Adolescent Sexual and Reproductive Health Programme to Address Equity, Social Determinants, Gender and Human Rights in Nepal

Report of the Pilot Project

World Health Organization

Government of Nepal
Ministry of Health
Department of Health Services

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Foreword

Nepal has shown its commitment to adolescent health through being a signatory to the International Convention on Population and Development (ICPD) Programme of Action. Nepal was also involved when the WHO South East Asia Regional Office (SEARO) developed the Regional Strategy for Adolescent Health and Development in 1996. In 1998 Adolescent Sexual and Reproductive Health (ASRH) was included in Nepal's National Reproductive Health Strategy.

In 2000 the National Adolescent Sexual and Reproductive Health Strategy was developed by the Family Health Division (FHD) of the Ministry of Health and Population (MoHP). Following the strategy, in 2007 the implementation guidelines for ASRH were developed, and in 2010 the National Adolescent Sexual and Reproductive Health Programme was developed by FHD. In addition National Adolescent Friendly Health Services (AFHS) standards and actions was developed as required at the programmatic and facility level.

The Nepal Health Sector Program II Implementation Plan 2010–2015 included the target of introducing 1000 AFHS in the public health system by 2015, thereby covering 25% of the government health facilities. Though the demand of service and utilization has not been studied the coverage is as per the NHSP plan. The national reproductive health review meeting in February 2015 identified gaps in quality assurance of the ASRH programme, weak capacity of service providers, poor supervision and monitoring, poor ownership of the programme at local level, poor linkage with other programmes and inadequate information education and communication (IEC) and behaviour change communication (BCC) materials. Many of these issues, particularly health promotion, improved monitoring and quality assurance, are being addressed in the Nepal Health Sector Program Implementation Plan 2016-2020. Also, FHD has revised the NAHD Strategy from 2000.

The Innov8 methodology has helped department of Health services to review the programme, drawing selectively on the principles of a human rights based approach and gender-responsive programming and the Tanahashi framework for effective coverage and the WHO framework on social determinants of health. The evaluation of health programmes in general don't account for the heterogeneity of the populations, subpopulations that are benefiting less from the health programmes that are often missed and hence are neglected. This tool Innov8 will identify the populations which are not covered by the national ASRH programme. The process has strengthened the ability of the ASRH programme to increasingly cover the vulnerable and left out people who are exposed to risk factors, and to expand access to health services and improve the health status of adolescents.

I would like to express my appreciation and my sincere thanks to all individuals who contributed during the workshop and developed this document. Equally, we acknowledge WHO headquarters, SEARO and the Country Office for Nepal in supporting the Family Health Division technically and financially during this whole process.

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Contents

Acronyms and abbreviations

AAAQ	availability accessibility acceptability quality
AA-HA!	Accelerated Action for the Health of Adolescents
AFHS	adolescent-friendly health services
ANC	antenatal care
ART	anti-retroviral therapy
ASRH	adolescent sexual reproductive health
BCC	behaviour change communication
BEONC/BC	Basic Emergency Obstetric and Neonatal Care/Birthing Centre
BPFA	Beijing Platform for Action and Programme of Action
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CERD	Convention on the Elimination of All Forms of Racial Discrimination
CREHPA	Centre for Research on Environment Health and Population Activities
CSO	civil society organization
DHO/DPHO	District Health Office/District Public Health Office
DoHS	Department of Health Services
EHCS	essential health-care services
EmONC	emergency obstetric and newborn care
EDP	external development partner
FCHV	female community health volunteer
FHD	Family Health Division
FP	family planning
GBV	gender-based violence
GER	gender, equity and human rights
GESI	gender equality and social inclusion
HERD	Health Research and Social Development Forum
HFOMC	Health Facility Operation and Management Committees
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
HMIS	Health Management Information System
HPs	health posts
HRH	human resources for health
ICPD	International Conference on Population and Development
IEC	information, education, communication
M&E	monitoring and evaluation
MCA	maternal, newborn, child and adolescent health
MoE	Ministry of Education

MoHP	Ministry of Health and Population
NGO	nongovernmental organization
NAHD	National Adolescent Health and Development
NADHS	National Adolescent Development and Health Strategy
NDHS	Nepal Demographic and Health Survey
NHEICC	National Health Education Information Communication Centre
NHSP II	Nepal Health Sector Programme II
NHTC	National Health Training Centre
NMICS	Nepal Multiple Indicator Cluster Survey
NPC	National Planning Commission
OPD	outpatient department
PHC	primary health care
PHC ORC	primary health care outreach
PHCCs	primary health care centres
PMTCT	prevention of mother-to-child transmission
PRS	poverty reduction strategy
RHCC	Rainwater Harvesting Capacity Centre
RHDs	Regional Health Directorates
SEAR	South-East Asia Region
SEARO	South-East Asia Regional Office
SDH	social determinants of health
SHPs	sub-health posts
SLC	school-leaving certificate
SM	safe motherhood
STI	sexually transmitted infections
SRHR	sexual and reproductive health and rights
UHC	universal health coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VDC	village development committees
WHO	World Health Organization

About this report

During the last quarter of 2015, a review was conducted to ascertain how the national Adolescent Sexual Reproductive Health Programme of Nepal could better address equity, gender, human rights and social determinants of health, hence working to ensure that "no adolescent is left behind". This review was led by the Family Health Division of the Ministry of Health and Population (MoHP) of Nepal, with support from the World Health Organization (WHO) and Health Research and Social Development Forum (HERD), and in conjunction with other members of an interdisciplinary review team. This report is a description of the review team's analysis, which applied a review methodology that has the following steps:

- complete a diagnostic checklist of the programme that serves as a baseline for the programme upon which all subsequent analysis is built;
- map the theory of the programme, including key stages, outputs and impacts;
- identify the subpopulations that are being missed or benefitting less from the programme, and prioritize one subpopulation for further analysis;
- describe the barriers and facilitating factors experienced by the prioritized subpopulation;
- identify the mechanisms (including structural and intermediate determinants) driving the inequities experienced by the prioritized subpopulation;
- consider how intersectoral action and social participation could help address the barriers experienced by the subpopulation and their causes;
- identify priorities for redesign of the programme to better tackle issues related to equity, gender, human rights and social determinants of health; and
- formulate suggestions for how the ongoing review, monitoring and evaluation cycles of the programme can help ensure that no one is left behind.

At the time of writing, this report reflects the preliminary assessments along the eight lines of action stated above. The redesign proposal and suggestions for ongoing review and monitoring and evaluation will be further elaborated in the Next Steps section at the end of the report.

2

Introduction of the country work

Nepal has shown its commitment to adolescent health through being a signatory to the ICPD Programme of Action. Nepal was also involved when the WHO South-East Asia Regional Office (SEARO) developed the Regional Strategy for Adolescent Health and Development in 1996. Following these commitments, in 1998 ASRH was included in the National Reproductive Health Strategy. In 2000 *the National Adolescent Health and Development Strategy* was developed by the Family Health Division (FHD) of the Ministry of Health and Population (MoHP).

Following the Strategy, in 2007 the implementation guidelines for ASRH were developed and in 2010 the National Adolescent Sexual and Reproductive Health Program was developed by the FHD. The key components of this programme are upgrading facilities to provide adolescent-friendly health services (AFHS), to generate demand for AFHS in the communities, equipping facilities with basic services to provide private and confidential services, providing health workers with an adolescent job aid, counselling flipchart and IEC materials, involving adolescents in decision-making through health facility operation and management committees, and providing appropriate sexual and reproductive health services.

The Department of Health Services (DoHS) is responsible for delivering preventive, promotive, diagnostic and curative health services throughout Nepal. It is supported by five regional health directorates (RHDs) across the country. The RHDs also monitor the health facilities in their respective regions. At the district level, the District Health Offices/ District Public Health Offices (DHOs and DPHOs) are responsible for implementing essential health-care services (EHCS) and monitor activities and outputs of district hospitals, primary health care centres (PHCCs), health posts (HPs) and sub-health posts (SHPs). There are altogether 2247 SHPs, 1559 HPs, 208 PHCC/HCs, 78 district/other hospitals, 10 zonal hospitals, 3 sub-regional hospitals, 3 regional hospitals, and 8 central level hospitals in Nepal (DOHS 2071/72).

The Nepal Health Sector Programme II Implementation Plan 2010–2015 included the target of introducing 1000 AFHS in the public health system by 2015, hence 25% of the government health facilities would be covered.

Many of the issues of implementing the National ASRH Programme, particularly health promotion, improved monitoring and quality assurance, are being addressed in the Nepal Health Sector Programme Implementation Plan 2016-2020, which is currently being approved by the Cabinet as the Nepal Health Sector Strategy. Also, FHD is currently also revising the National Adolescent Health and Development (NAHD) Strategy from 2000, in this process an assessment of adolescent-friendly health services may be undertaken to guide the strategy update process. Box 1 highlights the main aims of the review undertaken and described in this report, in relation to the above activities.

Box 1: Aims of the step-wise review of the Adolescent Sexual and Reproductive Health programme to strengthen its capacity to address equity, gender, human rights and social determinants

The review process aims to:

- identify what subpopulations are missed by the national ASRH programme; and
- strengthen the ability of the ASRH programme to increasingly contribute in the reduction of avoidable and unjust differences in exposure to risk factors, access to health services and improvement in health status of adolescents.

The findings will be able to make recommendations on how the ASRH programme to a greater extent can reach subpopulations that are currently being missed, and to review if the current recording and reporting mechanisms for ASRH/AFHS can improve to reflect health inequities in access and utilization. Furthermore, the findings will be able to guide the NAHD Strategy update to strengthen the focus on social determinants of health, gender, equity and human rights.

It can also be noted that the focus of the review is reflected in the Global Strategy for Women's, Children's and Adolescent's Health 2016–2030 and the emerging Global Adolescent Health Framework.

