex with multiple partners. Do with single partner only [...]; they behave nice and properly. They keep our privacy.*

Male participant in focus group discussion,  
Banke

The adolescent boys who had visited a health facility had mixed experiences in terms of how health workers treated them. Most gave positive feedback on the way they were treated. They said that the health workers counselled them well and answered their queries. They also shared that they could take condoms easily from facilities. Many participants shared that the health workers taught them how to use condoms properly and advised them not to have unprotected sex with multiple partners. A participant in Banke shared: "I got information about contraceptives and he [the health worker] also told me how to maintain sexual relations."

The adolescents also said that the health workers assured them that they would maintain confidentiality. They said that health workers talked to them in a separate corner. The findings of peer ethnography also suggest that confidentiality is maintained:

*They [health workers] provide us with both information and services if we ask them. They give condoms and counselling services. They provide the information secretly and maintain privacy.*

Male participant in peer ethnography,  
Banke

In an observation note from a field researcher in Banke, the ANM explained how to use a condom:

*When we were interviewing an ANM, two young boys came to the facility to ask for condoms for their brother. The ANM asked them if the condoms were really for their brother and they said they were 15 years old and they were for themselves (the office assistant later mentioned that one of them had come earlier as well and knows that the health facility does not provide condoms to people below the age of 12). The ANM asked them if they knew how to use a condom. One of them explained. The ANM said that it is not the right way and explained the correct way and gave the condoms to them.*

Field researcher, Banke

Most adolescents were pleased with the health workers' behaviour and said that they would happily go back to the health facility again. However, some adolescents did not have good experiences with health workers. Even though all the health workers emphasised that they no longer ask the marital status of adolescents who come to the facility, some adolescents shared that the health workers did ask whether or not they were married when they went to take condoms. Some of the adolescent boys mentioned that the health workers asked the question in a teasing way. They also said that it is difficult for them to ask questions if somebody in the health facility makes 'fun' of them:

**P10:** *They will not answer us. They ask us in teasing way, but they don't tell us.*

**P2:** *If there are people we know in the facility, then we don't go.*

**P10:** *We don't go if there are people known to us because they don't answer us. They laugh at us saying that we ask them such questions.*

Male participants in focus group discussion,  
Doti

Focus group discussion participants in Doti shared that at times the health workers asked why they needed condoms at such a young age. Fallon (2013,

p 326), in her study on emergency contraceptives, summarised that "judgmental attitudes and personal opinion have long been recognised as influencing decisions about availability of, and conditions for, access to contraceptive services for young people".

Similarly, adolescent girls, with few exceptions, said that they find the behaviour of health workers good and added that the health workers talk to them in a friendly manner. The girls also shared that there are separate toilets for males and females. They mentioned that the 'sisters' maintain privacy by taking them into a separate room.

**P1:** *Sister's behaviour is good. She takes us into a separate room and starts the conversation.*

**P6:** *The health workers take the girls into a separate room.*

Female participants in focus group discussion,  
Sonpur

One of the participants in Sonpur, Banke said that the health workers ask the married girls whether or not they want to have a baby. Girls' queries regarding menstruation are also well handled by the health workers. A participant in Titirihya, Banke said that the 'sisters' tell her not to use excess medicine during menstruation. The following quote is also of a positive experience with health workers:

*The ANM told me to use pads during menstruations and share problems with our mother as well. She also said that even when she is not in the health facility, we can tell our problems to the doctor without any hesitation.*

Female participant in focus group discussion,  
Doti

The peer ethnography and an informal interview with a former service user also indicate that health workers are friendly with adolescents. The peer ethnography revealed that health workers provide both information and services while maintaining confidentiality. The researchers in Doti met an adolescent boy who had been to a health post and he shared his experience:

*The ANM sister told me, “This adolescent stage is the age in which you can’t distinguish what is right and wrong. If you have any problems then you could talk to us... we will always maintain your confidentiality.” Our different problems are solved in the facility. Like, when we at times have the problems of wet dreams, then we go to the health facility. Also our female friends go there whenever they have heavy bleeding during menstruation.*

Male service user, Doti

While most of the adolescent girls in Banke had positive experiences of health workers’ behaviour towards them, some adolescent girls in Doti were discouraged by health workers’ behaviour. An adolescent girl who had accompanied her 20-year-old pregnant aunt to receive injections and iron tablets to the District Hospital in Doti lamented that the health worker did not listen to her aunt’s problems, said that there were no medicines and asked her to come back the next day. Although it was not directly related to the participant, the behaviour of the health worker towards the adolescent’s aunt acted as a barrier to her seeking services for herself.

A focus group discussion participant in Doti shared that a health worker told her to get married when she had irregular menstruation. She said: “The doctors here suggested that I get married [when I had irregular menstruation]. Someone said, ‘If you marry, your problem will be solved.’ If we marry, will the problem be solved?” [angrily]

Another focus group discussion participant from Doti mentioned:

*A girl from our hostel visited the hospital because her period was late. The sisters at the hospital told her that she is pregnant, but she got her period some days later. She had felt very bad about the health workers’ treatment. The sisters at the hospital had said that girls from hostel are like that [‘hostel ko keti haru yestai hunchhan’]. This kind of behaviour discourages us from visiting health facilities. We are scared.*

Female participant in focus group discussion, Doti

This focus group discussion was conducted with adolescent girls who lived in a hostel near to the Doti District Hospital. A field researcher from Doti observed that while she and her team members were conducting the focus group discussion, they were passed notes from others in the hostel. In these notes, the girls asked what they should do when they have white discharge. As the researchers didn’t know who sent the notes, they imparted the information that the girls could avail themselves of the ASRH services in the hospital and should see the health worker for a check up.

