CHAPTER I

INTRODUCTION

1.1 Background

Adolescence is the period of physical, psychological and social maturing from childhood to adulthood. Generally, the term “adolescents” refers to individuals between the ages of 10-19 years and the term “youth” refers to individuals between the ages of 15-24 years, while “young people” covers the entire age range, from ages 10-24 years (FHD/DOHS, 2000). Adolescence is the second decade of life and it is a period of rapid development.

Since about one quarter (26%) of the world’s population is between the age of 10 and 24 and one-fifth (18%) of the world’s population between 10 and 19, with vast majority living in developing countries, they have not received specific attention in most population and health research and programs (UN, 2011).

Nepal is faced with a large number of adolescents and youth populations in its population composition. About one fourth (24%) of the total population of Nepal is adolescents, about one third (32.5 percent) is young (10-24) population in Nepal indicating a high number of young people in Nepal’s population composition (MOHP, 2011).

Adolescent Sexual and Reproductive Health (ASRH) in Nepal has made improvements over the last 10 years, with an increase in the age at marriage. Proportion of currently married decreased to 29% (NDHS 2011) for 15-19 from 43% (NDHS, 1996). The percentage of adolescents that have begun childbearing is declining from 24 (NDHS, 1996) to 17 percent (NDHS 2011). But serious gaps remain. The contraceptive prevalence rate (CPR) among currently married 15-19 years old is extremely low (14% as per the NDHS, 2011). Adolescent child bearing is still common although decreasing. Comprehensive knowledge of HIV and AIDS is uncommon among male adolescents and youth but even less common among females. Testing for HIV is quite rare among adolescents and youth. Adolescents and youth in Nepal are vulnerable to multiple sexual and reproductive health problems, ranging

from early and unwanted pregnancies to sexually transmitted infections including HIV (NDHS, 2011). There are many social, community and individual level barriers to adolescents accessing correct information or services such as a fear that providing reproductive health information or services will promote promiscuity either before marriage or outside marriage. Very few of the adolescents are utilizing health services from any kind of health facility in Nepal. In order to address these issues, a concerted effort is needed to reach adolescents with the information and skill they need to live healthy and full lives (NHEICC, 2012).

In response to the issue of adolescents, Government of Nepal (GoN) has developed the 'National Adolescent Health and Development (NAHD) Strategy'in 2000. An implementation guideline on Adolescent Sexual and Reproductive Health (ASRH) was developed in 2007.The implementation Guide on Adolescent Sexual and Reproductive Health, 2007 guides district program managers to help key stakeholders (policy makers, administrators, community leaders, service providers, parents, teachers, CBOs, NGOs, organizations of or for sexual minorities and the media) create an enabling environment within the community (NHEICC, 2012).

In 2008, a draft national Adolescent Sexual and Reproductive Health Program was developed. The program was successfully piloted in 2009 in 26 public health facilities in Bardiya, Surkhet, Dailekh, Jumla and Baitadi districts. Based on the findings from the pilot intervention, Ministry of Health and Population, Department of Health services, Family Health Division has developed a national Adolescent Sexual and Reproductive Health program package in 2011 and is now being implemented gradually to meet the NHSP II target of making 1,000 health facilities adolescent friendly that aims to reduce the adolescent fertility rate to 70 per 1,000 women (15-19 yrs) by 2015. As of July 2013, Adolescent-Friendly health Services (AFS) has been implemented in a total of 732 health facilities in 49 districts. (DOHS, 2070 BS)

In Pyuthan, till now, Adolescent Sexual and Reproductive Health program has been implemented in all the 49 government health facilities of Pyuthan including all the 7 health facilities (Khalanga PHC, Maranthana HP, Dharampani HP, District Hospital, Sapdanda HP, Dakhaquadi SHP and Khaira SHP) within Pyuthan municipality. The program was started from 2012. The program was expanded to 13 health facilities

with the support of UNFPA and to remaining 36 health facilities phase wise with the support of Save the Children (DHO, 2071 BS).

The criteria of Adolescent-Friendly Health Services (AFS) include, among others, the availability of trained staff as well as information materials on ASRH, the delivery of services in a confidential way, youth-friendly opening hours, and the display of the AFS logo as well as the inclusion of two adolescents in the Health Facility Organization and Management Committee (MOHP/FHD, 2068 BS).

Under such a condition, this study has found out the status of service utilization by adolescents regarding their sexual and reproductive health and the correlated individual, social and health facility level barriers. This work has provided valuable insights for the further scale up of the program.

1.2 Statement of the Problem

Available data from Nepal Demographic and Health Survey 2011 reveals that many sexually active adolescents (15-19) have unmet need for contraception (41.5 %). Fifty percent of the pregnant adolescents do not deliver in an institution. Adolescents have nature of shyness; have incomplete knowledge about pubertal changes (including emotional and physical changes due to puberty) and HIV, AIDS and Sxually Transmitted Infection (NDHS, 2011).

Similarly, data from NDHS 2006 shows that adolescents have unsanitary menstrual hygiene practice, unhealthy and poor food habit. Fifty percent of pregnant adolescent girls (15-19) do not seek Antenatal Care (NDHS, 2006).

Adolescent Sexual and Reproductive Health (ASRH) program has been implemented throughout the district in Pyuthan, however, studies subjected to the health service utilization by adolescent population and to explore the individual, socio-cultural, economic and health status related factors on sexual and reproductive health service utilization are scarce, locally as well as in the national level. Lack of studies about adolescents focusing on the quality of service provided from limited resources and infrastructures is a major a challenge for effective implementation and scale up of the program. For the evidence based decision making process of designing and implementing the plans, policies, programs and strategies targeting the adolescent

population at district and above, there is dire need for scientific studies and their genuine findings.

In this context, this research attempts to carry out an analysis of barriers at individual, social and health facility level for the utilization of sexual and reproductive services among adolescent students of secondary and higher secondary level. More specifically, it seeks answers to the following research questions:

1. What is the service utilization status of sexual and reproductive health among adolescent students?
2. What are the factors for the use and non use of sexual and reproductive health service utilization among adolescent students?
3. What is the perception of adolescent students regarding the adolescent friendly service available at health facilities in Pyuthan?
4. What are the possible ways to improve the access and utilization of sexual and reproductive health services among adolescents?

1.3 Objectives of the Study

1.3.1 General Objective

To find out the barriers at individual, social and health facility levels for the utilization of sexual and reproductive health services by adolescent school students

1.3.2 Specific Objectives

1. To find out the socio-demographic characteristics of adolescent school students
2. To identify the adolescent students' knowledge and perception towards available SRH services in the health facilities
3. To find out the status of sexual and reproductive health service utilization among adolescent school students
4. To describe the family and socio-cultural factors for the use and non use of sexual and reproductive health services among adolescents
5. To explore the possible ways to improve the access and utilization of sexual and reproductive health services among adolescents

1.4 Operational Definition of the Terms

The operational definitions of some of the important variables used in this study are as given below.

