Assessing Supply Side Constraints Affecting the Quality of Adolescent Friendly Services (AFS) and the Barriers for Service Utilization

BACKGROUND

The purpose of this policy brief is to provide a snapshot on the situation of adolescents in Nepal as well as to present key findings and recommendations emanating from a study on barriers and constraints affecting the quality of AFS in Nepal which was conducted in 2014.

Adolescents in Nepal

Adolescents (10-19 years) account for 24.19% (6.4 million) of Nepal's population (Census 2011). This developmental stage marks the critical transition from childhood to adulthood, during which physical, emotional, cognitive and social changes expose adolescents to new health needs and risks. Based on data and information collected, adolescents are not fully aware of their sexual and reproductive health and rights (SRHR) nor are they able to exercise them fully.

As per the National Demographic Health Survey, 2011:

- The median age that girls marry is 17.8 yrs. whereas the legal age at marriage is 20 years,
- More than 2 in 5 girls are already married.
- 17% girls from 15-19 years are already mothers/ or pregnant with their first child.
- Unmet need for contraception in married adolescents (15-19 years) is 41.6%.
- 86% of married adolescents aged 15-19 are not using a modern contraceptive method.
- Nearly 1 in 10 adolescents experience physical violence during pregnancy.

In addition:

- Adolescent birth rate for women aged 15-19 years is 71 per 1000 (MICS 2014).
- 36.4% of youth (15-24 yrs.) who correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions (MICS 2014).
- Dropout rate: 19% (Boys: 16%, Girls: 22%) One of the reasons for drop out from school for girls is child marriage: 35% (NAYS 2012).

National ASRH Framework

A review of adolescents' SRH in Nepal reported that health services are an important source of sexuality education and counselling, although attention to providers' attitudes, skills and accessibility is key. (Kathmandu University medical journal 2009; 7(28): 445-53.).

Considering the adolescent health and development needs, the Nepal government developed a National Adolescent Health and Development Strategy in 2000 and (revised in) 2015, a National ASRH Program Implementation Guidelines 2011, and a National ASRH Communication Strategy (2011-2015) which affirm the rights of adolescents to comprehensive, non-judgmental and confidential counselling and services as well as delivery of Adolescent Friendly Service (AFS) with standard operating procedures, based on both national and global evidence and good practices related to SRH. These strategies and guidelines also include actions to increase adolescents' knowledge and skills and create a community and policy environment that supports adolescent health and development generating demand for AFS promotion through peer education linking with schools, media and interventions to increase community and parental support.

To increase universal access to Adolescent Sexual and Reproductive Health (ASRH) and improve the quality of care, the Family Health Division/DoHS was able to establish more than 1,000 AFS centers throughout the country as per target set in the Nepal Health Sector Program (2010-2015) established over 1,000 AFS centers as of end 2015. ASRH was also highlighted as a priority area in both the National health policy 2014 as well as in the new National Health Sector Strategy (2015-2020).

UNFPA
United Nations Population Fund
unicef
Government of Nepal
Ministry of Health
Department of Health Services
Family Health Division

AIM OF THE STUDY

The aim of this study was to explore the supply and demand side barriers impacting on the access and utilization of AFS by adolescents (aged 10-19 years) across diverse socio-cultural and geographical settings in Nepal. It was commissioned by the Family Health Division with technical and financial support from UNFPA and UNICEF and carried out by the Center for Research on Environment Health and Population Activities (CREHPA) and Burnett Institute Australia.

METHODOLOGY

A mixed facility observation and qualitative methods (focus group discussions, ethnographic study, in-depth and key informant Interviews) were used to conduct this study in 12 selected districts of Nepal with Ethical approval obtained from the Nepal Health Research Council (Ref No. 1173). Adolescents, parents and community gatekeepers (religious leaders, local leaders, parents, teachers, and peer educators) were selected specifically from communities serviced by 72 AFS centers to explore lessons learned, barriers and enablers related to AFS centers' access and service provision.