While most adolescents, as discussed earlier, had a positive view of health workers’ behaviour, a few, especially in Doti, had experienced or heard about health workers’ behaviour that discouraged them from visiting health facilities. Such behaviour from health workers creates a sense of mistrust among adolescents and discourages them from visiting health facilities and discussing problems with health workers. In some cases, health workers were judgmental. As most health workers have worked in the health facility for a long time, they are well acquainted with the community and know the people. This could influence their judgments about people. However, the inability of some health workers to put aside their personal opinions in fulfilling their professional duty could prevent the creation of a friendly environment for adolescents.

### Reasons for not visiting health facilities

Those who have never visited a health facility for SRH services feared that their issues would be talked about and that they would feel embarrassed. A lack of trust in health facilities was exhibited among such participants (who had never sought SRH services). These adolescents were often not aware that health facilities offer confidential services in private. In addition, boys in particular said that they feel uncomfortable because the health workers are senior to them: “How can you talk to an older person about your issues? It feels uncomfortable.” The adolescents also shared that in some cases the health workers are relatives, which adds to their discomfort as they feel shy and fear that the health worker might tell their parents. They also said

that they fear running into neighbours or people they know at the health facility. Embarrassment has been noted as a key barrier to young people discussing SRH topics and accessing relevant services in a range of countries as far apart as the United Kingdom (van Teijlingen et al. 2007) and Mongolia (Roberts et al. 2005).

Some adolescents said that they could not find the time to visit a health facility because of the long distance to school and the need to do household chores. Instead they shared their problems with friends or their mother and, hence, did not feel the need to visit a health facility.

### Use of IEC materials

In 2010, the MoHP’s National Health Education, Information and Communication Centre (NHEICC) and GIZ jointly developed a set of eight adolescent-friendly IEC booklets on issues related to adolescents’ SRH and rights. As part of the National ASRH Programme, NHEICC is distributing these booklets to all public health facilities that provide AFSs and to schools in the catchment area of these facilities as one component of the National ASRH Programme. These eight booklets cover the issues of:

- Friendship and love
- Marriage, pregnancy and abortion
- Menstruation
- STIs, HIV and AIDS
- Growing up and puberty
- Cigarette, alcohol and drugs
- Sexual and reproductive health and rights
- Sex and sexual relationships

The booklets were first developed by NHEICC in 2010 with the support of GIZ and are now being printed by NHEICC from their own budget as well as with support from various non-state actors working on ASRH. Generally, these booklets are being provided to AFS health facilities and schools in the catchment area of these health facilities at the rate of four sets per health facility and three sets per school.

In addition to the booklets, the following additional materials are provided to health facilities when introducing the National ASHR Programme:

- Demand creation posters: Posters were developed and printed in 2012 that provide information about where adolescents can obtain adolescent-friendly SRH services. Each health facility receives two copies.
- ASRH flipchart: NHEICC developed a flipchart in 2011 with support from the United Nations Population Fund to support health workers in ASRH counselling. One copy is distributed to each AFS health facility.
- Comic book: A comic book with information about where adolescents can obtain adolescent-friendly SRH services was developed by NHEICC in 2012 with support from UNICEF. One copy is distributed to each AFS health facility.

### Health workers’ perspective

The data suggests a common understanding among health workers that the ASRH Programme has come through the Family Health Division, but that the IEC materials were provided by GIZ. Both the health workers and adolescents who have read the booklets found these materials to be very helpful. Health workers have said that adolescents visit health facilities to read these booklets. The health workers maintain that the materials are adequate in quantity for adolescents to come and read, but not for wider distribution, except for in Bajapur where the health workers said that they have been distributing the booklets. Health workers also shared that although there is an insufficient quantity of booklets to allow them to be taken at home, at some facilities, the adolescents take them home and do not return them.

*At first there were booklets and we told them [adolescents] to read and keep them back there. But adolescents liked these booklets and so they took them home without informing us, and we didn’t care also. Whenever we saw someone carrying the booklets, we asked them to bring it back the next day, but they didn’t.*

Health worker, Banke

With adolescents taking the booklets away, some health workers feel that they need more. Health workers also said that they had distributed the booklets to school libraries and community libraries.

During the focus group discussions, a few of the adolescents who had read the booklets said that they asked health workers about the things that they didn't understand. This statement was partly confirmed by health workers. Most health workers in Doti said that adolescents were too shy to ask them questions about the booklets. However, in Banke, health workers mentioned that adolescents did ask questions. Although the adolescents could not specify what exactly they asked, the health workers said that they asked about contraceptives, physical changes, wet dreams, and smoking and drinking, among other things.