Adolescent students: Students of age group 10-19 years (WHO, 2002).

ASRH Service: Adolescent Sexual and Reproductive Health services as defined by WHO Adolescent Job Aid and as per the standards given by Adolescent Sexual and Reproductive Health Implementation Guideline 2007. It includes Family Planning, Maternal and Child health, Safe abortion, RTI, STI, HIV and AIDS, General health services related to menstural problems and Opportunistic Infections, Health education, information and communication services, General counselling and Referal services.

Cultural factors: Those factors which are closely related with the cultural practices distilled through the cultural norms in the society.

Demographic factors: Population related characteristics like age, sex etc

Economic factors: Those factors which are closely related to the economic resources and means of production in the society.

Individual views and perceptions: Those factors which are closely related with the psychological functions of the human body.

Related factors: Factors related to use and non use of sexual and reproductive health services among adolescent students.

Social factors: Those factors which are closely associated with the social constructs and values.

1.5 Rational / Significance of the Study

The study is simply a descriptive and explorative study which gives the basic foundation for the analytical studies to be conducted in the areas of Adolescent Sexual and Reproductive Health in future. The findings of the study explore the service utilization pattern of adolescents in the area of Sexual and Reproductive Health (SRH). It helps to identify the factors that determine the use of SRH services among adolescent populations. Such information is useful for the local and central level health service managers for the evidence based decision making during preparation and implementation of heath policies, programs and strategies in the areas of

Adolescent Health. It also provides genuine information for future researchers and academicians in the field of Adolescent Health.

1.6 Limitations of the Study

Since self-administered questionnaire were used in the study for data collection, therefore there might be the possibility of students not understanding the questionnaires properly and also chances of false reporting. This problem was tried to minimize by providing a brief explanation of the purpose of the study and general overview of the sections of the tools to the respondents before data collection.

Another limitation of this study was risk of non response as the data collection method was self administered questionnaire method. This problem was tried to overcome by increasing the sample size by 20% of the calculated sample size. However, there were varying degrees of response in many questions. So, the total response rate is low in some variables which may create inadequate evidence for broader generalizations.

Since sexual and reproductive health is a sensitive issue related to social and cultural norms among school students as well, there might be chances of not freely providing the information as requested. Similarly, there were chances of false reporting by making a copy of the nearby student. This problem was tried to overcome by assuring students that the answers provided would be kept completely anonymous, their personal details would be completely kept confidential and the data provided would be used for the purpose of the study only.

The study area was confined to Pyuthan Municipality only for the convenience of the researcher. The schools selected were also government schools only. So, the findings of the study may not be generalizable for the whole district and the country.

1.7 Organization of the Study

This thesis is divided into nine chapters. Chapter one contains introduction. This chapter includes the background of the study, statement of the problem, objectives of the study, operational definitions, rational, limitation and organization of the study.

Chapter two includes the discussion based on the review of relevant literature. In this chapter existing literatures in the area of adolescent sexual and reproductive health has been explored and presented in an organized way according to variables of the study. Based on the review of the literatures, a conceptual framework has been constructed on it. The design of the study has been constructed based on the conceptual framework of the study. A theoretical framework is prepared based on the findings of the study.

Chapter three deals with the research methods adopted for the study. It includes research design, study area, nature and sources of data, study universe, sampling unit sampling technique, techniques and tool of data collection.

Chapter four deals with the profile of study area.

Chapter five deals with the presentation of the socio-demographic characteristics of the school students.

Chapter six deals with the adolescent students' knowledge and perception towards available sexual and reproductive health services in the health facilities.

Chapter seven deals with the sexual and reproductive health services utilization practice and related barriers faced by adolescent students.

Chapter eight deals with the family and social level barriers associated with non use of sexual and reproductive health services among adolescents. It also documents the possible ways to improve the access and utilization of sexual and reproductive health services among adolescents.

Chapter nine contains the summary, conclusion, recommendation and directions for future research. The summary part briefly deals about the findings of the study. Conclusion part has presented the answer to the research questions related with the research objectives. Recommendations part has mentioned the recommendations based on the findings of the study. Directions for future research part have given recommendations to future studies on this topic.

CHAPTER II

LITERATURE REVIEW

In order to trace and identify the problems in any research work it is essential at first to have a literary assessment of the matter to be dealt with. It helps to avoid the possibility of duplication in research works and gives the work a literary genuineness. Without any regard to the past, it is illogical to pass away judgment on the present. Hence, the importance of the review of literature in any research work remains vital. In this study concept review has been made followed by theoretical review and review of previous empirical literature. The theoretical overview and the critical review of previous empirical literature provide incentive for guiding the study. Side by side the conceptual framework and theoretical framework has been also choked out.

2.1 Concept Review

2.1.1 Adolescence

The World Health Organization defines adolescents as young people aged 10-19 years. There are about 1.2 billion adolescents, a fifth of the world's population, and their numbers are increasing. Four out of five live in developing countries. Adolescence is a journey from the world of the child to the world of the adult. It is a time of physical and emotional change as the body matures and the mind becomes more questioning and independent. The second decade of life is a period of personal development almost as rapid as the first. Ten-year-olds are still children, although many are already exposed to challenges from the adult world. By the age of 20, young people are contributing members of society, acquiring rights at a variety of ages to marry, vote, drive, have sex, fight for their country or to go to prison (WHO, 2002).

Adolescents are no longer children, but not yet adults, and this period of change is full of paradox. Adolescents can seem old beyond their years, but need adult support. They can put themselves at risk without thinking through the consequences; display optimism and curiosity, quickly followed by dismay and depression biologically, they can become mothers and fathers, without being ready for the responsibility. They feel a growing sense of independence, but depend on adults for their material needs and as they change, so their needs change with them (WHO, 2002).

Early adolescence (10-13) is characterised by a spurt of growth, and the beginnings of sexual maturation. Young people start to think abstractly. In mid-adolescence (14-15) the main physical changes are completed, while the individual develops a stronger sense of identity, and relates more strongly to his or her peer group, although families usually remain important. Thinking becomes more reflective. In later adolescence (16-19) the body fills out and takes its adult form, while the individual now has a distinct identity and more settled ideas and opinions (WHO, 2002).

2.1.2 Why focus in Adolescent Sexual and Reproductive Health

Although adolescents make up a large proportion of the population in the developing world, where most humanitarian emergencies occur, their sexual and reproductive health (SRH) needs are largely unmet. In 2000, 29% of the population in developing countries was of adolescent age; in the least developed countries, adolescents accounted for 32% of the total population. Worldwide, adolescent females and males are reaching puberty sooner, marrying later and having more premarital sex. The unmet need for contraceptives among adolescents, however, is more than twice that of married women. One third of women worldwide give birth before the age of 20 with deliveries by women under 20 totaling 15 million annually. Pregnant adolescents are at increased risk of morbidity and mortality due to complications during pregnancy and childbirth, including obstructed labor, preterm labor and spontaneous abortion. Five million adolescents between the ages of 15 and 18 have unsafe abortions each year and 70,000 abortion-related deaths occur among this age group every year. Half of new HIV infections occur in 15-to-24 year olds, and one third of new cases of curable sexually transmitted infections (STIs) affect people younger than 25 (UNFPA, 2009).