72 AFS Centers in 12 Study Districts

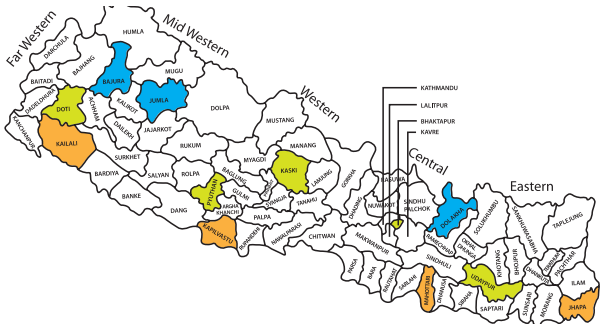

Chart 1: Summary of Data Collection Tools

Tool	Population	Number completed	Number of participants
Facility observation checklist and interview with facility in-charge	Health facilities and facility in-charge	72	72
Key informant interview	AFHS providers	72	72
	Community gatekeepers	10	10
Exit interview	Adolescent (10-19 yrs)	8	8
Focused ethnographic study (FES)	Young female aged 10 - 24 yrs	12 groups	123
	Young males aged 10 - 24 yrs	12 groups	118
Focus group discussion (FGD)	Adolescent girls	3 groups	28
	Adolescent boys	3 groups	28
	Parents of adolescent	3 groups	33
In-depth interview	Adolescent living with a disability	3 groups	3
Total		198	495

KEY FINDINGS

Through improvements have been made to increase the coverage of AFS and meet the health needs of adolescents, multiple barriers on the supply side were identified, from lack of individual knowledge, attitudes and skills of adolescents to family and community factors, attitude and skills of health workers, facility constraints, management, which still affect the accessibility and delivery of AFS. The most significant demand-side barriers identified in the study were low awareness of AFS centers among adolescents; shyness and their embarrassment affecting health seeking behavior, community level socio-cultural norms and attitudes towards adolescents' SRH such as fear and negative attitudes of community gatekeepers.

Awareness about AFS Centers for ASRH services

- Despite the expansion of AFS centers throughout the country implemented in a phase wise manner since 2009/10, very few parents of adolescents interviewed were aware of the services.
- Exit interviews revealed that only 2 out of 5 boys and none of the 6 girls had knowledge about AFS provided by the facility.
- Almost all (9/10) community gatekeepers were aware of activities carried out for adolescents.

Chart 2: Top five barriers seeking SRH services: adolescents girls vs. boys

GIRLS	BOYS
Shy nature	Shy nature
Lack of information regarding AFHS	Lack of information regarding AFHS
Distant location	Unsatisfactory treatement
Poor fiancial condition	Distant location
Unsatisfatory treatment	Lack of privacy

Chart 3: Top five SRH problems expressed by Adolescent girls vs. boys

GIRLS	BOYS
Adominal pain during menstruation	Wet dream/Nightfall
Distant location	Masturbation
Irregular bleeding during menstruation	Rashes/wounds in gential area
Irregular menstruation	Hydrocele
Body pain during menstruation	HIV/AIDS

Key supply-side challenges

- Insufficient training, monitoring and supervision of AFS centers and on site coaching for health workers (HW) to ensure quality service.
- Lack of presence of both male and female HWs in AFS centers to provide gender friendly ASRH services.
- Inadequate resources to upgrade facility environments to ensure privacy.
- Lack of monitoring and supervision from district level to support initiation as well as ongoing implementation of the ASRH Program.

Types of SRH services HWs felt comfortable to deal with (Total 72)

"SRH counselling or services" (26 out of 72)	"feel uncomfortable in providing safe abortion services to unmarried girl" (20 out of 72)	"feel uneasy to give condoms to unmarried young boy" (4 out of 72)	"feel uncomfortable with sexual minority/same sex people" (7 out of 72)

Presence of a trained HWs in AFS center with ASRH Program Implementation Guideline (2011)

- At least one trained HW was present in all the 72 AFS centers and two or more HWs in 61 (85%) AFS centers were convered.
- Presence of a single HW in AFS center poses a challenge for adolescents and young people of opposite sex.
- Level of confidence providing AFS (Providers' perspectives): Inadequate training was cited as the main reason for saying "No" by service providers as per the pie chart.

Are you confident in providing AFS?