3

Country background

In Nepal, adolescents constitute 24% of the population according to the census of 2011. The practice of early marriage and childbearing is very common in Nepal. The median year at marriage for men in Nepal was 21.6, whereas for females it was 17.8 (NDHS 2011). Among girls aged 15–19 years 29% are already married and 17% are already mothers or pregnant. Data from the Nepal Adolescent and Youth Survey 2010–2011 shows that adolescents from disadvantaged ethnic groups, religious minorities and adolescents with no education were more likely to have given birth than adolescents from advantaged groups and with higher education. Also, a higher percentage of girls aged 15–19 in rural areas had given birth than girls from urban areas. Age-specific fertility rate is 81 per 1000 women of the age group 15 to 19 years according to NDHS and it is 71 per 1000 women of the age group 15 to 19 years according to Nepal Multiple Indicator Cluster Survey (NMICS). The age-specific fertility rate among women aged 15 to 19 is highest among Muslims (137) and Dalits (110) compared with Brahmin/ Chhetri (52). Also, it is much higher for women living in rural areas (87) compared with those living in urban areas (42).

Education plays a vital role in empowering adolescents for acquiring knowledge and information, accessing services and practising positive behaviours. Evidence suggests that it also has a critical role in improving sexual and reproductive health outcomes. The Government of Nepal has envisioned ensuring access to complete, free and compulsory primary education to all children with special focus on girls, children in difficult circumstances, and those belonging to ethnic minorities (Ministry of Education- MoE 2003). According to the population monograph 2014, 90% of adolescents can read and write. On the other hand, NDHS 2011 reported 17% of female adolescents and youth and 4% of adolescents and youth had no formal education.

The Nepal Labour Force Survey 2008 reported that 49.4% of adolescents aged 14-17 years and 20.3% of adolescents aged 10–13 years are not attending schools. The adolescents who are not attending schools are primarily from rural areas. Inadequate levels of sanitation and hygiene and supply of water are some of the reasons why adolescents leave school and miss classes (NPC & UNDP, 2012). The drop-out rate of girls from schools is much

higher than boys and has been linked to poverty-related constraints. The main reasons attributed to dropouts are: (i) help needed at home, (ii) poor academic progress, and (iii) too expensive education costs for girls. However the total number of girls going to community primary schools is increasing by 3.5% annually on an average (NLSS, 2010/11).

The NDHS 2011 data also showed that 9% of the adolescents aged 15–19 years and 1% of children aged 10–14 years were employed. Young women (15-29) frequently experience gender discrimination at the workplace (Nepal Labour Force Survey 2008). The NDHS 2011 reported that 10% and 5% of women aged 15-19 experienced physical and sexual violence in Nepal. They are exposed to all prevalent forms of violence against women, e.g. dowry-related violence, marital rape, sexual harassment and intimidation at work, trafficking, forced prostitution, acid-throwing, rape, etc.

Contraceptive use is extremely low among married adolescents — 14% compared with the national average of 43%. Approximately 41.5% of 15-19-year-old adolescents have unmet needs which is very high compared with the national average of 27% among women of the reproductive age group (NDHS 2011). Unmet need of family planning among the rural adolescents and youth aged 15–24 is 39.5 compared with 27.2 among the urban counterparts. The proportion of women less than 20 years of age among the women coming for first antenatal care visit (ANC) is 21%. The proportion of never-married male adolescents and youth who had ever had sexual intercourse was 22% and only 1% among never married female adolescents in 2011. The proportion of males aged 15-24 who had reported their last sexual intercourse with an acquaintance or a commercial sex worker was 1.2 and 1.1 in NDHS 2006 and 2011 respectively. Only 39.8% of adolescents aged between 15–19 years know that abortion is legal in Nepal (NDHS 2011) and due to cultural reasons unmarried pregnant girls often resort to unsafe abortion to avoid stigma.

Additionally, only 59.7% of married adolescents aged 15-19 had knowledge of sexually transmitted diseases and HIV/AIDS. Only 1% of male and 3% of female adolescents and youth with no education had comprehensive knowledge of HIV and AIDS, compared with around 53% of those with school-leaving certificate (SLC) and above education. For both male and female adolescents and youth, the proportions reporting sexually transmitted infections (STI) or STI symptoms increased from 6% to 10% and 4% to 14% between 2006 and 2011 respectively. Furthermore, 635 000 people are living with HIV in Nepal and of them 5.5% are adolescents (NDHS 2011).

In 2014 a qualitative study assessing supply-side constraints affecting quality of AFHS and the barriers for service utilization was conducted by FHD, UNICEF, UNFPA and Crepha (a private, not-for-profit consultancy and research organization), using data from 12 districts. Key findings of this study were that barriers for service utilization included:

- Lack of clarity on informed consent and confidentiality on the part of the provider and clients;

- Weak monitoring and evaluation;
- Geographical accessibility;
- Cost of services and transportation;
- Waiting times;
- Lack of same sex health-care providers (barrier for both provider and client);
- Inconvenient opening hours for clients;
- Lack of sufficient knowledge on adolescent health needs among providers, including SRH;
- Family/community attitudes;
- Lack of knowledge about services;
- Shyness and lack of health-care knowledge.

However, the study did not specifically target key affected populations or other underserved/marginalized adolescents, including those living in rural/remote areas, due to lack of facility-level data.

Similarly, Table 1 presents the trends in the proportion of adolescents aged 15–19 years who have begun childbearing.

Table 1: Trends in differentials in percentage of adolescent girls (aged 15–19 years) who have begun childbearing

Residence	2001 (%)	2006 (%)	2011 (%)
Urban	12.6	16.4	9.3
Rural	22.5	18.8	17.8
Education			
No education	31.5	32.7	31.6
SLC and above	8.3	3.9	8.0
Wealth quintile			
Lowest	NA	18.2	18.4
Middle	NA	21.5	22.1
Highest	NA	14.4	6.7

(Source: NDHS 2001, 2006 and 2011)

Most communities in Nepal are patriarchal wherein women are expected to undertake both domestic duties and contribute to the household's efforts to generate enough food and income to survive. The economic contribution of women is substantial

but largely unnoticed because their traditional role as caretaker is taken for granted. The economic dependence of women on men has a significant impact on their decision-making autonomy (Thomas et al. 2012). The 2011 NDHS shows that only 45% of currently married women in Nepal participate in decisions pertaining to health care, major household purchases, and visits to family/relatives. Married women face many barriers in rural and hard-to-reach areas in accessing health services such as restriction of women's movements outside the house and availability of cash to pay for transport and health services.

Gender norms also inhibit women and men being treated by the health personnel of the opposite sex, particularly for the intimate health problems related to sexual and reproductive health. The peer study found that other members in the household in rural areas were reluctant in undertaking household chores in order to allow a daughter-in-law the opportunity to access health. Married women's timely access to health services is further compounded by perceptions among other household members that a daughter-in-law is using health-seeking behaviour as a way of avoiding strenuous and time-consuming domestic duties. In the year 2013 Nepal ranked 98 in the Gender Inequality Index. A Nepali proverb states: "Educating a girl is like watering your neighbour's garden". The rural communities don't consider educating their daughter a good investment as she is destined to marry and contribute to her husband's household. However this notion is changing slowly due to various awareness programmes which is reflected in the rising secondary school enrolment rates of girls in rural areas (NDHS 2011).

4 Overview of the review process

In February 2015, the WHO Country Office sought concurrence from the Ministry of Health and Population (MoHP) for piloting the stepwise methodology on the ASRH programme. The pilot of the 5-step review process was then shared in the ASRH sub-committee meeting and the External Development Partner (EDP) meeting. The 25 April 2015 earthquake caused disruption in the previous plans and preparations of review of the national ASRH programme. The process was postponed until the last quarter of 2015.

In September 2015, HERD was contracted to provide technical expertise, coordinate with FHD, WCO Nepal and review team members, facilitate the sensitization and review workshop and review process as a whole. Immediately after the contract HERD began to collect relevant documents and data from NDHS, Health Management Information System (HMIS), MICS, programme evaluations, scientific journal articles, reports from civil society and developments partners, country reports on human rights and other grey literature relevant to programme. A compendium of the relevant document was prepared.

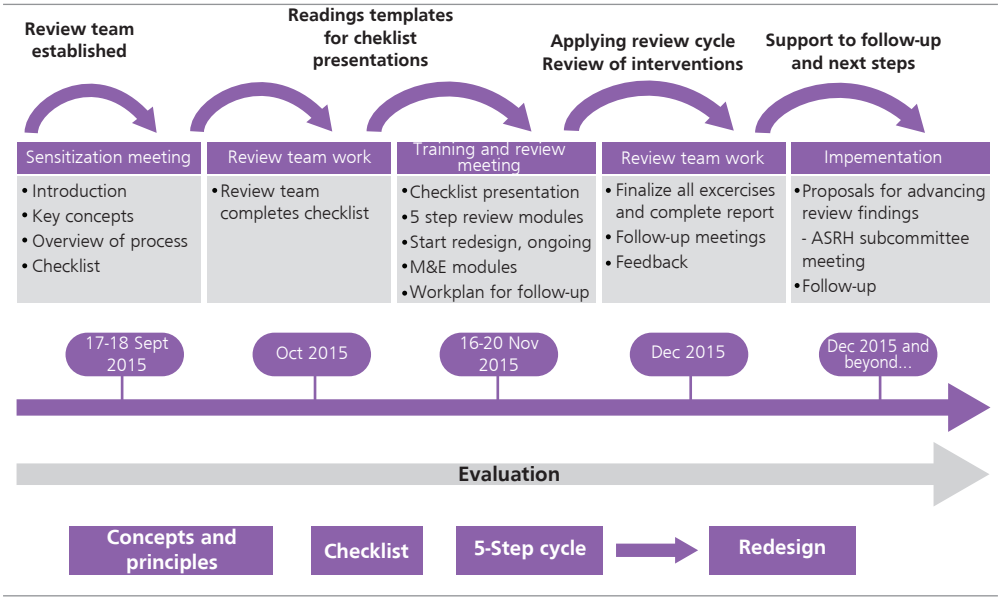
A review team was formed comprising of 15 experts, coming from national authorities (ASRH programme staff), and district-level managers working on the ASRH programme, research institutes, civil society and multilateral system partners. The timeline in *Figure 1* exemplifies the steps in the process.

A two-day sensitization meeting was held on 17-18 September 2015 on the core underlying concepts and principles of the review methodology and introduce the diagnostic checklist to the review team. Individual team members were assigned to complete certain sections of the checklist according to their expertise. A follow-up meeting for discussion and finalization of the checklist was held on 14 October 2015.