2.2 Theoretical Review

Theories are the base for any research work. It provides guidelines and way forward to conduct any studies by providing theroritical linkage for any study. The researcher has gone through theories and models that are utilized for behavioural researches in health sciences. The related theortical approaches and models that the researcher has encountered during literature search are mentioned here.

The study is based on different approaches to study the utilization of health services- the socio-cultural, socio-demographic, social-psychological, organizational

perspective of health facilities and social systems. None of the above approaches alone can provide details about service utilization. Each approach has certain benefits and limitations. All the approaches combined in total provide the overall picture of the service utilization status and the associated barriers for health service use among adolescents.

There are several psychological models of behavior that could be applied to health care utilization especially for mental or emotional reasons. For example, based on the premise that using health services is behaviour, social learning theory would attribute using health services to external social forces rather than inherent individual preferences (Ciechanowski, et al, 2002). Attachment theory, which proposes that early childhood experiences with caregivers shapes an individual's perceptions and behaviours within their interpersonal relationships, is another theory that has also recently been used to understand health service utilization (Ciechanowski, et al, 2002).

Specifically, individuals with certain types of insecure attachment styles may be more likely to report physical symptoms and visit a primary care giver. However, behaviour is only one of many factors that influence health care utilization. There are also societal determinants and influences from the health care system that play a role in determining service utilization. One model that accounts for these factors is the Andersen and Newman's Framework for health service utilization, which over the last three decades, has been used almost exclusively in the literature to conceptually organize the factors that influence the utilization of health services. (Ogrodick, 2004)

2.2.1 Anderson and Newman Framework for Health Service Utilization

The present study is based on Anderson and Newman's model of health service utilization. A conceptual representation based on this model is illustrated in figure 2.1. According to this framework, the factors that influence health service use can be classified into one of three broad categories: societal, health system and individual (Andersen, R. and J.F. Newman, 1973). In the present study, the basic framework of the Andersen and Newman model is used to examine the barriers of adolescent student's utilization of health services for sexual and reproductive health reasons.

However, this study also incorporates additional psychosocial factors outside of this framework which, based on the research literature.

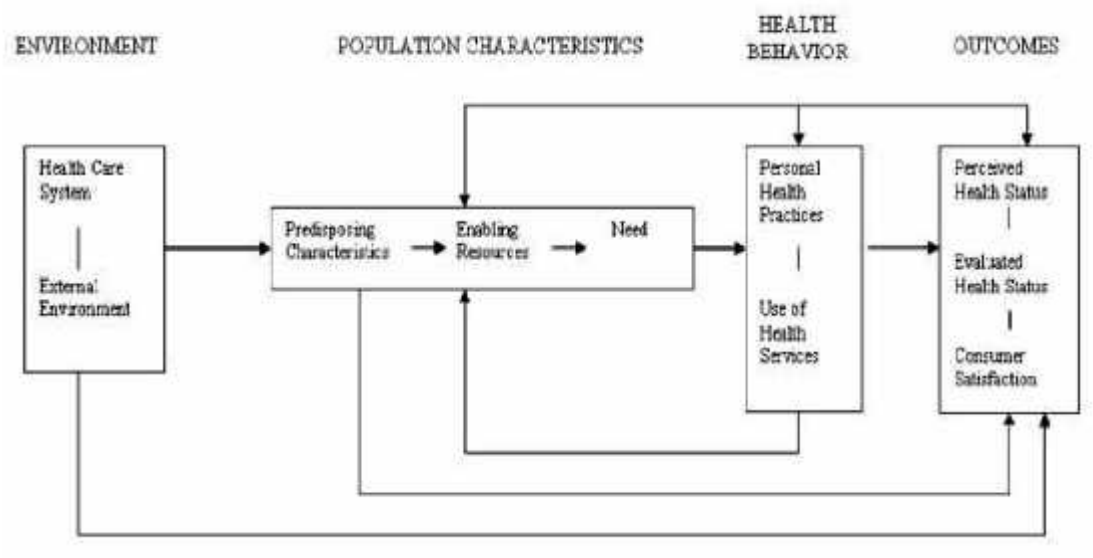


Figure 2.1: Anderson and Newman's Model of Health Service Utilization

Figure 2.1: Anderson and Newman's Framework for Health Service Utilization

Source: Anderson and Newman, 1973

According to this framework, an individual's access and use of health service is a function of three characteristics:

Predisposing Factors: The socio-cultural characteristics of individuals that exist prior to their health problems or illness.

- **Demographic Characteristics and Social Structure:** Age, gender, education, occupation, ethnicity, social networks, social interactions, and cultural factors
- **Health Beliefs:** Attitudes, values, and knowledge that people have concerning and towards the health care system

Enabling Factors: The logistical aspects of obtaining care.

- **Personal/Family**: Means that help to access health services such as income, sharing practices, family support and involvement in care.

- **Health System and Community related:** Available health personnel and facilities, behavior of health workers, confidentiality in health facility, waiting time, distance of health facility, health facility opening time etc.
- **Individual psychology**: Psychological characteristics such as shyness, fear, ability to share personal things.

Need Factors: The most immediate cause of health service use, from functional and health problems that generate the need for health care services.

- **Perceived**: "How people view their own general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether or not they judge their problems to be of sufficient importance and magnitude to seek professional help. It will better help to understand care-seeking and adherence to a medical regimen " (Anderson and Newman, 1973)
- **Evaluated**: "Represents professional judgment about people's health status and their need for medical care. It will be more closely related to the kind and amount of treatment that will be provided after a patient has presented to a medical care provider." (Anderson and Newman, 1973)

2.3 Review of Previous Empirical Literature

2.3.1 Status of Adolescent Sexual and Reproductive Health

Following are some of the indicators of adolescents: Median age at marriage, male 21.6 years and female 17.5 years, Contraceptive Prevalence Rate 14.4% among adolescents, Unmet need for family planning- 41.6% among 15-19 years, and Education status of adolescents, percentage of illiterate adolescents – Male 3.6% and Female – 12.5% (NDHS 2011).

In Nepal, the practice of early marriage is common and is deeply rooted in the culture. According to Muluki Ain 2020 BS, The legal minimum age at marriage in Nepal is 18 with the guardian's consent and 20 without the need for the guardian's consent. In fact, however, most women have married at younger ages. In Nepal childbearing begins early. Almost one-quarter of women who were age 25-49 in 2011 had given birth by age 18, and nearly one-half by age 20. Early marriage and resulting early sexual debut can lead to a number of potentially adverse outcomes, including

unplanned pregnancy and exposure to sexually transmitted infections. (FHD, 2068 BS)

Approximately, 42 % of 15-19 years adolescents have unmet need for Family Planning and also have problems in sexual behaviour, use of contraception, early pregnancy, unwanted pregnancy and abortion. NDHS (2011) showed 14.4% of adolescent use modern contraceptive methods among adolescents. Although fertility begins about the time of menarche, adolescent girls are not fully mature physically or mentally. Babies born to adolescents are more likely to be born preterm or at low birth weight and are more likely to die in the neonatal period. Many adolescent girls who become pregnant have to leave school, often with long-term adverse consequences for themselves, their families, and their communities.