*These educational materials are used by adolescents. Most of them [adolescents] ask questions relating to the flipcharts of the ASRH Programme. They usually ask questions relating to the STIs, contraceptives and about abortion. Some of them also ask about the physical changes they are experiencing. Mostly, they come to take information and services on contraception.*

Health worker, Banke

*Adolescents are using these educational materials a lot and they ask questions. For example, they ask about smoking and drinking alcohol; why it is said to be a bad habit and, if so, why it exists in our society. We counsel them by saying that this is a bad practice and you have to remove it.*

Health worker, Banke

The health workers who participated in the study suggested that a documentary film or short video regarding SRH could be an effective way of engaging adolescents and counselling them about ASRH. The focal person at Doti emphasised, "Based on the most-read booklets, it would be effective to prepare a separate booklet containing key messages, which could be distributed to adolescents".

### Adolescents' perspective

According to the participants in the focus group discussions, the major sources of SRH information for adolescents are health facilities, the radio, television and organisations working on SRH. Most of the adolescents mentioned 'Saathi Sanga Man ka Kura' (Chat with your best friend), a popular radio programme that imparts information relevant to adolescents and youth and the use of life skills. In Doti, adolescents referred to FPAN and the Restless Development Center. At Saraswatinagar Primary Health Care Centre, FPAN has established Yuba Suchana Kendra (Youth Information Center) targeting young people. The volunteers at the Restless Development Center in Bhumirajmandu give classes in schools on SRH. According to the project coordinator of FPAN at Doti, FPAN provides health education to adolescents related to SRH through peers and in schools with information on life skills, counselling and family planning services. Adolescents also mentioned clubs from where they can obtain information on SRH. Plan Nepal has formed clubs targeting young people. Some adolescents said they find 'these things' out on their own from others in their age group.

Most boys interviewed were aware of the IEC materials available in the health facilities, but only a few had actually read the booklets. The adolescent boys in Saraswatinagar were not aware of the booklets. All of the other participants in the focus group discussion agreed when one of them said:

*We do read posters, but we don't know about reading booklets. As this is a government facility, we come here to take medicine and return back.*

Male participant in focus group discussion,  
Doti

The adolescents who have read the booklets mentioned that they have learnt how to use condoms and also about the transmission of diseases. A focus group discussion participant in Banke said that the booklets are very helpful: "I got to know that there will be rupture of condom when air enters inside. I also got to know about the transmission of HIV and different physical and mental changes that appear in adolescents."

In addition to the booklets, most of the adolescents maintained that they learn from the posters in the health post that display information related to contraceptives and SRH. A participant from Doti said: "If we go to the health post, there is information on posters. We can know all things from there. There is a complete picture."

Adolescents said that the booklets are easy to understand and, if they don't understand anything, they ask the health workers. They learnt about the materials while visiting the health facilities for other reasons. The health workers also disseminate the information about IEC materials whenever adolescents visit them. A participant from Doti explained:

*I had gone to the health post when there was a meeting of the Green Club and our ANM sister said that there are different kinds of booklets for our age. They were about pregnancy, menstruation, HIV/AIDS due to drug addiction, danger signs seen in pregnancy and solutions, and the problems seen in adolescence and their solutions.*

Male participant in focus group discussion,  
Doti

However, in the focus group discussions, only a few girls admitted that they had read the booklets. Most girls were not aware of the booklets in the health post, but had seen the posters. They described the posters as mentioning contraceptives, pregnancy, delivery and how to use condoms. Some girls in Sonpur, Banke said that they felt shy looking at the posters, reading them and asking questions about them. One said, "I come here when I am sick and then return soon after the check-up". A participant shared how she could not read the booklets her brother had brought home:

*Once, my brother brought home booklets related to sexual and reproductive health from the health facility. I read them for some time, but did not complete them because of shyness and I was also afraid of my brother.*

One girl could not read the book that described the reproductive organs completely because she felt shy looking at both 'good' and 'bad' pictures. As talking about sexual health is not common in Nepal and is often considered to be an immodest activity (Dahal 2008; Regmi et al. 2010), girls can feel shy and embarrassed. Pokharel et al. (2006, p 157) also reported that Nepali teachers "did not want to deal with such sensitive topics and feared censure by their colleagues and society". In Nepal, health workers use English or Sanskrit-derived words as a way of talking about SRH without having to use everyday Nepali (Pigg 2002). Similarly, the above quote mentions being "afraid of my brother", which shows that social taboos are a potential barrier to accessing information.

While one girl spoke about taking these booklets home; others said that not being able to take such booklets home is a disadvantage. Some focus group discussion participants in Saraswatinagar, Doti shared that, although they know that the booklets are available in the health facility, their school is far away: "School is located far away from the health post, which is why we cannot go and study there. And in the evening we have to do household work and don't get time to study." This indicates that it is especially difficult for girls to visit health facilities because they are expected to engage in household work along with going to school.

## 5. Findings: Facilitators and Barriers to Implementation

Health workers in all of the facilities studied said that the ASRH Programme is useful and effective in addressing the SRH needs of adolescents. They said that adolescents learn about SRH through the programme's IEC materials. They can obtain information on STIs, contraceptives, abortion, pregnancy, and so forth, and have been sharing their problems more freely now that there is provision for maintaining privacy. This chapter presents the facilitators and challenges in implementing the National ASRH Programme.