Then a 5-day review meeting was held on 16-20 November 2015 to pilot the methodology to consider how the ASRH programme can further address key gender, equity, human rights and social determinants of health issues. During the meeting, the review team did a preliminary analysis of the mapping of the programme theory, identification of subpopulations being missed, description of barriers and facilitating factors, identification of mechanisms

driving inequities, and exploration of how intersectoral action and social participation can be helpful to overcome barriers. The review team prioritized one subpopulation that evidence suggested was particularly important for reducing inequities: adolescents living in rural/remote areas. They also were introduced to the redesign phase, which entails identification of proposals for how the programme could tackle inequities experienced by that subpopulation. At the meeting, the principles of a human rights based approach and gender-sensitive programming was shared.

Figure 1: Timeline of the 5-Step Review of the national ASRH Programme



After the review workshop, the review team completed the review exercises and began the redesign phase, including the identification of entry points and priorities for strengthening the focus on GER and SDH in the ASRH programme. The review team held a meeting on 31 December 2015 to finalize the review exercises and further reflect on the priorities for redesign. This review team report was prepared documenting the review process, findings/results and next steps needed to advance the work.

In support of the Government of Nepal, WCO Nepal and partners now will convene follow-up meetings with the review team and consultations with wider groups of stakeholders through the ASRH sub-committee meetings and in other platforms for refining, prioritization and further advancing the proposed recommendations. Additional details are featured in the section of this report on next steps.

5

Summary of the key findings from the checklist

The first step in the analysis conducted by the review team was completion of the diagnostic checklist, which constitutes a baseline of the current situation for the programme. Core aspects of the completed checklist for the National ASRH are summarized below.

The National ASRH Programme is supporting the MoHP in the achievement of the following goals and objectives of the National Adolescent Development and Health Strategy (NADHS) 2000 so as to promote the overall adolescent reproductive health. The goal and objective of the National Adolescent Health and Development (NAHD) Strategy are:

Goal

The overall goal of the NAHDS 2000 is to promote the health and socioeconomic status of adolescents.

Objectives

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

The goals and objectives are in line with NHSP II. The monitoring and evaluation of the programme was planned to be carried out by using the following indicators.

- Increase age at marriage
- Increase in use of modern methods of family planning
- Decrease unmet need for family planning
- Reduce adolescent pregnancy

- Reduce adolescent fertility rate
- Decrease prevalence of HIV infections.

The main achievements of the National ASRH programme are:

- 63 out of 75 districts have at least 13 AFS health facilities
- 1144 health facilities are adolescent□friendly
- Establishment of AFSH centres and AFS corners in health facility and schools
- Sensitization of stakeholders and service providers
- Increased communication with health facility, female community health volunteer (FCHV), mothers' groups.

The ASRH programme has laid down certain criteria to identify the target population and priority subpopulation. It considered the magnitude of the problem. For instance, for piloting "My First Baby programme", Pyuthan and Kapilbastu districts were chosen because there is a high prevalence of child marriage. "*Kishore Samuha*" (female adolescents groups) are also formed and a comprehensive package called *Rupantaran*[1] addressing the issues of adolescence is rolled out, which aimed to support the areas identified under the National Plan of Action on holistic development of adolescents, endorsed by the National Planning Commission.

The regular health needs were assessed in consultation with stakeholders (beneficiaries and line agencies). The further analysis of NDHS data on adolescents disaggregated by gender, region, urban and rural, ethnicity, and economic criteria was done to assess the differential needs of specific subpopulation. The Barrier study conducted in 2015 and National Adolescent and Youth Survey in 2011 was useful in assess various needs and barriers faced by adolescents in Nepal in accessing health services.

The National ASRH programme is conducting the following activities nationwide to promote adolescent health: Counselling, family planning services, audio/visual messages and IEC materials for ASRH promotion, safe abortion services, school health education, management of gender-based violence (GBV) cases and other general health services.

The major barriers that the ASRH programme is facing in rolling out these activities are lack of sufficient availability of IEC materials, inadequately trained service providers, opening hours of AFS clinics, and inadequately trained teachers for school health education. There are also some challenges in implementation like inadequate

1 *Rupantaran* meaning "transformation" in Nepali is a comprehensive package aimed to support in the areas of 6 domains: heath and heatlh services; protective environment; education and skill; livelihood, employment and economic literacy; participation and citizen involvement; and gender equity and social inclusion. It is identified under the National Plan of Action on holistic development of adolescent, endorsed by the National Planning Commission

coordination between different government agencies and donors for planning and managing programmes; poor integration with other public health programmes; poor human resources for health (HRH) training and management for ASRH; poor coordination with nongovernmental sectors, lack of proper monitoring and supervision of AFS.

In its responses to the checklist, the review team indicated that the original programme does not explicitly mention objectives on equity. It did, however, state that the programme assesses the differential needs of specific subpopulations (with data disaggregated by sex, region, urban and rural, ethnicity, and income level). Challenges for intersectoral action and social participation were also identified.

Five-step review process

6

The five-day review workshop held from 16-20 November 2015 in Kathmandu focused on the review of the health equity, social determinants, and gender and human rights in relation to the national ASRH programme. Various modules were used to help focus the review process through group works among the members of the review team. Templates were used to work on the various review steps.

Five review modules were used to proceed with the following components of analysis:

1) Understanding the theory of the programme
2) Identify who is being left out by the programme
3) Analyse the barriers and facilitating factors
4) Identify the mechanisms generating inequities
5) Look at the role of social participation and intersectoral action

At the meeting, two modules of the follow-up and re-design were also introduced briefly; the review team would work with them more after the meeting to consolidate the emerging findings from the review steps, and develop a proposal for strengthening/"redesigning" the national ASRH programme to better address equity, social determinants, gender and human rights. These modules aim to guide the review team in considering necessary adjustments to the programme. The review process engaged all the review team members in a participatory manner and discussions were kept well-balanced to address the needs of the review process.

6.1 Theory of the ASRH programme

At the foremost of the review process, the review team reflected on the Preliminary Programme Theory of the national ASRH programme which is as follows:

Box 2: Preliminary Programme Theory of the National ASRH programme

If information and services on SRH to address ASRH issues is provided through AFSC in health facilities and schools, an enabling environment in schools and the community will be created, so that more adolescents will access and benefit. Then the programme targets will be reached, ultimately contributing to national development.

Understanding the existing programmatic theory is very essential as it reflects on where and how the present provisions of the national ASRH programme focuses on, and to assess the need for review mechanisms that generate inequity among the target groups.

6.2 Key stages of the ASRH programme:

From the various activities of the programme, the establishment of the adolescent friendly services (AFS)[2] is prioritized as the key stage which directly relates to the provision of sexual and reproductive health services for the adolescents in the existing health facilities. It comprises the following activities:

(1) Selection of health facilities to be upgraded to AFSs

(2) District-level orientation programmes for the implementation of ASRH programmes

(3) ASRH orientation programme for health service providers

(4) ASRH programme orientation for Health Facility Operation and Management Committees (HFOMC) and local stakeholders

Key stages are essential phases of the development process of the programme which are necessary for achieving the intended outcomes. The key stages of the ASRH programme are presented the Table 2.

For the development of the ASRH Programme, the planning process at the central level (budget allocation and district selection) was agreed as the first stage. Then the orientations at the regional and district level are organized. Following that, the selection of the health facilities to be upgraded to AFSs is done, which is followed by the orientation to the district level stakeholders, health providers, and HFOMC and local stakeholders.

These orientations are aimed at orienting about the implementation of the National ASRH Programme. At the local level, adolescent friendly corners are also established where various IEC materials are available that is expected to help to increase the knowledge about sexual and reproductive health among the school adolescents. After

2 Adolescent-friendly services refer to the environment and condition in which adolescents can easily access and utilize ASRH services in a friendly manner. Therefore it must be understood that AFS are services sought by adolescents being provided without any discrimination by the health facility and health service providers.

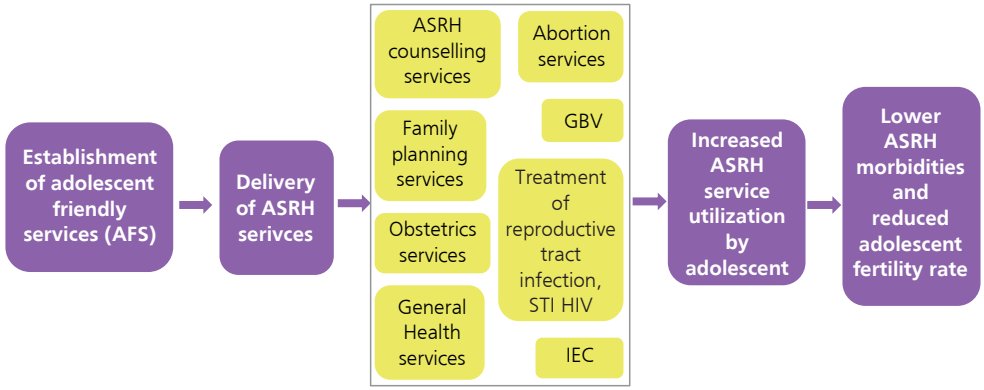
the establishment of the AFSs, it is intended that the adolescents utilize information, and SRH services from the facilities without any discrimination.

Table 2: Key Stages of the ASRH programme and the sub-populations that get and do not get access or benefit in every stage

Key stage of the programme	Which subpopulation(s) access and benefit more?	Which subpopulations do not access or benefit, or do so to a lesser extent?
Planning	• Active adolescents and youths at the district/ community level where the AFS expansion is met	• Out of school adolescents
Orientations/training • Regional level • District level • Community level	• School adolescents • Active (club members) adolescents • Adolescents living near to AFS centres	• Out-of-school adolescents • Differently able • Married adolescents • Street adolescents
Establishment of AFS centres	• Easy to access places • Well-functioning Health facilities • Adolescents living near to AFS	• Adolescents in the hard-to-reach rural places
IEC/BCC materials production	• Near to AFS centres adolescents • School adolescents	• Out-of-school/uneducated adolescents • Rural hard-to-reach areas • Migrants • Street adolescents
Is there a key stage particularly critical? Which?		
• Service delivery • Recording/Reporting • Monitoring/Follow up		

Additionally, service delivery was identified as the priority activity (Figure 2). At present, the service delivery does not comprise outreach services which could address the ASRH needs of the out-of-school adolescents. After upgrading the health facility to be adolescent-friendly, it is expected that the environment of the health facilities be conducive to the adolescent utilizing health services including SRH. All these programme activities are expected to increase the utilisation of SRH services and reduce the morbidities related to SRH as well as adolescent pregnancy.