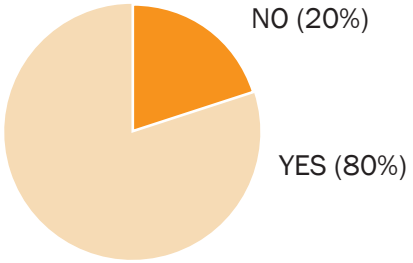

Chart 4: Barriers to accessing SRH services from AFS center: Adolescents' perception

Shyness/Fear/Ignorance	Distance/Accessibility	Quality of Care	Environment
Shy nature (0.474)	Facility far away (0.239)	Unsatisfactory treatment (0.154)	Provider is female/male
Ignorance about AFHS (0.315)	No transportation facilities	Lack of medicines, equipment & FPCs	Lacks privacy (0.186)
Fear of exposure	Service provider not avaliable on time/not fulltime	Long waiting time	Lacks a seperate room
Fear of parents	Facility remains closed	Do not trust the provider	Long waiting time
	No suggestion box	Negative attitudes when FPCs asked	
	Condom box not placed outside	Service provider scolds/ unfriendly behaviour	
	Lack time to visit facility	Discriminates the poor	
	Inconvenient opening hours	Refer clients to own private clinic	

Chart 5: Top 10 persons/places for seeking SRH advice or care: Boys vs. Girls

SL	BOYS (N=118)	%	SV	GIRLS (N=123)	%	SV
1	PHCC/HP/SHP	81.4	0.652	PHCC/HP/SHP	78.5	0.602
2	Friend/Partner	65.3	0.406	FCHV	68.6	0.463
3	Pharmacy	49.2	0.295	Friend	66.1	0.363
4	Hospital	46.6	0.275	Hospital	62.8	0.374
5	Teacher/Health teacher	36.4	0.228	Parents/Relatives	62.0	0.407
6	Health worker	36.4	0.172	Pharmacy	43.8	0.174
7	FCHV	30.5	0.177	Health worker	42.1	0.226
8	Doctor	28.0	0.138	Doctor	24.0	0.137
9	Elderly people	26.3	0.135	Traditional faith healer	23.1	0.122
10	Parents/Relatives	23.7	0.105	Teacher/Health teacher	22.3	0.101

Parents & Community Based Stakeholders' Perceptions

"There is a vast difference between the generations, now a days when young girls and boys meet they may have sex. So, to get rid of the consequences of early sex, counseling is essential in this age"

-FGD with parents, Jumla

"If a married young person comes to seek services, then nobody cares. But if an unmarried young person comes to seek services, people in the community start backbiting about her."

-FGD with Parents, Kaski

KEY RECOMMENDATIONS

1. Address the demand side constraints

Adolescents (10-19 years) account for 24.19% (6.4 million) of Nepal's population (Census 2011). This developmental stage marks the critical transition from childhood to adulthood, during which physical, emotional, cognitive and social changes expose adolescents to new health needs and risks. Based on data and information collected, adolescents are not fully aware of their sexual and reproductive health and rights (SRHR) nor are they able to exercise them fully.

- Greater coordination between Family Health Division (FHD), Ministry of Education, National Health Education, Information and Communication Center (NHEICC), I/NGOs and district- level counterparts, is needed to improve linkages between schools and AFS centers and to strengthen referral network to increase awareness and demand for services.
- Schools have the potential for reaching large groups through curriculum-based sexuality education or school-based delivery of information through peer educators, distribution of IEC materials, or HWs support through school health programs.
- Reinforce and support the role of HWs of AFS centers in delivery of education and promotion of services integrating health literacy into life-skills based programs.

2. Address the supply side constraints

Strengthening management, monitoring and supportive supervision of AFS centers by developing comprehensive, skill-based ASRH training packages for health workers with supportive supervision; increasing support to AFS center to improve the accessibility, acceptability and appropriateness of the services; developing self-assessment of quality improvement tool and certification criteria for AFS centers are crucial in addressing the supply side constraints.

2.1 Strengthen the delivery of AFS

FHD with the support of development partners should increase support and resources provided to facilities during the establishment of AFS centers.

Each AFS centers should ensure at least two adolescent/young active members participate in the Health Facility Operation Management Committee (HFOMC) as invitees for meaningful contribution in the design, implementation, monitoring and evaluation.

AFS centers should integrate with general health services ensuring privacy & confidentiality such as:

- Emphasis on visual and audio privacy of consultation rooms
- FHD should develop specific guidance concerning informed consent and confidentiality of adolescents.
- It should also consider the feasibility of delivering some services as outreach services (education, condom distribution and supply of IEC materials)

2.2 Strengthen monitoring, supervision and overall management

- FHD, with the support of development partners, should develop self-assessment of quality improvement tool and certification criteria for AFS centers to ensure minimum standards are met, and used as a basis for monitoring to ensure standards are maintained.
- It should improve accountability & monitoring of AFS centers at both district and central level.
- Regular supportive supervision is necessary to ensure the quality of care and motivation of HWs as well as recording and reporting of services provided to adolescents through the Health Management Information System (HMIS).
- 23 AFS centers (32%) had arranged a separate time/day for provision of AFS. Such dedicated opening hours for adolescents should be increased (at least once per week).