### Physical infrastructure

The health workers were asked what the enabling factors were for the implementation of the programme. Most of the opinions of the health workers are represented in the following quotes.

*The signboard [signboard with AFS logo] has helped [...], also the trained health workers and we have these eight [IEC] booklets that have helped. The educational materials and flipchart have also helped.*

Health worker, Doti

*The programme made provision for seating (benches, chairs, etc.). There is a separate toilet for females and males in this health post, which makes it easy for them to use the services. The toilet is neat and clean with tiles and a flushing system. Water is always available in the toilet as well as for drinking.*

Health worker, Banke

The health workers said that the 'signboard' is helpful as it informs adolescents that services are available. They also said that the physical infrastructure in terms of waiting area, toilets and making water available has helped the programme.

### Confidentiality and privacy

Health workers said that they maintain privacy when giving services to adolescents and assure them of confidentiality:

*The availability of educational materials, the adolescent-friendly sexual and reproductive health related hoarding board outside, posters, pamphlets, and the availability of temporary contraception, medicine, treatment, counselling, and reproductive health related services – although a separate counselling room is not available, but counselling services are given from the delivery room [...] – all help in the implementation of this programme.*

Health worker, Banke

Health workers also shared that, in line with their efforts to maintain privacy while giving services to adolescents, they provide services from ANC clinics, use curtains or talk to adolescents in a separate corner. Adolescents confirmed that the health workers talk to them separately and assure them of confidentiality. An ANM recollected a young girl who visited the facility for emergency contraception:

*Once a girl studying in a nearby school came secretly and was panicking [...]. In that situation, considering her emotional state, I talked to her alone [...] and got to know that she had sex with her boyfriend and was afraid that she may have become pregnant and had come for a solution. I gave her emergency pills to solve this problem and then gave her counselling about safe sex. After that I asked her to take a condom and tell her partner to use it, but she declined. After two months, I met her on the road and wanted to talk her, but she was with her friend so I walked away as stranger to her. I had promised her that her secret information would not be flashed out.*

Health worker, Doti

### Orientation to the programme

The orientation provided to selected FCHVs, schoolteachers and members of the HFOMC and village development committee at the beginning of the programme has raised awareness about the SRH services available at health facilities. The health workers mentioned that the School Health Programme is important in supporting the effective implementation of the ASRH Programme as it can reach large numbers of adolescents, even though it is not part of the National ASRH Programme.

### Sex of health workers

The health workers shared that the biological sex of the service provider is crucial in the effective implementation of the programme. An AHW in Banke said: "Male staff look after adolescent boys and female staff look after adolescent girls; for this reason they come to this health post." The focus group discussion participants also stated that they felt comfortable with health worker of their own sex and that there should be separate service providers for men and women.

However, this is not the case in all facilities. In the Doti District Hospital, all AFS service providers were female. One male AHW did receive the orientation, but now works elsewhere in the hospital. This AHW said that he does not recall adolescents coming in with SRH issues. Some boys

said that they turn back from facilities without seeking services if there are only female health workers. Adolescent girls also said that they feel uncomfortable with male service providers.

### Trust and familiarity

Trust and familiarity have been described as facilitators of the programme. One ANM explained how her long association with the health post helps her relationship with adolescents:

*I have spent 17 years in this community in the sub health post. Because of that, the trust factor with me among the people is high. I counsel them and give them suggestions. The way we treat them is good and just because of this they come here for services. They do not hide their problem from us. Both men and women talk freely with us about their problems. Girls talk freely about the pill, Depo-Provera and condoms; they ask about contraceptives and take them from us. Both males and females come to take condoms. These are the things that have influenced adolescents to use these services from our sub health post.*

Health worker, Banke

However, being personally acquainted with a health worker does not always help adolescents to access services, as discussed earlier. Some adolescent boys, in particular, said that they felt uncomfortable going to health facilities to talk about SRH if they knew the health workers personally as they feel shy and also fear that the health workers might tell their parents. A participant in Doti explained: "We don't go if there are people we know because they don't answer us. They laugh at us saying that we ask them such questions."

### Lack of refresher training

The health workers had not received any refresher training after the original programme orientation as such training is not part of the programme. This has created problems in service delivery, especially because some of the oriented workers had been transferred. In one primary health care centre, a laboratory assistant was providing services to adolescents in the absence of other oriented staff.

A new ANM was there who had been in the facility for a week, replacing the previous ANM who was oriented on the ASRH Programme but had been transferred. According to the laboratory assistant, the AHW who had received the orientation was mostly absent from the health facility. The focal person at Doti shared the opinion that a programme cannot be effective with a once-off orientation. He maintained, "We are expecting big outputs with little input", referring to the fact that there is no regular follow up and the programme has not been given priority. Health workers suggested that all of them should be trained so that there are fewer problems when one health worker is either transferred or on leave.

### Lack of separate space

None of the health facilities, apart from the facility at Saraswatinagar, Doti, had a separate room for adolescents. At Saraswatinagar, there was a youth information centre and this room was used to provide SRH services to adolescents. The health workers used the ANC clinic/room to provide services to adolescents, especially to girls, and talked to adolescents in a corner or used curtains. Both health workers and adolescents thought that this was not enough. Although most of the adolescents said that they were satisfied with the health workers' behaviour in maintaining confidentiality, they suggested that having a separate room for adolescents would be easier when they have to wait for health workers as they shared that they feel shy to visit the facilities because there are a lot of people.