Figure 2: Key stages of the priority activity: establishment of the AFS



The preliminary review of the ASRH programme showed that most of the activities were designed for the adolescent as a whole. It also seemed that the adolescents enrolled in the schools are targeted through activities such as adolescent-friendly centres and ASRH education sessions at schools in the ASRH implemented districts.

In considering the original theory and diagram of the programme, the review team agreed that most of the programme activities were not sufficient to address the needs of the sub-population of adolescents who reside in the rural hard-to-reach areas of the country. One of the sub-populations of such rural hard-to-reach adolescents includes out-of-school adolescents. Identification of the sub-populations who are left out by the programme or among whom the inequity persists was done during the review workshop in November 2014 through an exercise reflecting on the available data on health, employment, education, gender, human rights and other social determinant of health. This is further elaborated below.

6.3 Groups that are not accessing or benefiting from the programme.

The National Adolescent Sexual and Reproductive Health Programme was designed to reach all adolescents. However due to various factors like budget constraints and lack of human resources, many adolescent sub-populations are still deprived of adolescent-friendly services. The majority of the young people live in rural areas. The age-specific fertility rate among women aged 15–19 years is twice higher in rural populations than urban population. But at present AFSs are mainly concentrated in well-equipped health facilities in easily accessible areas.

Following its completion of the analysis on "subpopulations being missed by the programme or who benefits less", the review team identified various adolescent sub-populations that should be targeted, as have been tabulated in Table 3. Among these, the sub-population identified as "rural hard-to-reach" were earmarked for further analysis across the subsequent steps of the review.

Table 3: Sub-population that should be targeted with the ASRH programme

Sub-population	Why selected	Source
Rural hard-to-reach	• Majority of young people (82%) live in rural areas. • Age-specific fertility rate among women 15-19 years of age: Urban 42, Rural 87 • AFS at present is mainly concentrated in well-equipped health facilities in easily accessible areas • Literacy: Literacy: among boys aged 15-19 yrs: in rural 95.81% and urban 98.51% and among girls aged 15-19 yrs: in rural 89.59% and in urban 97.52% • 90% of female youth and 88% of male youth ever married live in rural areas • Unmet Need of family planning among the rural adolescent and youth age 15-24 is 39.5 compared to 27.2 among the urban counterparts • Condom use among rural male adolescents during last sex 41.3% vs 62.8% in urban • Comprehensive knowledge among men and women is low in rural areas Versus urban: 40 (F), 42 (M); rural: 23.5 (F), 32 (M)	Population Monograph based on Census 2011 NDHS 2011 National Youth and Adolescent survey ASRH implementation guideline (Selection criteria)
Urban slums	• Adolescent fertility rate (15-19): highest quintile 103, lowest quintile 32 • Access to delivery by skilled birth attendant: highest quintile 85%, lowest quintile 45%	NDHS 2011
Married adolescents	• Age-specific fertility rate among women 15-19 years of age: 81 • Median age at first marriage among women aged 20-49 (in years): 17.8 • Median age at first birth (in years): 20	NDHS 2011 Nepal MICS
Out-of-school adolescents	• 49.4% of adolescents in the age group 14-17 and 20.3% of adolescents in the age group 10-13 are out of school.	Nepal Labour Force Survey 2008
Minority and disadvantaged	• AFR is very high among minority populations such as Muslims (137), Dalits (110) etc. compared with Brahmin/Chettri (51) • Ethnic minority like Muslims women (55%) experience high GBV compared with Brahman/Chhetri: (20%)	NDHS 2011
Displaced (emergency and disaster)	• Over 605 254 houses were destroyed leaving hundreds of thousands of families without a roof over their heads. • Damaged 446 district and sub-district public health facilities and caused severe damage to certain buildings of central hospitals. • Out of 360 established Basic Emergency Obstetric and Neonatal Care/Birthing Centre in 14 districts, 112 were severely damaged and 144 were partially damaged disrupting reproductive health and maternal and neonatal health services. • Increase in women trafficking and gender based violence cases immediate post-earthquake.	

6.4 Analysis of the barriers and facilitating factors

In a survey conducted on the HIV/AIDS programme among adolescents, young adults and migrant labourers in 6 districts of Nepal, only 25.5% respondents reported to have ever used sexual reproductive health services. The reason for not utilizing the services being:

- *Services are not friendly.*
- *Services are not easily accessible (NEW ERA 2006).*

Currently the AFS are provided by 1144 health facilities covering 63 out of 75 districts. However the facilities that were selected for scale-up of AFS were the ones which had proper infrastructures according to stringent criteria, laid down by ASRH implementation guideline. This requirement has led to AFS centres being established in urban and semi-urban areas depriving rural hard-to-reach adolescents of adolescent-friendly services.

In the mountain region, four of 19 individuals and in the hill region three of 10 individuals have to travel 1-4 hours to reach the nearest health or sub-health post (NHSP II). In general rural hard-to-reach adolescents are being deprived not only of AFS but general health services as a whole. The out-of-pocket expenditure that they have to bear in reaching health facilities in these rural hard-to-reach areas and the cost of some services has also limited their access to these services.

The lack of trained service providers in AFS and high absenteeism of staff in governmental facilities is a major challenge in the way of the successful implementation of the ASRH programme. This situation is exacerbated in rural areas in the hilly and mountain regions where the people are heavily dependent on the government health facilities and have to walk hours, or travel a lot, to receive health care. This often involves indirect costs such as transportation costs, food and lodging, and medicines. Therefore, when they are not attended to by the service provider when they reach the facilities their expenses go in vain.

Health workers are reluctant to work in the rural hard-to-reach areas due to poor infrastructure, equipment and supplies in the health facilities, as well as inadequate incentives to health workers working in these areas (SOLID Nepal and Merlin Nepal, 2012). On the other hand, in the Terai region health facilities are generally overcrowded, which invites issues such as lack of privacy and confidentiality while seeking reproductive and sexual health services (Thomas et al. 2012).

Adolescents are reluctant to access the ASRH and health services in general due to lack of confidentiality and privacy as well fear of getting stigmatized. Other barriers that have been hindering effective coverage of AFS are poor integration with other public health programmes and poor supervision and monitoring system. The operating hours of AFS health centres at present are such that most of the adolescents are at school at that hour and cannot access AFS. For rural adolescents, these issues are particularly of concern as they are largely involved in household chores even when they are not in

schooland. This limits them from seeking health-care services. AFHS health facilities have the provision of providing special clinics to adolescents, especially during lunch hours.

In addition, demand generation activities for ASRH have been poor. Many adolescents are still unaware of the existence of AFS at the health facilities. The inadequate availability of IEC/BCC materials has also been a major barrier for adolescents in accessing information related to AFS services (Barrier Study) In addition, rural young people are more likely to be embarrassed accessing sexual health services than urban young people (Regmi et al 2010).

There are also important issues related to gender norms, roles and relations that can be highlighted, and that influence adolescents living in rural and remote areas even more so due to a prevalence of traditional/conventional views in those communities. As mentioned before, in Nepal, there are gender norms around the health-seeking behaviours that create hindrances for females. Moreover the cultural norms revolving around proving fertility after marriage can act as a barrier for the use of contraceptives. These kinds of norms can put married female adolescents into health risks.

Facilitating factors

The programme policy and guidelines have been directed to focus the programme activities on rural and marginalized groups of populations. Studies also have found that adolescents (both girls and boys) prefer government facilities for receiving advice and treatment for their SRH problems, as they were perceived to be accessible, free and able to provide a range of services delivered by skilled providers (MoHP 2015).

The ASRH services are free of charge and do not need much infrastructure and extra human resources. A separate room for AFS within the health facility is enough to provide the counselling services and other reproductive health services that can be delivered as regular services. The health facility staff themselves can be trained in AFS. School teachers can also be trained in adolescent health needs and rights for the school health education programme.

Furthermore the national health system has a good organogram that extends well enough to the rural areas which includes the existence of health facilities, outreach health workers, satellite clinics, and female community health volunteers (FCHVs). All these mechanisms facilitate the service delivery in rural hard-to-reach areas, which could be best utilized for the implementation of the ASRH Programme.

Other facilitating factors are:

- Adolescents have been recognized as one of the vulnerable target populations by policy-makers.
- Scaling up of AFS and integration of AFS with other public health programmes has been a priority agenda for the government.

- Recognition of ASRH issues in peer education programmes and school health education programs.
- Changed perceptions of service providers regarding need of adolescent health services.
- Several national youth organizations are advocating the needs and rights of adolescents.

6.5 Summary of the mechanisms generating health inequities

The review process focused on linking the barriers and facilitating factors of the national ASRH programme with the mechanisms of the underlying social determinants of health, including those related to gender and human rights. Its aim is to uncover and understand the relationships and mechanisms operating behind the barriers and facilitating factors identified by the review team, which relate to the socioeconomic position of the priority sub-population (rural hard-to-reach adolescents) through structural and intermediate social determinants of health. The main focus of this is to understand how the context in which these adolescent groups live and where the ASRH programme is developed determines differentials in health needs and effective coverage of health services provisioned by the programme.

The review team applied conceptual frameworks and methods from the field of social determinants and analysed issues related to gender and human rights to identify the mechanisms generating health inequities. The framework of social determinants comprised the following areas, which are discussed below in relation to the ASRH programme and rural hard-to-reach adolescents:

Structural determinants

These are the underlying social determinants of health inequities. It includes:

Socioeconomic and political context

The structural mechanisms that generate stratification and social class divisions and which includes aspects such as the governance, macroeconomic policies, social and public policies, political institutions as well as cultural and societal values.

The review team identified the country's liberal economic policies, internal conflict, political instability, and prevalent sociocultural norms and values as the socioeconomic and political contexts that determine the socioeconomic position of the rural hard-to-reach adolescents.