According to NDHS 2011, percentage of illiterate adolescents is: Male 3.6% and Female 12.5%. In 2011, 17 percent of all female adolescents and youth and 4 percent of all male adolescents and youth had no formal education. At the other end of the education scale, 27 percent of women age 15-24 and 39 percent of men age 15-24 had received their SLC by the time of interview in 2011, roughly doubling from 2006 when 12 percent of women and 22 percent of men age 15-24 had received their SLC (Khatiwada et al 2013).

In this context, there are scarce studies in Pyuthan which reveal the health service utilization status of adolescents. This study provides some evidence in case of adolescents of Pyuthan about their service use status, met and unmet need and possible supporting and hindering factors for sexual and reproductive health service utilization.

2.3.2 Barriers to Access and Utilization of Sexual and Reproductive Health Services by the Adolescents

Adolescents in Nepal do not have adequate access to appropriate information and services about sexual and reproductive health issues from service providers. They do occasionally visit health facilities for treatment of illness, but not for Adolescent Sexual and Reproductive Health issues. In a recent survey, 76% respondents felt that the services they were getting were not adolescent friendly. Key issues for adolescents are lack of confidentiality in service provision, and the lack of quality counseling

services. The respondents shared that the behavior of service providers was rude and unhelpful hindering access to health services not just of young people, but also for people from marginal and economically deprived communities. Lack of money for treatment, fear of going alone for treatment as a result of not finding anyone to accompany them to health service centers/health institutions, lack of privacy, distance to health service centers and waiting time are amongst a few of the reasons for the poor health status of adolescent girls (NHEICC, 2012).

Married adolescents point to getting permission (28%), not knowing where to go for treatment (30%), concerns that there may not be a female health service provider (52%), long distance to health facility (55%), and travelling through the public transport (54%) as barriers to accessing health services. There is a great deal of stigma associated with unmarried adolescents accessing Adolescent Sexual and Reproductive Health services because of social disapproval of sexual activity among adolescents. Activities on Sexual and Reproductive Health (SRH) for young people on Gender Based Violence (GBV) and Lesbian Gay Bisexuals and Transgender (LGBT) issues are not available (FHD, 2005).

In another survey, the respondents mentioned that the condoms were not available to unmarried young people. Health workers explained that they provided condoms to young people and married only upon request. They did not keep the condom in accessible places on the outer walls of Health facility because they were misused by children. The other reason given was that people take many at one time, and culturally it's not comfortable to keep condoms in Public Places (SRHR, 2009).

National Communication Strategy for Adolescent Sexual and Reproductive Health (ASRH) Nepal 2012-2016 reveals the following key barriers for adolescents to accessing and using ASRH.

- Limited financial and human resources to implement Adolescent Sexual Reproductive Health programs and fluctuating responses based on external donor support
- Isolated efforts of coordination among organizations
- Very few adolescent friendly clinics/services currently available in the country
- Limited technical skills of health care providers, teachers, NGOs, to implement Adolescent Sexual Reproductive Health (ASRH) programs

- Incomplete sexual and reproductive health information in current school curricula
- Adolescents have few trusted sources of correct information on ASRH issues
- Parental, teacher and community limited knowledge about Sexual and Reproductive Health and resistance to adolescents learning about Adolescent Sexual Reproductive Health influneced by social norms and values
- Other available services for adolescents such as HIV Prevention, Prevention of Mother to Child Transmission (PMTCT) not integrated into Sexual and Reproductive Health services

Also, key facilitating factors found were,

- Government commitment to adolescents- ICPD 1994, Nepal Health Sector Programme-Implementaion Plan II (NHSP 2, 2010-2015), Children's rights convention, 1989 (CRC), Convention on Discrimination Against Women (CEDAW)
- The government and NGOs already providing sexual and reproductive health services to adolescents through a limited amount of adolescent friendly service and sex education in classes 8, 9 and 10 curriculums.
- The use of new media and technologies, FM, and mobile phones are emerging among young people as a tool for communication (NHEICC, 2012)

Based on these findings, the study explores whether the barriers to service utilization in Pyuthan district are similar or different to other studies. Good practices in the local context as well as local context specific barriers have been explored and approporiate intervention modalities suggested based on the findings of this study.

2.3.3 Adolescent Friendly Sexual and Reproductive Health (ASRH) Program

To address the unmet needs of adolescents in sexual and reproductive health, Government of Nepal has started an innovative approach - National Adolescent Sexual and Reproductive Health program. The overall goal of the program is to promote sexual and reproductive health status of adolescents. The primary objective of the Adolescent Sexual Reproductive Health (ASRH) program is to reduce Adolescent Fertility Rate. However, the indicators such as age at marriage,

Contraceptive Prevalence Rate among adolescents, Unmet need for family planning among adoelscents and Education status of adolescents will also be monitored by the program.

In response to the issue of adolescents, GoN has developed the 'National Adolescent Health and Development (NAHD) Strategy in 2000. An implementation guideline on ASRH was developed in 2007.The implementation Guide on ASRH 2007 guides district program managers to help key stakeholders(policy makers, administrators, community leaders, service providers, parents, teachers, CBOs, NGOs, organizations of or for sexual minorities and the media) create an enabling environment within the community (NHEICC, 2012).

In 2008, a draft national ASRH program was developed. The ASRH program was successfully piloted in 2009 in 26 public health facilities in Bardiya, Surkhet, Dailekh, Jumla and Baitadi districts. Based on the findings from the pilot intervention, Ministry of Health and Population, Department of Health services, Family Health Division has developed a national ASRH program package in 2011 and is now being implemented gradually to meet the NHSP II target of making 1,000 health facilities adolescent friendly that aims to reduce the adolescent fertility rate to 70 per 1,000 women (15-19 yrs) by 2015. As of July 2013, Adolescent-Friendly health Services (AFS) has been implemented in a total of 732 health facilities in 49 districts (DOHS, 2070 BS).

Till now, ASRH program has been implemented in 49 government health facilities of Pyuthan and in all the health the 7 health facilities within Pyuthan municipality since FY 2068/69. The program has been expanded to 13 health facilities with the support of UNFPA and to remaining 36 health facilities with the support of Save the Children (DHO, 2071 BS).

The criteria of adolescent-friendly health services include, among others, the availability of trained staff as well as information materials on ASRH, the delivery of services in a confidential way, youth-friendly opening hours, the display of the AFS logo as well as the inclusion of two adolescents in Health Facility Operation and Management Committee. Government of Nepal has set achieving the target of scaling up 1,000 public health facilities to Adolescent Friendly Services by 2015 (DOHS, 2069).