An AHW at Doti said, "We need separate rooms for adolescents where they can read different useful materials, share their problems and queries with health workers and with their friends who come with similar problems and queries." Health workers agreed that the ANC rooms are busy with regular services and the adolescents might feel uncomfortable to approach them. In Doti Hospital, the ANMs who provide services to both male and female adolescents shared that especially boys hesitate to seek services as the ANMs are in the ANC room, which is crowded.

The focal person at the central level said that it is not possible to have a separate room in all of

the facilities, because many operate from small buildings with a limited number of rooms. He suggested that the ASRH Programme should create better linkages with schools: "School is the best place to disseminate information to the adolescents. They feel comfortable in school to receive information where they can easily access the IEC materials too."

### Hesitation by adolescents to visit health facilities

Some health workers shared that one of the challenges is that not all adolescents come to health facilities. An ANM at Banke mentioned, "Around 75% of adolescents visit health facilities and the remaining 25% do not come due to hesitation, concerns about privacy and the idea that their questions won't be addressed by the health workers". Although the percentage is only one health workers opinion and may not be accurate, the concern raised about adolescents not visiting health facilities was shared by a number of adolescents in focus group discussions. Adolescents said that they did not visit health facilities because they cannot talk about their problems to the health workers who are older than them. Adolescents also worried about meeting relatives or neighbours at the health post and were not sure that their problem would remain confidential. They shared that the community might have a negative view of them if they are seen visiting the health facility. Most adolescents were too 'shy' to talk about sexual problems with health workers. Some feared that they might have to have their sexual organs examined, which would be embarrassing for them.

### Negative societal perceptions

Both health workers and adolescents shared that the predominantly negative view in Nepali society about the use of family planning and obtaining information related to sexual health stops adolescents from seeking services. According to them, Nepali society generally perceives that contraceptives are only for married people and providing SRH information to children will 'spoil' them. An ANM from Doti shared:

*Earlier, the guardians used to perceive it [the giving of information on SRH to adolescents] in a negative way. When their children were given information on contraceptives and booklets to study they used to ask questions such as: "Why did you give this type of book as it spoils our children?" or, when a condom was given, "Why did you give them contraceptives?" It was difficult for us to provide [ASRH] services as they [parents] didn't understand the importance of the services and information [...]. Now, this is changing.*

Health worker, Doti

*Firstly, there was a perception [among health workers] that family planning services are only for married couples, but after this training our perception changed. However, people in the community haven't been able to change their perception to this day. Regarding this topic, society has a negative perception of both service providers and recipients [...]. It is difficult to make people understand when they think that unmarried people should not be curious about sex, taught to use a condom or told anything about sexual intercourse. Therefore, we should be sensitive and it is necessary to maintain privacy and confidentiality while providing services to adolescents. If we can't do so, then they may not come again, even when they have problems.*

Health worker, Doti

Community perceptions about SRH might act as a barrier to providing AFS to adolescents, which demonstrates the need to raise community awareness regarding adolescents' SRH needs and the importance of addressing those needs. Focus group discussions highlighted the need for more awareness activities in the community to create an environment for adolescents that is conducive to accessing SRH services.

### Workload of health workers

Some health workers blamed their workload for not being able to give much time to adolescents and the ASRH Programme. This was reflected in discussions with adolescents who said that health workers are very busy with other patients. A health

worker in Doti said, "What happens in a health facility is we are busy with our own work, so are not able to allocate separate time to focus on adolescents".

Some of the health workers also pointed out that patient flows are very high and they cannot give as much time to adolescents as they should:

*You see that we only have two buildings and patient flows are very high [...]. So if adolescents come at that time [when we are busy], then I refer them to the sister for counselling so that I can do patient checks at that time.*

Health worker, Banke

*I provide services to all the patients and it is really difficult for us to manage time for them. This is a birthing centre too, because of which we give services at night in case of delivery [...]. So it is a challenging task. Mostly unmarried adolescents visit the sub health post in the evening, mainly for contraceptives. So it is difficult to provide them with services at night.*

Health worker, Banke

Birthing centres keep staff busy, even in the evening and at night, making it difficult to provide services to adolescents at the same time. It is also important to note that adolescents visit this health facility (in Banke) at night for contraceptives, which might suggest that some adolescents, particularly unmarried ones, are reluctant to seek SRH services during the day, perhaps because they fear that they will be seen by others.

### Opening hours and availability of health workers

Most facilities had written on their AFS display board that services are available from 10 am to 2 pm, except at Doti Hospital, which was open 2–4pm, and Bhumirajmandu Health Post, which was open 10am to 3pm. In Titirihya sub-health post, opening times were not displayed. Some adolescents stated that the opening hours at the facilities did not suit them as they clashed with school time. They also complained about health workers not being available at the facilities. One

interviewee said: “It [the health facility] opens from 10 am to 2 pm, but it is actually open from 11 am to 1 pm. After 1 pm there is no one [staff] at the health facility.” Adolescents at Saraswatinagar also shared that health workers are hardly ever

available at the health facility. The focal person at the central level reiterated that services should be made available to adolescent at all times, rather than setting aside a specific time slot.