During the review process, liberal economic policies were identified as the priority structural determinant that influences the health and overall development outcomes of the rural hard-to-reach adolescents. Economic policy has promoted privatization in the health sector and quality health services become expensive and inaccessible to the poor

population. The ASRH programme, however, is being run by the government sector free of cost and the direct impact of economic policy was not reflected in it. However, the outcome of investment in health programmes is only seen in the long run and hence the government is reluctant to invest in health programmes including ASRH.

Socioeconomic position

It refers to the different positions people hold in the social hierarchy, measured according to resources and prestige. Some of the socioeconomic positions that the rural hard-to-reach adolescent groups of Nepal face are: high school drop-out rate; early marriage; gender discrimination towards girls in seeking education; gender-based violence; gender roles and relations, and workload.

These factors are caused due to the poor economy facing these adolescents in the rural areas. Sociocultural factors of certain ethnic groups such as the practice of early marriage and early childbearing, especially restrictions on mobility and low-decision making power of female adolescents, have an impact on adolescent health and their health-seeking behaviours.

Intermediary determinant

These are the factors that shape people's health-related choices and outcomes and which are influenced by the structural determinants of health inequities. The main categories of intermediary determinants of health are:

Material circumstances

Determinants linked to physical environments, including living conditions and consumption potential, are material circumstances. The rural, hard-to-reach adolescents are often working in poor conditions. Weak consumption capacities of these adolescents also make them vulnerable to various health problems by limiting their access to and utilization of various resources and facilities, which generally are easier for the well-off ones.

Psychosocial circumstances

Includes psychosocial stressors, such as negative life events, stressful living conditions and lack of social support. Rural hard-to-reach adolescents are often exposed to various psychosocial circumstances that generate inequities. The adolescents from rural hard-to-reach areas often migrate to urban cities of Nepal, mainly Kathmandu, to earn a livelihood. They are mainly employed in unskilled labour sectors such as garment factories. A survey reported that there is high prevalence of unsafe sex and drug abuse among these adolescents and 11% of adolescent girls working in the factories had been victims of rape. The same study also reported that one in every four interviewed adolescent girl working in factories experienced unwanted pregnancy and one in 10 girls had aborted their last unwanted pregnancy (Puri 2002).

Behavioural and/or biological factors

Behavioural and biological factors such as smoking, dietary practice and alcohol consumption and others make them vulnerable and generate differences in terms of health outcomes and overall development. A study found that the adolescent girls of the 13-15-year age group in rural Chitwan district were not properly maintaining menstrual hygiene.

Only 6% of 150 girls knew that menstruation is a physiological process. The overall knowledge and practice were 40.6% and 12.9% respectively (Adhikari P et al. 2007). Additionally, with the legalisation on safe abortion in 2002 and easy availability of the drugs for medical abortion it was found that more women from rural remote areas are likely to undergo such procedures which mostly takes place at uncertified private facilities and homes without trained medical supervision (Rocca et al 2013).

Health system

The health system itself can directly intervene on differences in exposure and vulnerability by ensuring equitable access to health services and the promotion of intersectoral action to improve health and well-being. The health system also acts as a mediating force or buffer against the impacts of an illness or disability on people's lives. For instance, lack of proper infrastructure in health facilities, lack of trained service providers, and high rate of absenteeism among health-care staff have an impact on accessibility and quality of services.

At present the ASRH programme is based on particular set standards on AFS (availability of human resources, infrastructure, etc.) preventing expansion to hard-to-reach adolescents in remote places, thereby creating inequity.

Table 4 presents the mechanism of how these structural determinants influence rural hard-to-reach adolescent health outcomes.

Table 4: Influence of public policies on social stratification mechanisms in relation to health inequities and the ASRH programme

Public policies	Impact on adolescents in rural hard to reach areas
Macroeconomic, social and public policies	• Liberal policy and privatization of schooling, combined with lack of social security network, and unequal distribution of land have increased gap between rich poor and rich, urban and rural. • Poor rural adolescents get lower quality education and then are forced to leave school, seek employment, migrate for work, get married early; Vocational education is also focused in urban area rather than rural.
Analysed social determinant	**Relation to ASRH**
Health sector	• Health sector based on particular criteria of AFS (availability of HR, infrastructures etc) has been a barrier factor for expansion of AFS to hard-to-reach adolescents in remote places creating inequity.

Theory of inequity

After assessing various barriers and factors that have generated inequity among the rural hard-to-reach adolescent people, the review process established a theory of inequity that illustrate the mechanism that creates the inequity among target population groups of the national ASRH programme. It is as follows:

Box 3: Theory of inequity of the National ASRH Programme

Rural hard-to-reach adolescents are deprived of AFSs because most of the health facilities do not provide AFS due to inadequately trained HR and infrastructure. Inadequate IEC materials (production and distribution), and inability to reach out-of-school adolescents have created a barrier to access to information. Underfinancing due to lack of advocacy and weak inter/intrasectoral collaboration are problems for expansion and effective coverage of AFS.

Intersectoral action

At present, the Ministry of Health and Population has been working closely with Ministry of Education for school health education and with various youth organizations for demand generation. Apart from it, coordination is largely limited between different departments within the MoHP in implementing the national ASRH programme. Various coordination mechanisms that are present in the National ASRH Programme are as follows:

- with community-level youth organizations, youth clubs, health clubs, organizations working on ASRH issues and other organizations to provide information and education on ASRH.
- with different NGOs in schools and communities through locally existing youth information centres to disseminate information about AFSs availability. The following activities are being conducted for this purpose:
  - Install anonymous query box in schools to collect the queries of adolescents regarding ASRH problems and answer them, and organize discussions.
  - Conduct classes on ASRH by coordinating with school authorities. Organize quiz contests and debate competitions to relay information about the ASRH programme.
  - Mobilize peer educators of different NGOs to disseminate information on AFSs.
- with National Health Education Information Communication Centre (NHEICC) to inform about the availability of AFSs through school health education.
- with local population management programme being conducted by the Population Division of the MoHP.
- with National Health Training Centre (NHTC) to train service providers on AFS.

The above-mentioned mechanism for the intersectoral actions was deemed important for the greater success of the national ASRH Programme. There is good collaboration with the NHEICC in regard to the production of the IEC/BCC materials and other training manuals. Likewise the NHTC is responsible for the training of the service providers. Also, while implementing the ASRH programme at rural areas, there is a practice of coordinating with local youth groups and community organizations, which contributes to effective social mobilization.

Various challenges in implementing adolescent health and development cannot be tackled by the health sector alone. The decisions made at the political levels and in various other sectors beyond health shapes the structure and functioning of the health-care system. The social determinants of health (SDH) can only be addressed by health in all policies and intersectoral action. It is important to address the social factors that influence health, but which reside outside the health system and in sectors other than health.

The effective implementation of any health programme also depends on the proper coordination between various stakeholders, government, external development partners, private sector and civil society. The Ministry of Health and Population should not only engage different ministries in planning and implementation of the adolescent development strategy but there is also the need for proper coordination and engagement of various departments within the MoHP.

During the review process the sectors within and outside of health that should be engaged with the national ASRH programme were identified to improve social determinants of health, gender and human rights issues of the rural hard-to-reach adolescents as well as other groups of adolescents. The scope of collaboration between various sectors has been presented in the Table 5 below, identifying areas where existing cooperation exists and/or could be strengthened.

Table 5: Scope of collaboration between various sectors

Sector	Scope of collaboration – examples
Legislation and regulation	• Prohibit the marriage of girls under 19 years of age. • Ensure that laws and policies enable adolescent girls to have safe abortion services. • Ensure a supportive legal framework to protect against GBV.
Education	• Provide scientifically accurate and comprehensive sexuality education programmes within and outside of schools that include information on contraception use and acquisition. • Implement policies to keep in school pregnant and parenting adolescents (eg. re-entry policies allowing girls to continue their education during and after pregnancy).
Finance	• Present the evidence base and advocating for an adequate resource needed to scale up the ASRH Programme
Social protection	• Cooperation with the health sector for measures for adolescent's financial protection (e.g., waivers, vouchers, exemption for or reduced co-payments) so that health services are free at the point of use or affordable to adolescents.
Women's development	• Cooperate for programmes to support adolescent girls to stay in school, postpone the age of marrying, enhance income-generation capacity, etc.
Labour	• Ensure gender-sensitive strategies for decent work for youth, implementation of employment and skills development programmes, and enabling entrepreneurship by increasing access to markets, finance and other resources.
Health	• Ensure availability of adolescent friendly services • Ensure availability of commodities and IEC/BCC materials
Information and communication	• Provide information on adolescents needs and rights • Use of mass media for dissemination of information to adolescents
Sports	• Encourage participation of adolescent in various sports and physical activity
Agriculture and Tourism	• Ensure employment opportunities and engagement of adolescents in productive jobs.

Social participation

Social participation is important as it increases the community ownership of the programme and makes it accountable towards the target population. The ASRH programme has ensured social participation by involving various stakeholders in the HFOMC. It has insured the participation of school teachers, local social workers and leaders, FCHVs and adolescents. However, involving adolescent representatives is not mandatory according to the ASRH Programme Implementation Guideline 2011 and can be included as the invitee members of the HFOMC. Besides these, HFOMC should involve adolescents and youth in any type of activity related to ASRH.

Social participation could improve service delivery. Also, in order to address the inequity, social determinants of health, gender and human rights in the ASRH programme, the following mechanisms could be embraced:

- Adolescents to be a member of HFOMC at the local level (1-Male and 1-Female youth member).
- Formation, coordination and mobilization of child clubs, junior and youth Red Cross circles.
- Ensure meaningful participation of society leaders and adolescents in each step of the programme (design, implementation, M&E).
- Make necessary changes in guidelines and protocols to ensure the participation of all stakeholders concerned.
- Conduct advocacy to sensitize the community about the importance of ASRH.

There are facilitating and hindering factors for social participation as presented in Table 6 below:

Table 6: Facilitating and hindering factors for social participation

Facilitators factors	Hindering factors
Ward citizen forum is existing in the each Village Development Committees (VDCs)	ASRH as neglected issue (perceived as less important issue)
Social mobilizers in each Village Development Committees (VDC) through local body	Inadequate empowerment of adolescents on their right and duty
Child clubs, Junior red cross etc.	Negative perception about ASRH issue by society
Invitees in Health Facility Operation and Management Committees (HFOMC), Rainwater Harvesting Capacity Centre (RHCC), etc.	