Health services needed to be available at health facilities, PHC/ORCs and FCHVs includes**:** General ASRH Counselling, Information, Education and Service for adolescents on: FP, MCH, Safe abortion, RTI, STI, HIV AIDS, Menstural problems, Health education, Referal services (MOHP/FHD, 2068 BS).

In this context, the study has explored the health system related aspects as per the protocols and guidelines of adolescent friendly health services. These conditions are directly related to the use and non use of services among the target group. It is one of the important dimensions of this study.

2.4 Conceptual and Theoretical Framework of the Study

2.4.1 Conceptual Framework

Conceptual framework for the study is as follows:

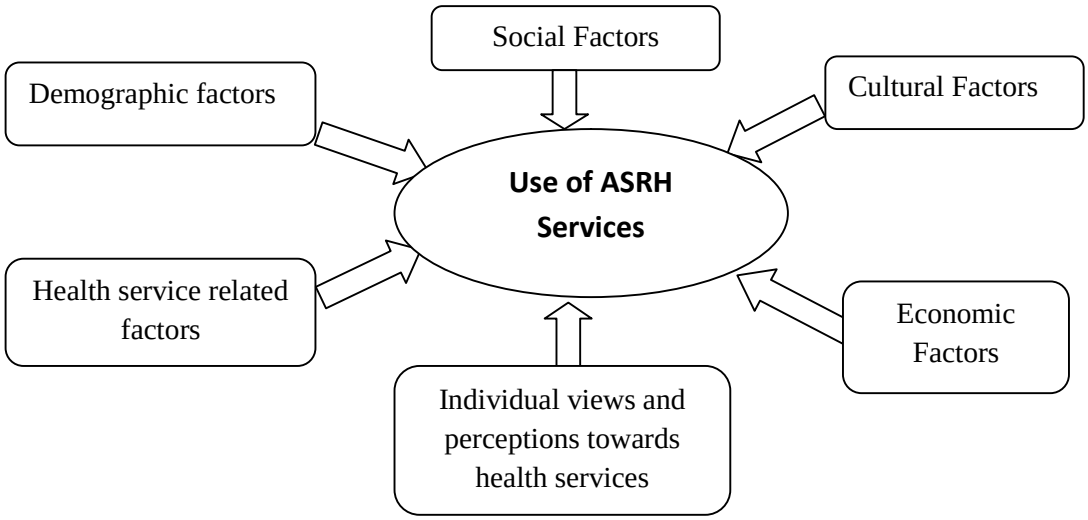


Fig: 2.2 Conceptual Frameworks

The conceptual framework for this study is based on the available literatures on utilization of sexual and reproductive health services by adolescents. This framework assumes that health service utilization is influenced by various domains such as demographic and socioeconomic characteristics of respondents, social and cultural variables related with service use and individual perceptions and views regarding service utilization.

Demographic and socio-cultural variables such as age, sex, ethnicity, religion, marital status, co residence status, educational status, occupation have been studied at first to find out the characteristics of the respondents.

Similarly, the study explores the social and cultural factors which are found to be associated with service use such as source of information for service, time to reach the service, family support for service use, gender preference of the service user for service provider, comfortability of respondent to go to receive the service due to spouse/family/social reasons, reason for discomfort, ever faced gender based violence while receiving heath service and any problems faced at community for using sexual and reproductive health services.

The framework also includes individual perception related factors about available health service used such as satisfaction status of service use, reason for dissatisfaction, perception towards service provider, privacy, time of use of service, good and poor aspects about health service and suggestion for improvement based on client views.

Similarly, another domain studied is health service related factors. So, knowledge about type of adolescent friendly health services available, place of availability of service, time and distance for the service use and source of information about the availability of the services were studied. Similarly, practice related factors about health service use such as ever used sexual and reproductive health service, frequency of use, reason for use, reason for non use, type of facility visited for the most recent service, current service use status were also studied so as to find out the service utilization status and the barriers associated with the service utilization.

2.4.2 Theoritical Framework

The theoretical framework for this study is based on Anderson and Newman's Framework of health service utilization. The purpose of this framework is to show the relationship between various domains and discover the underlying conditions that either impede or facilitate the use of health services.

Theoritical Framwork

The theoretical framework of this study is presented below in the figure.

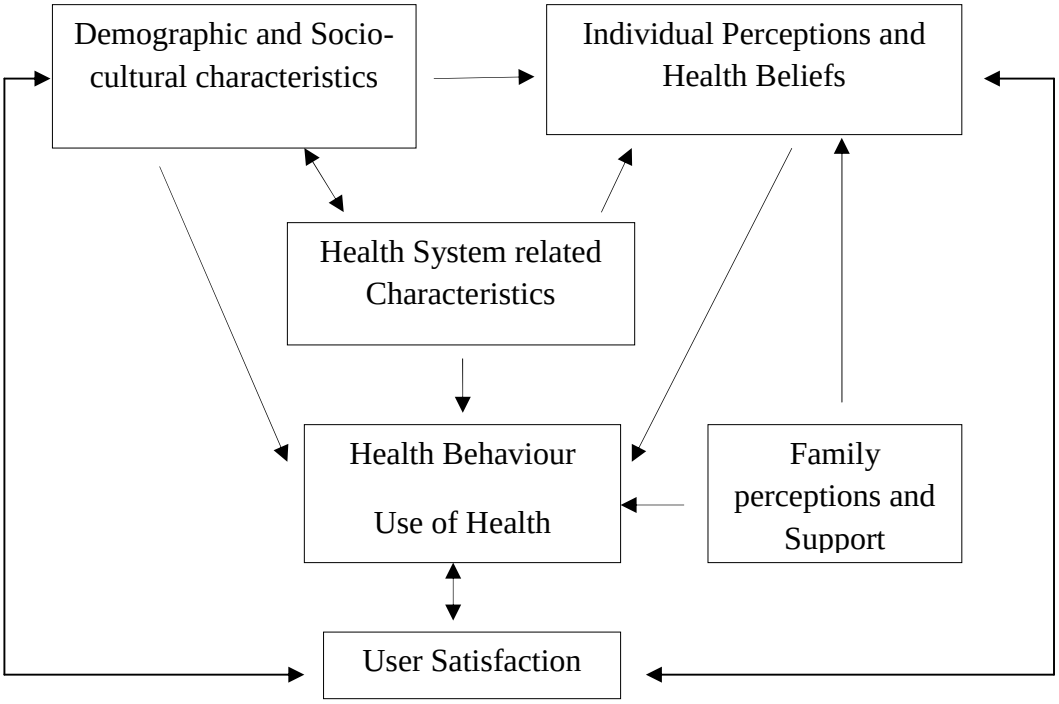


Figure 2.3: Theoritical Framework of the Study

A theoretical framework for viewing health services utilization is presented, emphasizing the importance of the three major domains : (1) Individual determinants of utilization (2) Characteristics of the health service delivery system, and (3) Socio-cultural beliefs and practices of families and communities related to sexual and reproductive health, and. These three factors are specified within the context of their impact on the access and and utilization of health care services.