## 6. Key Findings and Recommendations

This chapter sets out the major findings and recommendations of the evaluation.

**Key finding 1:** All health workers are aware of the National ASRH Programme and its components, except for a few who shared that the programme is only about delivering family planning and maternal health services. While the School Health Programme and the training of peer educators are not part of the National ASRH Programme, health workers stressed that these are effective ways to share about the SRH services available at health facilities.

**Recommendation:** While in all orientations on the National ASRH Programme there is a section on cooperating with other actors in the field of SRH (including schools), the ASRH Programme should coordinate more closely with schools to effectively impart information about SRH issues and sensitise adolescents about the adolescent-friendly SRH services available at health facilities.

**Key finding 2:** Health facilities have oriented selected FCHVs, teachers and other people in the village development committee about the National ASRH Programme and health workers perceive community awareness to be a key factor in facilitating adolescents’ access to SRH services.

**Recommendation:** As community awareness is seen as a key factor in facilitating adolescents’ access to SRH services, community-based activities should be undertaken to increase awareness of the importance of adolescents’ access to SRH services.

**Key finding 3:** The recording and reporting of the ASRH Programme has not been regular and consistent. Health workers mentioned not having a separate recording register for the programme and suggested that the programme be included in the HMIS 32 (monthly reporting format).

**Recommendation:** During supervision visits, the district focal persons should pro-actively check the quality of data being recorded by health workers for the ASRH Programme, address any issues and encourage regular reporting.

**Recommendation:** A district level review could be organised for all health facilities providing ASRH services to provide health workers with refresher training about the reporting format and to address any confusion regarding recording and reporting for the ASRH Programme.

**Key finding 4:** All health workers stated that there have been significant changes in their behaviour as a result of the programme. They shared their previous reluctance to provide contraceptives to adolescents as they thought it would ‘spoil’ them and their previous belief that adolescents should not talk about SRH or use contraceptives. Now, when asked about changes in their behaviour towards adolescents seeking SRH services, almost all health workers expressed adolescent-friendly attitudes. However, one health worker mentioned a gap in the training of health workers, which was

also stressed by the focal person at the central level, namely, that, in addition to managerial aspects, such training should also cover technical knowledge and skills on SRH topics and on the counselling of adolescents in SRH.

**Recommendation:** Conduct refresher trainings and technical trainings for health workers as behaviour change needs reinforcement and must be supported with knowledge and skills.

**Key finding 5:** Health workers were aware of the importance of maintaining privacy and ensuring confidentiality while providing services to adolescents. They mentioned using curtains or meeting adolescents in ANC clinics, but they were not able to give much separate time to adolescents because of high patient flows.

**Recommendation:** The provision of services to adolescents should be promoted as a routine service and treated as equally as important as other health services. The provision of services to every patient or client in a health facility should be confidential; this builds a patient-friendly approach in health service delivery in the long term.

**Key finding 6:** Few adolescents stated that they had visited health facilities for SRH services. Most of those who had visited related positive experiences, while a few had bad experiences regarding the attitude of health workers. According to health workers, unmarried adolescents visit health facilities to access services related to the ASRH Programme more than married adolescents. Furthermore, adolescent boys visited health facilities more than adolescent girls. At the same time, adolescent girls tended to have detailed knowledge about the specific health services offered, e.g., for STIs, menstrual problems, acne, pain during sexual intercourse and even abortions. Most adolescents who visited health facilities shared that they were happy with the health workers' behaviour and that health workers treated them in a friendly and helpful way, did not ask for their marital status and maintained confidentiality while providing information and services.

**Key finding 7:** Those adolescents who had not used SRH services were concerned about confidentiality, which seems to be one of the main reasons for adolescents not visiting health facilities for SRH services, in addition to feeling embarrassed to talk to health workers who are older than them or acquaintances.

**Recommendation:** As many adolescents did not seem to be aware of the availability of confidential counselling services in the facilities, awareness raising activities should be targeted at adolescents to impart information about AFS. In addition to closer coordination with schools, there should also be coordination with local clubs and other organisations working in SRH to encourage adolescents to use SRH services.

**Key finding 8:** Most boys interviewed were aware of the IEC materials available in the health facilities, but only a few boys and girls said that they had actually read the booklets. Both health workers and adolescents who had read the booklets found these materials to be very helpful. Health workers shared that the quantity of materials is adequate for adolescents to come and read, but not for distribution.

**Recommendation:** The IEC booklets on ASRH should be distributed to health facilities in greater quantities, as well as to schools and clubs, and adolescents should be encouraged to read them.

**Key finding 9:** The ASRH Programme does not cover all health facilities in each district, but just 13 facilities. This limited coverage has implications for the priority given to the programme at all policy levels. It is also poses problems with reporting, as the reporting of AFS is not part of the HMIS 32. In addition, there is a problem when health workers who have been oriented on the programme are transferred out and replaced by health workers who have not been oriented.

**Recommendation:** Introduce the ASRH Programme in all health facilities in a district so that, eventually, the programme is scaled up nationwide.