Proposed redesign of the programme

7

The main aim of the redesign of the programme was to modify the programme in order to better respond to the needs of all the adolescents, especially adolescents of the rural hard-to-reach areas who face barriers arising from their social, cultural, economic and geographical characteristics (Figure 3). This is an effort to address inequity, social determinants, and gender and human rights issues of the ASRH Programme.

The specific aims of the redesign were:

- to minimize or remove barriers at all stages of implementation of the programme, with the focus on one specific intervention – establishment of the Adolescent Friendly Services (AFSs);
- to reinforce or create facilitating factors that will support the realization of each stage of the intervention(s), or the stages where the barriers are most prominent;
- to propose innovative interventions in line with the general aim of the programme that support the achievement of health equity; and
- to revise where necessary the programme implementation guidelines so that it clearly reflects that the programme addresses the needs of all adolescents and specifically those in a vulnerable situation.

7.1 Overview of the improvement proposals

For improving the national ASRH programme in relation to address equity, social determinants of health, gender and human rights aspects, expansion of quality adolescent-friendly services (AFSs) is identified as the main intervention which will facilitate the provision of the necessary ASRH services to the rural hard-to-reach adolescents. Various levels of scope of change and their activities were also highlighted during the review process, which is presented in the Table 7.

Table 7: Identification of the adjustments for redesign and activities to facilitate them

Proposed adjustments	Activities or facilitating factors
Modification of programme contents	• Adapt/develop interventions for adolescents in rural hard-to-reach and urbanized slum areas, including out-of-school adolescents, married and migrant adolescents. • Adapt services to account for gender norms, roles, relations that could inhibit seeking services. • If community outreach (beyond using schools) is done by elder providers and adolescents fear lack of confidentiality, adapt for age-sensitivity and privacy, and enhance provider's capacity • Adapt IEC/BCC materials for different needs and target groups and ensure sufficient quantity.
Integration with social programmes and other sectors	• Institutionalize inter and intra-sectoral coordination at national level • Working through Local Governance to engage other sectors for adolescent health and development (such as to tackle causes of early marriage and pregnancy (eg. social protection for poor families, education, cultural norms), eg. stigma associated with adolescent reproductive health.
Structural or organizational changes	• Have a CORE TEAM in each of the districts and a CORE TEAM nationally for adolescent health and development that facilitates intra/intersectoral coordination. • Formation of authorized Adolescent health and development Committees at different levels (Engage Gender Equality and Social Inclusion (GESI) units at district health offices in ensuring coordination of intersectoral activities for disadvantaged youth) • Strengthen the primary health care outreach (PHC ORC) in rural/remote areas and urban slums also for ASRH (providing training to them and integration of measures in their set of activities) as feasible.

Proposed adjustments	Activities or facilitating factors
Management and financing improvements	• Increase investment and assemble evidence on the rationale for investing more in youth (almost one-quarter of population), in particular disadvantaged youth. • Mainstreaming local resources (level funds) available in other areas. • Link up with the Youth Agenda 25 Policy so that resources (monies) can be available through that and advocacy and links with other sectors can be brokered. • Improve intra health sector coordination (through ASRH committee and other) with other programmes that relate to adolescent health, with ideas for this being. • Improve MoHP inter-division coordination by nominating one person in each division and having a mechanism. • Use the AHDS as a platform for supporting coordination, and include focus on disadvantaged populations. • External development partners/CSOs align and enhance coordination with equity focus. • Enhance appropriate AFS focus in activities of RH and other health services.
Human resource adjustments	• Enhance the focus on AFS and ASRH in main pre-service and ongoing training opportunities for health professionals and FCHVs. • Ensure frontline capacity building of staff at local health posts in adolescent health, including ASRH, and address staff retention issues through ensured handover. • Provide capacity building materials/supports that tackle social and cultural norms that make providers and teachers shy away from ASRH.
Normative/ standard setting, regulation or legislation	• Incorporate into health staff and teacher performance reviews and quality control measures around ASRH, to correct providers and teachers shying away from ASRH. • Advocate and support to enforce the law against early marriage, including through engaging other sectors and social participation. • Look at standardization criteria for ASRH, to be also equity sensitive for rural remote areas.

Proposed adjustments	Activities or facilitating factors
Social participation mechanisms	• Adolescent to be member of HFOMC at local level (1-Male and 1-Female adolescent/youth member). • Strengthen coordination and mobilization of child clubs, junior and youth red cross circles. (and create, where not present). • Ensure the participation of society leaders and adolescents in each step of the programme (design, implementation, M&E). • Make necessary change in guideline and protocols to ensure the participation of all concerned stakeholders. • Conduct advocacy to sensitize the community about the importance of adolescent health and development, including ASRH.
Planning, review and M&E cycles	• Improving overarching monitoring capacity of programme and capacity to disaggregate data aligned with HMIS. • Increase ownership of the programme and respond appropriately by the District Health System (District Management Committee (Core Team idea), and integrate into ASRH into: • District needs assessments • District planning and budgeting • M&E (Reinforce quality monitoring components, e.g. facility assessment data, and participatory monitoring (social audits).

Also, the revised programme theory reflecting the specific measures that consider the needs and circumstances of the rural hard-to-reach adolescents is presented in Box 4.

Box 4: Revised theory of the programme reflecting the equity approach

Consideration of the rural hard-to-reach adolescents as groups with less access to the national ASRH programme will facilitate the equitable access to the programme activities and services for the whole target population. Expansion of quality AFSs in the rural hard-to-reach areas will minimise various socio-cultural, economic and geographical barriers among others, which will contribute to achievement of programme's goal and objectives. Policies and interventions that take into consideration SDH and health inequities, intersectoral collaboration and social participation can improve quality and accessibility of ASRH services to all who are in need and thus improve health equity and bolster the achievements.

Figure 3: Key stages of the National ASRH Programme for redesign

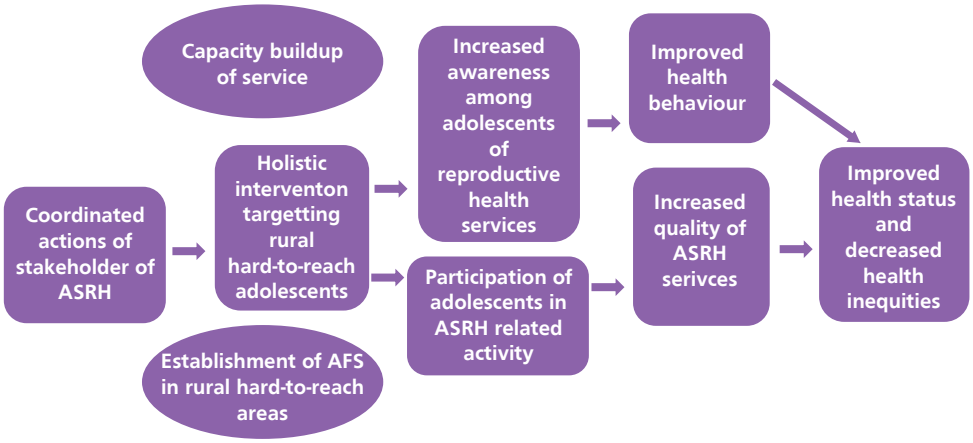
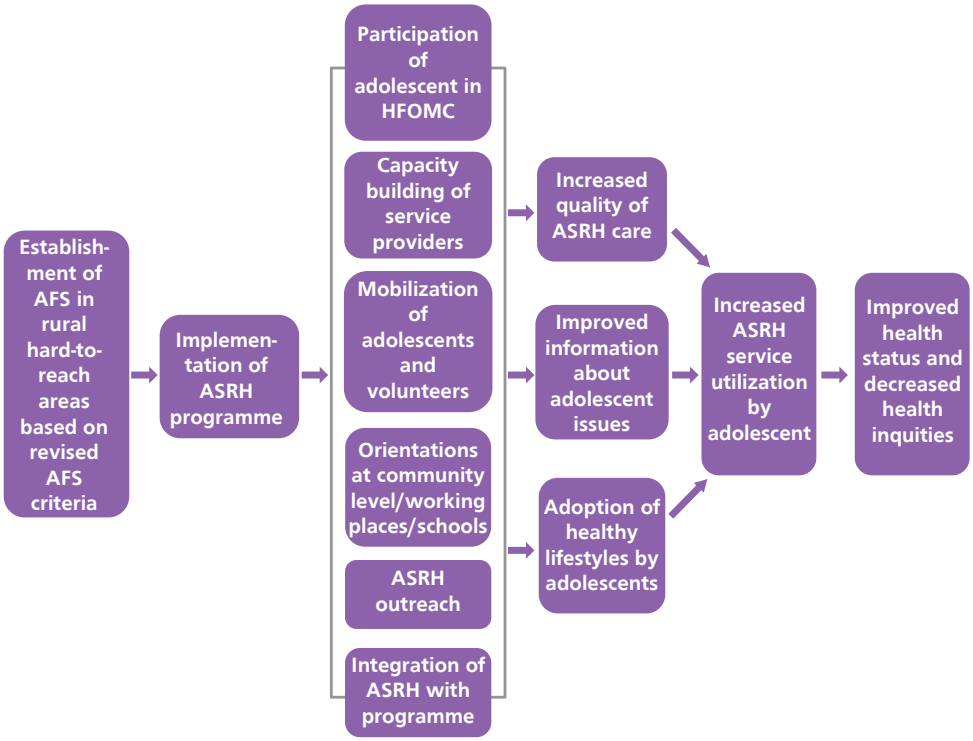


Figure 4: Revised activity of the key activity of the ASRH programme: establishment of AFS



7.2 Evidence base for formulating the proposed adjustments

To be able to achieve the desired output from the programme is a must. Setting up mechanisms where the improvement achieved through any adjustment is needed so that the programme progress can be measured and weighted against the desired output. The proposed changes that are made into the ASRH Programme can be measured from meeting minutes to the national level reports. Table 8 illustrates the evidence base for the proposed changes of the national ASRH Programme.