Figure 2.3 shows the relationships of the main components of the framework. Societal determinants of utilization are shown to affect the individual determinants both directly and through the health services system. Various types of individual determinants then influence health services used by the individual. Empirical findings in the subsequent chapters demonstrate how the framework might be employed to explain some key patterns and trends in utilization of sexual and reproductive health services.

CHAPTER III

RESEARCH METHODOLOGY

3.1 Study Site and Rationale for the Selection of Study Area

Pyuthan district lies in the Rapti Zone; mid western development region of Nepal. It was one of the powerful Chaoubise Kingdom in Gandaki region in Nepal before unification by Prithvi Narayan Shah. The district is bordered by Gulmi in the east, Dang and Rolpa in the west, Rolpa and Baglung in the North, and Dang and Arghakhanchi in the south. The district is at 305 to 3659 metre height elevated from sea level and has a area of 1365 Sq km. Pyuthan Khalanga is the head quarters of this district which is joined with Mahendra Highway at Bhalubang Dang district with a black topped road at a distance of 68 Kms. The famous touristic and religious site Sworgadwari lies at this district which is at a distance of 61 Kms black topped road from Bhalubang and 15 km rural road thereafter.

The district has a total population of 228,102, female 128049 (56.13%) and male 100053(43.86%). It is inhabited by diversified caste/ethnic groups like Brahmin (9.85%), Chhetri (24.95%), Dalits (18.13%), Magar (32.57%), other ethnic groups (7.75%), Sanyasi Dashanami (3.3%) and others (3.45%). According to District Glipse of Pyuthan municipality 2071, the district has two electroral constituencies, 11 illakas, and 47730 households. The district ranks as 53rd in Human development Index and has HDI of 0.426. It has a literacy rate (above five years) of 67.01%, malnutrition rate of 42.5%, Infant Mortality Rate (IMR) 54/1000, family with access to drinking water 78.28%, and poverty rate of 32.2. Major religions in the district are Hindu (96.6%) followed by Buddist 2.81% (CBS, 2068 BS).

Pyuthan Municipality is the recently declared municipality which consists of former seven VDCs within Pyuthan district- Pyuthan Khalanga, Maranthana, Dharmawati, Dakhaquadi, Bijayanagar, Bijuwar and Khaira VDCs. It is located on the central part of Pyuthan district which includes the headquarters Pyuthan Khalanga.

It is surrounded by Phopli, Lung, Tusara and Torbang VDCs in the north, Chuja, Raspurkot and Dharampani VDCs in the east, Dhuwang, Ramdi and Nayagaun VDCs in the south and bounded by Barjibang, Jumrikanda and Majhkot VDCs from the west. Most of the people in the district are Magars followed by Chhetri, Brahman, Sanyasi and dalit castes (CBS, 2068 BS).

Pyuthan district has been primarily selected for the study of utilization of sexual and reproductive health due to various reasons. One reason is the convenience of researcher. Second reason is that the sexual and reproductive health service related data of Pyuthan was low. The key indicators such as institutional delivery was only 28% and Contraceptive Prevalence Rate among married women of reproductive age group was 41% (DHO, 2071 BS). As prevalence of child marriage (marriage below age 18) in Pyuthan was as high as 33% and prevalence highest among female (WCO, 2013). As child marriage was very high in Pyuthan, it was expected that the proportion of the adolescents among reproductive health service users might also be large. Third reason is adolescent friendly health service has been implemented in Pyuthan since 2012. So, it would be a great opportunity to study service utilization by this group, to find out the status of program implementation and relevant barriers in at different levels.

3.2 Research Design

The study is cross sectional descriptive study. It is also an explorative study. Both qualitative and quantitative techniques were used. Quantitative technique is the major design and includes survey among adolescent school students attending secondary and higher secondary level during the study period. Qualitative technique was carried out at different levels to support, triangulate and collect extra information related with adolescent students' service utilization on Sexual and Reproductive Health. Key informant interviews were carried out with health facility in charges and service providers from each health facility nearer to the schools so as to explore health system related factors affecting service utilization. Ten case studies were conducted with randomly selected respondents to explore information on sexual and reproductive health service utilization. Focus group discussions were carried out with separate groups of girls and boys.

3.3 Nature and Sources of Data

The study is based on the primary data collected by the researcher himself. Primary data was collected from the field using anonymous self-administered questionnaires. The adolescent students of age 10 to 19 years were the only source of primary data. Moreover, focus group discussions and interactions were conducted with some students and indepth interview was carried out with service providers to identify more about the qualitative information and triangulate the findings. Mostly, the data and information used in this study are quantitative in nature.

3.4 Universe and Sampling method

The universe of this study was adolescent school students. Adolescent students (who were at or above the age of 10 to 19 years) studying at the secondary and higher secondary school level in Pyuthan Municipality were the study population. There were in total 3656 students, 1851 male and 1805 females, in 11 secondary and higher secondary schools of Pyuthan municipality from class 9 to 12 (DEO, 2071 BS).

Schools were selected randomly from total government schools in the municipality. The proportion of students in two strata, class 9 -10 and 11-12 was calculated. Proportion of male and females in each stratum were also calculated. In total 418 students, 213 male and 205 females were selected proportionately from three schools in Pyuthan. Data was collected from those students who were present on the day of data collection in the school. Students over 19 years of age were excluded from the study. All together 418 students were sampled through stratified proportionate random sampling technique in this study. After exclusion, finally 412 students were taken for final analysis.

3.5 Methods of Data Collection

3.5.1 **Self Administered Questionnaire**: Data was collected by using an anonymous self-administered questionnaire. The questionnaires were prepared based on standard questionnaires available in the literature. The questionnaire set was later translated into Nepali language. The set was pretested and finalized. Verbal consent from the respective school authorities was obtained after explaining the purpose of the study. The purpose and objective of the study was clarified as well as necessary instructions were given to the students

prior to distribution of the questionnaire. Students were encouraged to be truthful in the responses by assuring that the information they provided would remain confidential. Moreover, the students were allowed to quit at any time if they wished to do so, since their participation was completely voluntary.

3.5.2 **Key Informant Interview:** Key Informant interview was carried out with three service providers of Khalanga PHC, Bijaynagar HP and Khaira SHP. Key informant interviews were carried out mainly to explore and validate the findings related with health services provided from the health facilities.

3.5.3 **Focus Group Discussion:** Two focus group discussions (one among male students and another among female students) were carried out among the students so as to explore the knowledge and practices related with individuals, service utilization from the health facilities and, family and social belief and practices related with sexual and reproductive service utilization.

3.5.4 **Observation:** Observation method was followed to validate the findings from self administered questionnaires and interviews. This method was used so as to observe the facility readiness indicators that were available to provide adolescent friendly health services in health facilities.