## References

- Collumbien, M; Qureshi, AA; Mayhew, SH; Rizvi, N; Rabbani, A; Rolfe, B; Verma, RK; Rehman, H; Naveed-i-Rahat (2009) 'Understanding the context of male and transgender sex work using peer ethnography.' *Sexually Transmitted Infections*, 85(Suppl II): ii3-ii7
- Creswell, JW (2009) *Research design: Qualitative, quantitative and mixed methods approach*. Los Angeles: Sage Publications
- Dahal, G (2008) *Sexual and contraceptive behaviour among men in Nepal: The need for male friendly reproductive health policies and services*. Lewiston, NY: Edwin Mellen Press
- Fallon, D (2013) "They're gonna think it now": Narratives of shame in the sexual health experiences of young people.' *Sociology*, 47(2): 318-332
- Family Health Division (2011) *National Adolescent Sexual and Reproductive Health Program Implementation Guide*. Kathmandu: Family Health Division, Department of Health Services
- Forrest Keenan, K; Teijlingen van, ER; Pitchforth, E (2005) 'The analysis of qualitative research data in family planning and reproductive health care.' *Journal of Family Planning and Reproductive Health Care*, 31(1): 40-43
- Khatiwada N; Silwal PR; Bhadra R; Tamang TM (2013) *Sexual and reproductive health of adolescents and youth in Nepal: Trends and determinants: Further analysis of the 2011 Nepal Demographic and Health Survey*. Kathmandu and Calverton, Maryland: Ministry of Health and Population, Nepal, New ERA and ICF International
- Mulhall, A (2003) 'In the field: notes on observation in qualitative research.' *Journal of Advanced Nursing*, 41(3): 306-313
- Neuman, WL (2000) *Social research methods: Qualitative and quantitative approaches*. Boston, USA: Allyn and Bacon
- Pigg, S (2002) 'Expecting the epidemic: A social history of the representation of sexual risk in Nepal.' *Feminist Media Studies*, 2: 97-125
- Pokharel, S; Kulczyki, A; Shakya, S (2006) 'School-based sex education in Western Nepal: Uncomfortable for both teachers and students.' *Reproductive Health Matters*, 14: 156-161
- Pretzlik, U (1994) 'Observational methods and strategies.' *Nurse Researcher*, 2(2): 13-21
- Price, N; Hawkins, K (2002) 'Researching sexual and reproductive behaviour: a peer ethnographic approach.' *Social Science and Medicine*, 55: 1325-1336
- Regmi, P; Simkhada, P; van Teijlingen E; Acharya, D (2010) 'Dating and sex among emerging adults in Nepal.' *Journal of Adolescence Research*, 26 (6): 675-700
- Roberts, AB; Oyun, C; Barnasan, E; Laing, L (2005) 'Exploring the social and cultural context of sexual health for young people in Mongolia: Implications for health promotion'. *Social Science and Medicine*, 60: 1487-1498
- Silwal, PR; Schildbach, E (2013) *Introducing adolescent-friendly services in the public health system in Nepal*. Kathmandu: GIZ

Simkhada, P; van Teijlingen, E; Acharya, DR; Schildbach, E; Silwa, PR; Shrestha, J; Pandey, PL (2012) 'Sexual and reproductive health of adolescents in rural Nepal: Knowledge, attitudes and behavior.' *Nepal Population Journal*, 17(16): 3–10

van Teijlingen, ER; Ireland, J (2003) 'Research interviews in midwifery.' *RCM Midwives Journal*, 6: 260–263

van Teijlingen, ER.; Pitchforth, E (2006) 'Focus group research in family planning and reproductive health care.' *Journal of Family Planning and Reproductive Health Care*, 32 (1): 30–32

van Teijlingen, E; Reid, J; Shucksmith, J; Harris, F; Philip, K; Imamura, M; Tucker, J; Penney, G (2007) 'Embarrassment as a key emotion in young people talking about sexual health.' *Sociological Research Online*, 12 (2) [online journal]. Available at: [www.socresonline.org.uk/12/2/van\\_teijlingen.html](http://www.socresonline.org.uk/12/2/van_teijlingen.html) (accessed 27 July 2013)

Wilkinson, S (1988) Focus groups in health research.' *Journal of Health Psychology*, 3: 329–348

## Annex 1. Semi-Structured Interview Guide

### Mid-term evaluation of the National Adolescent Sexual and Reproductive Health Programme

Semi-structured interview guide at health facility level (*This is just a guide to direct the interview. Please adapt according to the responses developed between you and the participant during the interview.*)