Table 8: Proposed changes and the respective evidence base

Proposed changes	Desired result/Expected results: Outputs and outcomes	Evidence base
AFS criteria revised to help the establishment of AFS in rural hard to reach adolescents	Establishment of AFS in rural hard-to-reach areas	DPHO
Adolescents (social) participation in HFOMC	Child/adolescent participation rate increased, adolescent's issues addressed	HFOMC minutes
Integration (intersectoral coordination) with other sectors like education and develop mechanism to ensure planned activities have been done	Ensured planned activities have been done effectively and efficiently	Lead Ministry (MoHP)
AHD unit advocate to get sufficient budget in this issue and ensure the issues have been considered in national plans and programmes	More programmes that brings positive changes in the life of adolescents	Need Evaluation/ Survey
Strengthen AHD monitoring system so that data could be used in different level and programme could be monitored properly and get intended support as and when needed	Institutionalization of integrated monitoring and supervision system at different levels so that get intended support as and when needed	Tracking reports: Management Division and DHO/DPHO
Hard to reach areas focused interventions: interaction with various groups like parents, adolescents girls groups, mother groups etc	Availability and accessibility of information and creation of supportive and safe environment	Mapping reports of local bodies and DHO/DPHO

Table 9: Implementation plan for the Redesign

Workplan component	Actions	Time frame	Responsible parties	Required resources
Identification of forthcoming milestones in programme planning and review process (to feed into)	• Review the need of ASRH committee in centre and districts	Jan 31	FHD	
Identify objectives and priorities for redesign	• NAHD strategy finalization incorporating the recommendations of 5-step review and translate into Nepali. • Costed implementation plan on ASRH based on strategy for 5 years. • Review the criteria of AFHS and make necessary change in guideline to reach prioritized sub population (rural hard-to-reach adolescents)	Jan 31 April 31	Review team/FHD	

Workplan component	Actions	Time frame	Responsible parties	Required resources
Review of the evidence base	• Develop advocacy tool based on evidence	Dec 31	Review team/FHD	
Identify level and scope of changes	• Identifying feasible intervention (working document)	Dec 31	FHD/ASRH Committee/EDP	
Ex-ante evaluation	• Review various evaluation report and findings	Jan 31	FHD	
Engagement with other health sector actors, other sectors, and civil society	• Stakeholders meeting (including non-health sector) • Costed Implementation plan (CIP) on ASRH based on the NAHD Strategy for 5 years	Jan 31 March 31	FHD/MOHP/ External Development Partner (EDP)	
Redesign proposal	• Redesign of the ASRH Programme based on the review process findings	April 31	ASRH Committee	
Piloting of the redesign	• Family health division will implement the programme based on CIP and district level micro-planning		FHD/RHCC	

8.1 Issues of scaling up and approaches to address them

The NDHS 2011 reported that only 32.7% of male and 25% of female aged 15-19 had comprehensive correct knowledge of HIV/AIDS. In Nepal knowledge about family planning among adolescents and youth is almost universal (99.9 percent). However, only 14 percent of married adolescent girls age 15-19 are currently using a modern contraceptive method. Health care providers agree that teaching young people about sexual and reproductive health is important, and are concerned that many opportunities to reach adolescents with the sexual and reproductive health information and services that they need are being missed. The Ministry of Health and Population in Nepal is also fully aware of need of making existing health services in the country adolescent friendly.

The unstable political environment has been a major hindrance in successful scale of any health programmes not just AFS in Nepal. The 10 years of armed Maoist conflict followed by delay in formulating constitution for several years and now the border blockade has pushed several health and development agendas to uncertainty. In addition, several health facilities were destroyed during recent earthquake. The infrastructure of Public health facilities has been very poor in rural hard to reach areas. The high absenteeism of health service providers in these rural hard to reach areas has deprived people living in these areas of basic health services.

Some of the challenges that needs to be addressed in scaling up of adolescent friendly services are illustrated in the Table 10 below.

Table 10: Issues of scaling up and approaches to address them

Issues	Recommendations
Inadequate coordination between different government agencies and partners for planning and managing programmes	• Multi-sector response at different levels adopting integrated approach for AHD activities
Programme design is poorly coordinated with Adolescent Development Strategy (National Planning Commission – NPC)	• Incorporating the findings form the review process into the National Adolescent Health and Development Strategy • Aligning AFS in all health facilities with the National Health Policy • Coordinate with the stakeholders to make all HFs AFHS sites

Issues	Recommendations
Poor ownership of programme at local level	• Ensuring the participation of local communities and agencies in programme planning and implementation • Ensuring the social participation of the youths and adolescents
Lack of uniformity and inequitable distribution of ASRH programme and poor integration with other public health programmes	• Strictly following the Programme Implementation Guidelines by the districts • Revising the criteria for selecting the ASRH sites • Integrating ASRH Programme into youth and adolescent leadership and other developmental activities/programmes • Conducting mobile out-reach camps to address out-of-school adolescents
Poor HRH training and management for ASRH	• Strict adherence to training manuals for conducting • Establishing the evaluation mechanism of the trainees and trainers • Ensuring trained staff retention mechanism at AFS sites • Consider piloting performance-based incentives • Increase access to and coverage of training. • Develop a more comprehensive, competency-based ASRH training programme • Strengthen the capacity of districts to provide supportive supervision of AFHS providers
Awareness of AFHS among adolescents is very low	• Delivery of information and promotion of AFHS through currently under-utilised channels. • Greater coordination is needed to improve linkages between schools and AFHS • Menstrual Hygiene Management Programme integration in school health programmes • Adolescent pregnancy prevention and management interventions as a targeted intervention in needy areas
Some groups of adolescents are underserved by AFHS	• Increase guidance on supply-side actions needed to deliver AFHS for young key affected populations and marginalized adolescents

8.2 Monitoring and evaluation of the proposed adjustments

The 2011 ASRH Programme Implementation Guide specifies that each AFHS should collate client data disaggregated by age and service type by using the miscellaneous column of the HMIS register for Out-patient Department (OPD). Additionally a separate monthly reporting form should be used for reporting of adolescent friendly services being utilized, and sent with the HMIS 32 to district, region and centre. The district ASRH Focal Person or DPHO is required to conduct six monthly monitoring and supervision visits to all AFHS with quarterly and annual review of the overall programme at district, regional and central level. However, according to the data from 12 districts, majority of facilities studied did not maintain a separate or complete AFHS register. While there were many recorded adolescent clients on OPD, family planning (FP), Antenatal Care (ANC)/ Prenatal care (PNC), or abortion registers, this data was generally not extracted into the AFHS reporting form, or any other format that would allow tracking of utilization by adolescents or monitor progress. In some facilities data on age, sex and marital status were not recorded in any registers, making it impossible to determine utilization of services by adolescents. Poor recording was reflected in poor reporting mechanisms. Reporting of AFHS to DPHO was also lacking in most facilities. Some of the districts had developed a separate reporting format but facilities were not reporting regularly to DPHO. For effective monitoring of the national ASRH programme following adjustments illustrated in the Table 11 should be made in the programme monitoring and evaluation framework. There should be advocacy to incorporate disaggregated indicators on ASRH in the HMIS and other health service tracking surveys.

Table 11: Monitoring and evaluation framework for the proposed adjustments

Input/process indicators	Activities	Output indicators	Outcome indicators	Impact
AFS site selection criteria revised Number of AFSs established	Planning, intersectoral coordination for selection of AFS sites	Number of AFSs established in rural hard-to-reach areas	Number of adolescents receiving services from AFSs disaggregated by age, sex, ethnicity, education, urban/rural, wealth quintile etc.	• Age at marriage decreased • Contraceptive Prevalence Rate Increased • Unmet need decreased • Adolescent pregnancy decreased • Age specific Fertility Rate among adolescents decreased • RH related Morbidities (STI/RTI etc) and mortality decreased among adolescents
Number of Training manuals developed	Trainings for service providers	Number of trained service providers disaggregated by sex and geography	• Number of AFSs providing quality AFSs • Number/% of adolescents who perceive that providers deliver service with discrimination	• Number/% of adolescents who are aware of adolescent friendly services disaggregated by age, sex, ethnicity, education, urban/rural, wealth quintile etc.

Input/process indicators	Activities	Output indicators	Outcome indicators	Impact
Number of Manuals and guidelines developed for orientations	Orientations about ASRH issues at schools/ communities/ working places	Number of orientations conducted Number of adolescent/ teachers/providers receiving AFS orientation	Number/% of adolescents/teacher/ provider who perceive that there is discrimination among Adolescents at community and working places	• Number/% of adolescents who are aware of ASRH issues disaggregated by age, sex, ethnicity, education, urban/rural, wealth quintile etc.
Number of AFS related commodities purchased	Distribution of commodities	Number of AFS related commodities distributed	Number/% of AFS sites containing adequate commodities for AFS	• Number/% of AFS sites providing quality AFS • Number/% of adolescent clients who are satisfied with service
Number of Manual developed for Mobile ASRH camps/outreach clinics	Mobile ASRH camps/ outreach clinics	Number of Mobile ASRH camps/ outreach clinics conducted	No of adolescents who received ASRH services from mobile ASRH camps disaggregated by age, sex, ethnicity, education, urban/rural, wealth quintile	• Number of AFS sites where AFS is integrated with outreach sites • Number/% of hard to reach adolescents receiving AFS services • Number/% of hard to reach adolescent who enjoy happy and healthy life

Input/process indicators	Activities	Output indicators	Outcome indicators	Impact
Number of IEC/ BCC materials produced	Distribution of IEC/ BCC	Number of IEC/BCC materials distributed	Number of AFS centre and schools with adequate IEC/BCC	• Number/% of adolescents who know about behaviour and number/% of adolescent's attitude.
Number of schools containing adolescent information corner	Supply of IEC/ BCC materials at adolescent information corner	Number of Adolescent information corner containing adequate IEC/BCC materials	Number of adolescents/ teachers using IEC/BCC materials from adolescent information corner	
Revision of guideline prepared by Management Division ensuring the mandatory participation of adolescent in HFOMC	Participation of adolescents in HFOMC and ASRH related programme	Number of HFOMC including adolescent members in the committee disaggregated by sex and age	Number of HFOMC including adolescent members in the committee disaggregated by sex and age	Number/% of adolescents who are empowered to practice child rights

Conclusions

9

The application of 5 steps review process to the National ASRH programme has enabled to identify the so-called hidden barriers to implementation of the activities. The new programme theory is more focused and enriched with interventions that are expected to improve the quality of the ASRH and its implementation, which will lead to further availability, accessibility and coverage of the services for all adolescents, specifically those from the most vulnerable groups. The importance of collaboration with different stakeholders and of social participation has been recognised by all participants in the review process and will be adopted as a practice in the future during development and implementation of the new NAHD strategy.