3.5.5 **Case Study:** Ten case studies were conducted with randomly selected respondents to explore indepth information on sexual and reproductive health service utilization.

3.6 Methods of Data Analysis and Presentation

This study was designed and modulated as a descriptive study based on qualitative and quantitative data originating from primary source. All the data and information collected from the field through self-administered questionnaires were systematically arranged, summarized, processed and presented in tabular forms. Data entry and analysis were carried out through SPSS 16. Information collected from other primary and secondary sources such as FGDs, key informant interviews and case studies are presented to supplement the findings from quantitative survey and triangulate the data as and where necessary. The processed data and information with analysis were presented and described in separate chapters.

CHAPTER IV

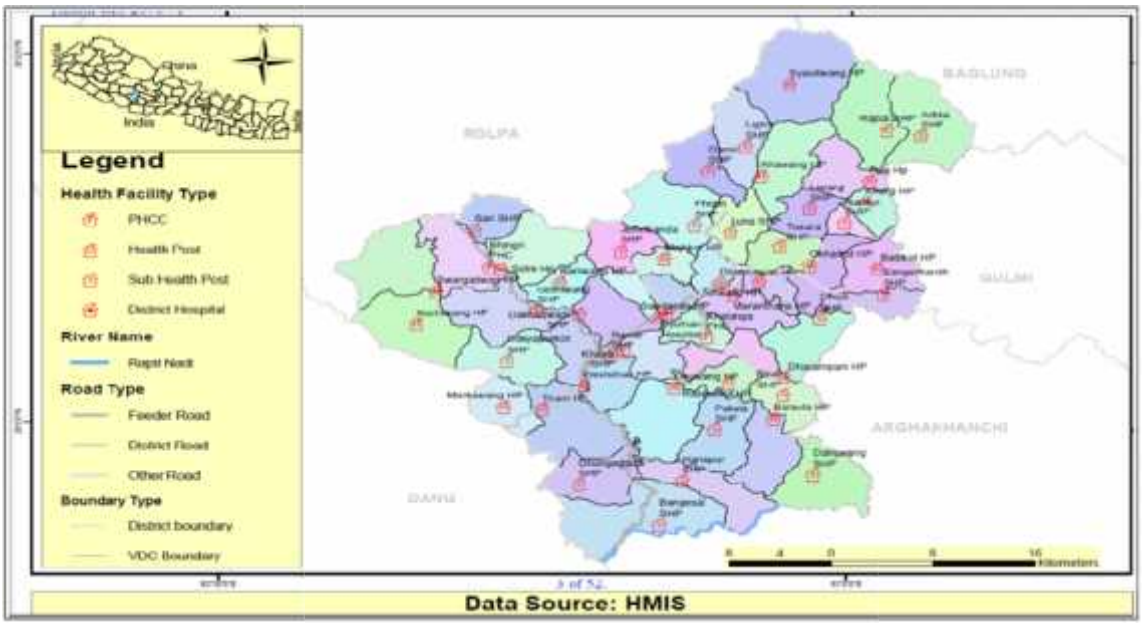
PROFILE OF THE STUDY AREA

4.1 Profile of Pyuthan District

4.1.1 Physio- Geographic Settings

Pyuthan district lies in the Rapti Zone; mid western development region of Nepal. It was one of the powerful Chaoubise Kingdom in Gandaki region in Nepal before unification by Prithvi Narayan Shah. The district is bordered by Gulmi in the east, Dang and Rolpa in the west, Rolpa and Baglung in the North, and Dang and Arghakhanchi in the south. The district is at 305 to 3659 metre height from sea level and has an area of 1365 Sq km (132890 hectares). The district has all types of climates of mountainours, hilly and plain areas. Pyuthan Khalanga is the head quarter of this district which is joined with Mahendra Highway at Bhalubang Dang district with a black topped road at a distance of 68 Kms. The famous touristic and religious site Sworgadwari lies at this district which is at a distance of 61 Kms black topped road from Bhalubang and 15 km rural road thereafter (DDC, 2071 BS).

Map 1: Map of Pyuthan District



Source: DHO, Pyuthan, 2071 BS

4.1.2 Demographic and Socio Economic Characteristics

The district has a total population of 228102, female 128049 (56.13%) and male 100053(43.86%). It is inhabited by diversified caste/ethnic groups like Brahmin (9.85%), Chhetri (24.95%), Dalits (18.13%), Magar (32.57%), other ethnic groups (7.75%), Sanyasi Dashanami (3.3%) and others (3.45%). According to District Glipse of Pyuthan , 2071 BS published by DDC Pyuthan, it covers an area of 1365 Sq km (132890 hectares); likewise, It has a area of 1309 Sq Km and population of 228102 (CBS, 2068 BS) with 42 VDCs and one Municipality in it. It has 2 electroral constituencies, 11 illakas, and 47730 households. The district ranks as 53rd in Human development Index and has HDI of 0.426. It has a literacy rate (above 5 years) of 67.01%, malnutrition rate of 42.5%, IMR 54/1000, family with access to drinking water 78.28%, and poverty rate of 32.2. Major religions in the district are Hindu (96.6%) followed by Buddhists 2.81% , Muslim 0.26%, Christian 0.24% and others 0.09% (CBS, 2068 BS). The district has been declared as the fifth open defecation free district of the country.

Table 4.1: Basic Demographic Information

Indicator	**Number**
Total Population	228102
Male	100053 (43.86%)
Female	128049 (56.13%)
Household number	47730
Population Growth Rate	0.71
Population Doubling Time (Years)	97.62
Avarage Family Size	4.78
Litetacy Rate	67.01
Population Density (per Sq. KM)	174
Sex Ratio	78.13
Human development Index Rank	53
Human Poverty Index	47.9
Life expectancy rate (Years)	62.5

Source: CBS, 2068 BS

4.1.3 Political and Administrative Divisions

It is a mid hilly district lying in Midwestern Nepal under Mid Western Development Region and Rapti zone. The district has two electroral constituencies. It has in total 11 illakas. The district has in total 42 VDCs and a recently declared Pyuthan municipality. The total households in the district as per the census 2011 are 47730 in which total 49472 families stay in these households (DDC, 2071 BS).

4.1.4 Natural Resources

Out of the 132890 Hectares of land in the district, 25.2% of land eligible for cultivation however only 13% is used for cultivation. About 3500 Hectares of land has been irrigated till date. The district has in total forest which is 42.9% of the total land area. The district has two major rivers: Jhimruk and Madi. Jhimruk River has multipurpose use of irrigation as well as electricity generation from the hydropower project (DDC, 2071 BS).

4.1.5 Health Service Utilization

The district has in total 49 government health facilities among them there is one 15 beded government hospital, 2 Primary Health Care Centers, 23 Health Posts and 23 sub Health Posts. There is one private hospital and many private medical halls.Along with the health facilities, 155 PHC/ORCs, 251 EPI clinics and 441 FCHVs are also providing health services to the general population. Total adolescent population in the district as estimated by Health Management Information System for FY 2070/71 was 59863 (DHO, 2071 BS).