1. What is the understanding of ASRH intervention by health sector staff?
  - Are you aware of the ASRH intervention in your facility? When was it introduced?
  - What does it comprise?
  - Is there one member of staff responsible for ASRH? Or is it the responsibility of several staff?
  - Were you there when it started? Have you been trained for this? Have any other staff been trained for this?
2. What actions have been taken to implement and monitor ASRH interventions in the facility?
  - What has been done to implement the ASRH interventions here? (creating confidential spaces, putting up the logo, training, meetings with community, etc.)
  - Has the community been part of it?
  - Do you have IEC materials? Are they enough? How do young people respond to them?
  - How is the reporting/recording done? Who does it? Are there any issues in recording and reporting?
  - Do people come to ask/learn about the programme? (from GIZ, government, researchers, I/NGOs, etc.)
3. What are the facilitators and barriers to implement the ASRH programme? (probe about attitude, context, human resources, infrastructure)
4. Do adolescents come to health facilities to discuss SRH issues? (age/sex/married/unmarried)
5. In your opinion, do you think the adolescents in this community can easily access the services provided by you? What do you think could be enabling factors or barriers to them? (age/sex/married/unmarried)
6. Has this intervention been helpful to the adolescents? Do you have a system for recording feedback from the adolescents who use the services?
7. Apart from this intervention, what do you think could be other ways that have influenced adolescents' knowledge, attitudes and practices related to SRH and how? (radio/television programmes; magazines; interaction with peers/seniors/counsellors; other projects that have an SRH component; schools etc.)
8. Has this programme made any difference to how you viewed issues faced by adolescents? Could you please reflect on your own thinking before and after the intervention?
9. Have you noticed change in your own behaviour in responding to adolescents?
10. Do you think the intervention is effective in addressing the SRH needs and issues of adolescents? What changes, if any would you like to suggest to this intervention to make it more effective?

## Annex 2. Focus Group Discussion Guide

### Mid-term evaluation of the National Adolescent Sexual and Reproductive Health Programme

Focus group discussion guide for adolescents (*This is just a guide to direct the discussion. Please adapt according to the discussions developed between the participants.*)

1. What is the understanding of ASRH intervention by the adolescents?
  - Are you aware of the ASRH intervention in your nearby health facility? When was it introduced? What does it comprise?
  - Has the community been part of it? (orientation for different groups in community/ distribution of IEC materials, etc.)
2. Do adolescents go to health facilities to discuss SRH issues? (age/sex/married/unmarried) Are there discussions in your schools or other forums?
3. Do you think adolescents get to participate in the health facility management and operation committee (HFOMC)? (How and why?)
4. In your opinion, do you think the adolescents in this community can easily access the services provided by health facilities? (Probe about health worker's attitude; secure infrastructure; issues of confidentiality and privacy)? (age/sex/married/unmarried)
5. What do you think could be enabling factors or barriers to access health services? (age/sex/married/unmarried)
6. What do you think about the IEC materials? Are they helpful?
7. Do you think that adolescents have been helped by the intervention? Is there a way you provide feedback at the health facility regarding the intervention?
8. Apart from this intervention, what do you think could be other ways that have influenced adolescents' knowledge, attitudes and practices related to SRH and how? (radio/television programmes; magazines; interaction with peers/seniors/counsellors; other projects that have an SRH component; schools etc.)
9. Has this programme made any difference to how you view SRH issues faced by adolescents? Could you please reflect on your own thinking before and after the intervention?
10. Do you think the intervention is effective in addressing the SRH needs and issues of adolescents? What changes, if any would you like to suggest to this intervention to make it more effective?

## Annex 3. Peer Ethnography Guide

### Mid-term evaluation of the National Adolescent Sexual and Reproductive Health Programme

Peer ethnography guide:

#### Process:

Select an adolescent male and a female interviewer (peer interviewer) from the vicinity of health facility

Ask him/her to identify peers/friends of his/her age group

Explain the study to the peer interviewer and the rationale behind it

Train the interviewer in the following questions

Discuss the questions and emphasize on probing

#### Questions:

What kind of SRH issues do adolescents face?

Do they go to health facilities to discuss these issues?

Are they aware of the ASRH intervention in the health facilities?

What kind of services do the health facilities provide to the adolescents?

Are the services accessible? What are the enabling factors or barriers to access the services?

Are the services effective/ helpful? Why do they think so?

Have they noticed any change in the behaviour of health workers in the facility?

What can be done to make the services more effective to address SRH issues of the adolescents?

## Annex 4. Observation Checklist

Name of Health Facility:

Date:

Observed by:

SN	Observation criteria	Yes	No	Further clarification/description
1	The AFS logo is displayed in visible place in health facility			
2	The opening times for AFS are visible outside the health facility			
3	The monthly reporting of use of services by adolescents is done using the given format (ask where the Original Copy of the sheet is and observe it)			
4	Separate opening hours for adolescents at least once a week are in place (note that 10-4 everyday may mean 2-4 with extra hour on Friday)			
5	The health facility is clean and there is clean drinking water and toilet facility			
6	Health facility has adequate space for providing services in general (looks congested or not)			
7	Provision for privacy (when counselling or treating adolescents) is available (can be separate room or curtained space)			
8	Anybody can see name of person using any types of services (not confidential)			
9	IEC materials are displayed			
10	ASRH flipchart is available (if not visible, may ask health worker)			
11	Health facility is located in appropriate place (easy access for adolescents)			

Conclusions of the observer



Deutsche Gesellschaft für  
Internationale Zusammenarbeit (GIZ) GmbH

Health Sector Support Programme (HSSP)  
Department of Health Services  
Teku, Kathmandu, Nepal  
T +977 1 4261404  
F +977 1 4261079  
E [hssp@giz.org.np](mailto:hssp@giz.org.np)  
I [www.giz.de/nepal](http://www.giz.de/nepal)