Some of the results that are not linked directly to the ASRH, but could have an impact on participants' future work, are as follows:

- All participants agreed that the revision process was a learning opportunity, and at the same time they improved their capacities for integrating into ASRH a health equity approach based on SDH and health inequities.
- The improvement of collaboration with different stakeholders and of social participation were also seen as important benefits.
- The process offered an opportunity to create strong networks and alliances between participants.

The most important benefit for the participants was that they realized that the success of every intervention could be compromised if it does not take into consideration that vulnerable groups confront specific barriers, and that identification of and overcoming these barriers should be part of the development and implementation of every intervention.

10

Lessons learned and limitations of the review team analysis

Despite the ASRH having been designed to reach all adolescent populations, some groups are not accessing and not benefiting from it. In the future, more attention should be given to equity – identifying appropriate ways to minimize the barriers and identifying facilitating factors – in order to fully implement the activities and achieve the defined goals. Since not all the barriers and facilitating factors can be addressed by the health sector, greater collaboration with other sectors is vital, so there is a need to create a mechanism for collaboration and coordination with other sectors beyond health, at national, regional and/or the local level.

The main limitation encountered in relation to the proposed methodology was the time involved: team members held 2 meetings, of 3–4 hours each. This is also due to the ongoing political crisis on the Indo-Nepal border leading to a scarcity of fuel in the country which hampered the overall programme management and execution.

11

Suggestions to strengthen the review methodology and training process

The review process has been very effective in understanding the gaps in the national ASRH Programme in addressing in equity and other social determinants of health. Modules used to highlight the theory of programme review were duly focused to unleash the scope for the review process as well as the redesign. Given the depth of the modules the review workshop should be organized for seven days which would provide the review team to complete the review and redesign modules in a comprehensive way.

Similarly, during the review period many unavoidable circumstances such as the earthquake and the Indo-Nepal border blockade arose that led to scarcity of fuel and other essential goods in Nepal, particularly Kathmandu Valley, and adversely affected the smooth implementation of the review process. Therefore, the extension of the review period (which was just a little more than 3 months) would have accommodated enough space required for coordination among review team members and multiple meetings for finalisation of the review process.

12

ASRH during earthquake

On 25 April 2015, a devastating earthquake of 7.8 magnitude struck Nepal, killing over 8790 people, injuring 22 300 and displacing 2.8 million people. The earthquake destroyed over 605 254 houses leaving hundreds of thousands of families without a roof over their heads. It also damaged 446 district and sub-district public health facilities and caused severe damage to certain buildings of central hospitals (such as Maternity Hospital and Bir Hospital, both in Kathmandu), causing an interruption in the delivery of health services. The largest number of completely destroyed health facilities was in Sindhupalchowk, Nuwakot and Gorkha districts. Out of 360 established Basic Emergency Obstetric and Neonatal Care/Birthing Centre (BEONC/BC) in 14 districts, 112 were severely damaged and 144 were partially damaged. In the severely damaged, all reproductive health and maternal and child health service delivery were disrupted.

Every year, thousands of Nepalese women are trafficked overseas and the majority of them end up in Indian brothels. The chaos caused by the earthquake has been an opportunity for the traffickers to lure women from rural villages in Nepal in the name of lucrative jobs overseas (Bruke 2015). The damage to the houses, loss of family protection and livelihoods raised the risk of sexual and gender-based violence, human trafficking, child labour, and early marriage for women, girls and boys manifold.

Also, out-of-school adolescents are prone to sexual exploitation in camps, increasing the vulnerability of trafficking. The lack of segregated toilets, poor living condition and lack of privacy for women and girls in shelters has also led to women and children feeling unsecure and prone to sexual violence. Shelter Cluster REACH assessment in Gorkha, Bhaktapur, Kathmandu, Sindhuli and Sindhupalchowk found that no female-headed households reported to have received support to repair or rebuild their houses (PDNA).

Reproductive health (RH) sub-cluster, under the health cluster, formed in Kathmandu (first meeting on 29th April) to facilitate coordination and implementation of the SRH services. An ASRH working group formed within the RH sub-cluster to ensure that ASRH issues are integrated within the overall RH response. Twenty-two developmental partners and 11 humanitarian partners were

engaged in RH response. Tents for setting up medical facilities (including maternity units), equipment, instruments, medicines & supplies were sent to initiate Emergency Obstetric and Newborn Care (EmONC) services to the affected districts, including for C-sections. Equipment and supplies for providing other ASRH services like management of STI, management of rape and Family Planning (FP) commodities were also sent to the affected district in adequate quantities. The mobile RH camps were conducted in earthquake affected districts, dignity kits were distributed to vulnerable female groups, RH kits were distributed to pregnant and postpartum women, transition home for pregnant and lactating mother were established nearby Maternity Unit and referral mechanism to One-Stop Crisis Management Centres (OCMC) were developed.

ASRH services were integrated with RH response during the earthquake (Table 12). Adolescent-friendly corner and IEC corner were established in mobile RH camps which was facilitated by Youth Health Educator for raising *for awareness for delay marriage; family planning, safe motherhood (SM), Danger Sign, Hygiene*. Psychosocial counselling service were provided by Psychosocial counsellor for sexual and gender-based violence (SGBV) in such camps.

Table 12: Mechanisms to address the needs of adolescents displaced by the earthquake

Proposed adjustments	Activities or facilitating factors
Modification of programme contents	• Health cluster should ensure minimum initial service package reaches adolescents. • Identification of vulnerable adolescent groups and manage them in a safe place • Use of Multisectoral Initial Rapid Assessment tool for need assessment. • Communication regarding where and how to get ASRH services • Provision of psychosocial counselling in the regular health services • Peer group education on ASRH issues should be ensured
Integration with social programmes and other sectors	• Coordination with education/protection cluster to reach out to adolescents

Proposed adjustments	Activities or facilitating factors
Structural or organizational changes	• All the activities related to adolescent health should be channelled through One-Stop Crisis Management Centre. • Mobile outreach ASRH camps for vulnerable adolescents • Referral centre should be established for victims of physical and sexual violence • Ensuring smooth BEONC and family planning services (RH camps) • Ensuring anti-retro viral therapy (ART) and Prevention of Mother-to-Child Transmission (PMTCT) services for management of HIV positive adolescents
Human resource adjustments	• Mobilization of health workers to disaster-hit areas • Training health workers on ASRH during emergency package.
Normative/standard setting, regulation or legislation	• Zero tolerance for gender-based violence should be ensured
Social participation mechanisms	• Encouraging youths and adolescents for advocacy against Gender based violence
Planning, review and M&E cycles	• Advocacy for incorporating questions related to ASRH in Multisectoral Initial Rapid Assessment tool • Identification of strategies adopted by organisations working for youth and adolescents during emergency • Reviewing the challenges encountered in previous emergency situations

Next steps

13

Following the workshop where Innov8 tool was used to assess adolescent health programme in Nepal, the programme was evaluated and recommendations made to make the programme accessible to unreached, most vulnerable, high-risk populations. The recommendations were incorporated in the revised National Adolescent Development and Health Strategy. The strategy is in the process of endorsement. As a follow-up the regional workshop on ''Reaching Every Adolescent: Regional Workshop on Strengthening GER and SDH'' was conducted on 21-23 June 2016. The action plan is being developed by the review team and the government and includes major partners. All are committed to follow up on the action plan.

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Annex 1

Comparison of the Initial Programme Theory, Theory of Inequity, and Revised Programme theory of the National ASRH Programme

Summary of Initial Programme Theory	Theory of inequities postulated at the end of the review phase	Revised programme theory to better address GER/SDH
If information and services on SRH to address ASRH issues is provided through AFSC in health facilities and schools, an enabling environment in schools and the community will be created, so that more adolescents will access and benefit. Then the programme targets will be reached, ultimately contributing to national development.	Rural hard-to-reach adolescents are deprived of AFSs because most of the health facilities do not provide AFS due to inadequate trained HR and infrastructure. Inadequate IEC materials (production and distribution), and inability to reach out of school adolescents have created a barrier to access to information. Underfinancing due to lack of advocacy, weak inter/intrasectoral collaboration are problems for expansion and effective coverage of AFS	Consideration of the rural hard-to-reach adolescents as groups with less access to the national ASRH Programme will facilitate the equitable access to the programme activities and services for the whole target population. Expansion of the quality AFSs in the rural hard-to-reach areas will minimise various socio-cultural, economic and geographical barriers among others which will contribute to achievement of programme's goal and objectives. Policies and interventions that take into consideration SDH and health inequalities, intersectoral collaboration and social participation can improve quality and accessibility of ASRH services to all who are in need and thus improve health equity and further achievement.

In 2015, World Health Organization worked with the Nepal Ministry of Health to redesign the country's Adolescent Sexual and Reproductive Health, through a pilot study utilizing the Innov8 Approach an 8-step review process geared towards helping health programmes better address gender, equity, human rights and social determinants of health. The aim was to identify the adolescent subpopulations being missed, increase coverages, identify inequities and take a holistic approach to adolescent health and development. Specific barriers experienced by different subpopulations such as distance and cost of travel, inability to come during opening hours, lack of privacy and confidentiality, adverse gender norms, among other factors were uncovered through the pilot.

This publication presents the findings, barriers and recommendations from the pilot, which subsequently informed the new National Adolescent Health Program, to ensure that "No one is left behind". Measures include an increased focus on outreach services (in particular in disadvantaged areas), capacity building of health workers on adolescent-friendly and gender-responsive services, and ensuring that adolescent representatives participate in local decision-making processes on health through enhanced community engagement. The findings further reiterate the need to engage other government sectors, such as education and nutrition, to tackle the causes of early marriage and pregnancy, as well as mental and school health. As national health programmes strive to meet the 2030 Sustainable Development Agenda and the targets set out in the Global Strategy for Women's, Children's and Adolescents' Health, integrating lessons from the Innov8 pilot helped strengthen the national programme's ability to reach vulnerable adolescents, reduce inequities, and improve the overall health of adolescents in Nepal.

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