2.3 Improve capacity building of HWs and supportive supervision

- FHD should improve coordination with the National Health Training Centre (NHTC) to increase access to and coverage of capacity building of HWs in developing a more comprehensive, competency and skill-based ASRH training package for HWs working in AFS centers and train at least 3 HWs both male and female from all facilities including regular refresher training.
- FHD/NHTC should explore the possibility of incorporating adolescent health competencies into pre-service education for all primary level health workers.

2.4 Increase support to AFS centers of health facilities to improve the accessibility, acceptability and appropriateness of AFS

- FHD should provide increased guidance on procedures for integrating AFS with general health services at facility level. This requires training to even supportive staff and clear registration procedures in order to provide comprehensive and non-judgmental care.
- FHD, with the support of development partners, should develop more specific guidance on confidentiality and informed consent of legal minors, since there are situations when it may be in the best interest of adolescents to breach confidentiality.
- FHD and development partners should:
  i. Increase support to districts and facilities to create a more welcoming and accessible facility environment.
  ii. Explore the feasibility of delivering SRH counseling and services outside of the facility setting to reach also marginalized adolescents and to overcome some barriers associated with accessing facility-based care.
  iii. Increase guidance on supply-side actions needed to deliver AFS for young key affected populations and marginalized adolescents.
- It is also recommended that FHD and development partners support further research to identify the specific needs, barriers and preferences of underserved adolescents to inform specific supply-side actions which is not covered yet.

In conclusion, there is a need to implement a multi-ministerial and a multi-sectoral approach (involving in particular the Ministry of Health, the Ministry of Education, the Ministry of Women, Children and Social Welfare) in order to effectively address both supply and demand side constraints in order to increase universal access to SRH by adolescents girls and boys, marginalized and disadvantaged communities working through different levels; individual, family/ community, health provider, health facility, management and policy level.

Chart 6: Multiple barriers impact on access to and delivery of AFS

Policy Level Insufficient guidance on supply-side actions needed to improve access for marginalised and underserved young people; lack of clarity concerning informed consent and confidentiality for young adolescents.
Management Level Inadequate and incomplete reporting lack of regular monitoring and supportive supervision; insufficient resources to provide an adolescent-friendly environment (particularly privacy) lack of youth participation in HFOMC; inadequate prioritisation of AFHS.
Facility Level Poor physical access (distant location and lack of transport); costs of services and transport; lack of privacy; insuffiecient medicines and supplies (including IEC materials; long waiting time; lack of providers and/or lack of both male and female providers; inconvenient opening hours; AFHS poorly integrated with general health services.
Health provider Level Inadequate training and supportive supervision; insufficient knowledge about adolescent helath and development including SRH needs; inadequate counselling and communication skills; judgmental attitudes and discomfort providing some counselling and services; young people's perceptions that providers are not trustworthy and provide poort quality care.
Family/community Level Fear of parents and community members; judgmental attitudes and disapproval of family and community gatekeepers, particulary regarding provision of some SRH services (such as contraception.
Individual Level Embarrassment/shyness; lack of awareness of AFHS; lack of awareness of own health needs.

Progress to date (2015)

At the time of developing this policy brief, several steps have already been taken to implement the above recommendations, including development and endorsement of the self-assessment quality improvement and certification criteria tool-2015, certification of several AFHS centers in selected districts (Sindhuli, Pyuthan, Achham, Bajhang) in 2015, endorsement of revised ASRH training package-2015 (Trainer's guide, Participant's handbook and Reference materials) and extensive ASRH training of health workers from AFS centers, establishing ASRH Clinical Training Sites following the standardized 5 step process and more. For more information please contact Ghanashyam Pokharel, Sr.Public Health Administrator, FHD, pokharelghanashyam@gmail.com, Dr.Jhalak Gautam, Sr.Integrated MO, FHD, jgautamdr@gmail.com & Ms. Manju Karmacharya, ASRH Officer, UNFPA, Nepal, karmacharya@unfpa.org

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