According to the Annual report of DHO, in total 25861 patients received heath service from OPD, 4184 patients received services for emergency , 2138 were discharged from indoors and 732 deliveries were conducted in health facilities in FY 2070/71 BS (DHO, 2071 BS).

Regarding public health indicators, the district has immunization status of over 96% for all antigen’s, institutional delivery 28% and Contraceptive prevalence rate as % of Married Women of Reproductive Age as 41. (DHO, 2071 BS).

4.1.6 Agricultural Activities

Most of the people were engaged in agriculture (93%) but only few (1.3%) of them were practicing the professional agriculture all others were practicing conventional agro farming. Animal (cow and buffalo) farming was the next major agricultural practice for milk production and earning money by selling milk at local dairy. Few of the farmers were engaged in production of seasonal vegetables eg Tomato, Potato, Couli flower, Cabbage, Brinjals, Chilli etc and used to sell at Khalanga, Bagdulla, Bijuwar, Jumri, Bhingri and Machhi. Rice, wheat and barley are the major crop production in the study area (DDC, 2066 BS).

4.1.7 Facilities for Information and Communication

All the television channels, radio frequencies and FM stations were found to be accessible in the study area. Cell phone (mobile) services were available through N-Cell, Hello network and Nepal Tele-Com. Local daily newspapers and few national newspapers were available at the same day of publication. Local internet facilities were available mainly through 2G and 3G netork of Nepal Telecom as well as through Sky-Pro and Ncell. ADSL service is available at urban areas. For transportation, Khalanga – Bhalubang road (68 kms) connects the district with Mahendra highway (DDC, 2066 BS).

4.2 Introduction of Study Area

Pyuthan Municipality is the recently declared municipality which consists of former seven VDCs within Pyuthan district- Pyuthan Khalanga, Maranthana, Dharmawati, Dakhaquadi, Bijayanagar, Bijuwar and Khaira VDCs. It is located on the central part of Pyuthan District which includes the headquarter Pyuthan Khalanga. It is surrounded by Phopli, Lung, Tusara and Torbang on the north, Chuja, Raspurkot and Dharmpani in the east, Dhuwang, Ramdi and Nayagaun VDCs on the south and bounded by Barjibang, Jumrikanda and Majhkot from the west. Most of the people in the district are Magars followed by Chhetri, Brahman, Sanyasi and dalit castes (CBS, 2068 BS).

Specific data regarding the municipality is not available as the municipality is a recently declared municipality of Nepal. However, data from various sources have been collected and presented below to the extent possible.

4.2.1 Socio-Demographic Characteristics

Pyuthan municipality has a population of 37045, out of which 16028 are males and 21017 are females. There are 9259 households in total in this municipality as per the data available from census 2011 (CBS, 2068 BS). The estimated number of adolescent population in Pyuthan Municipality given by Health Management Information Section of DoHS is 9928. (DHO, 2071 BS).

It is inhabited by diversified caste/ethnic groups like Brahmin, Chhetri, Dalits, Magar, other ethnic groups, Sanyasi Dashanami and others. Majorities are Hindus followed by Buddhists (CBS, 2068 BS). Most of the people were engaged in agriculture practicing conventional agro farming. Animal (Cow and Buffalo) farming was the next major agricultural practice. Rice, wheat and barley are the major crop production in the study area. Few of the farmers were engaged in production of seasonal vegetables as well eg Tomato, Potato, Couli flower, Cabbage, Brinjals, Chilli etc. In Khaira, fish farming has been started in a large area .The settlement pattern in these VDCs is mixed. Larger part of the municipality is rural area having a few urban centres with urban facilities in it. Former Pyuthan Khalanga, Bijuwar and Dharmawati VDCs now in municipality have larger portion of urban area with hospitals, many government offices, major city markets, departmental stores, banks and other urban develoments. Areas other than Khaira have electicity provided by Nepal Electricity Authority while Khaira has electricity provided by Butwal Power Company from Local Jhimruk hydropower (DDC, 2071 BS).

The district municipality has in total one 15 beded government hospital, 1 Primary Health Care Centre, 3 Health Posts and 2 Sub Health Posts. There is one private hospital and many private medical halls. Though Pyuthan has been declared as a municipality, old health structures in the former VDCs are still functioning as per the VDC level orgaogram with 9 FCHVs in each ward and 3-5 Primary Health Care/Outreach Clinics in each former VDCs (DHO, 2071 BS). Various non governmental organizations such as Kalika Bikash Kendra, Health for Life, Nepal

Red Cross Society, UNFPA, Marie Stopes are also working in this Municiplaity (DHO, 2071 BS).

The study area is accessible to national level television channels and local FM stations. Cell phone (mobile) services are available through N-Cell, Hello Network and Nepal Telecom. Local daily newspapers and few national newspapers are available at the same day of publication. Local internet facilities are available mainly through 2G and 3G netork of Nepal Telecom as well as through Sky-Pro and Ncell. ADSL service is available at urban areas. For transportation, black topped road is available connecting up to the district headquarters. Agricultural roads are available throughout all the wards of the municipality.

4.2.2 Cultural Practices

As majority of the peoples in the study area belong to Hindu followed by Bouddha religious groups, they celebrate the major festivals celebrated by the Nepali community such as Bada Dashain, Deepawali, Teej, *Dahi Chyura Khane* in Baishak Pandhra, Janai Purnima, Dewali, Kul Puja, Maghe Sakranti, Fagu Poornima, Chaite Dashain etc. Among religious minorities, Baisakh Poornima among Buddhists, Eed and Bakarid among Muslims and Christmus among the Christians are the major festivals. They had shown the practice of co-existence and respect to each other's cultural practices while celebrating the festivals.

In Pyuthan Municipality, various cultural gatherings occur from time to time. During Tihar, "Chitikhela mela" also called "Dalle Sarayen" is the famous gathering in the day of *Tritiya to Panchami* after *Bhaitika*. During this gathering lot of people from the whole district and beyond the district get collected in Chitikhola near Bijuwar. Similar gathering called *"raam"* locally occur in various places also during this one month from Dashain to Tihar at Khaira and Punya Khola. During this gathering, the famous *"Saraye Naach"* is danced with swords in the hands of young people. Thousands of people gather to see such dances. Similarly, other famous gatherings are *Khaira Fulbari Mela* and *Dakhaquadi Hikmateswor Mela*.

Newar communities in Khalanga and Bijuwar celebrate various feasts and festivals. *"Dhan Nach"* is one that is shown during Asar 15. *Gai Jatra* festival is also

celebrated here. *Lakhe Naach* is another famous dance of Bijuwar and Khalanga shown by Newar communities. Other feasts and festivals celebrated by Newar community in Khalanga are *Paltan Jatra* and *Ganesh Jatra* (celebrated in the week during Rishi Tarpani) , *Khar Jatra* (celebrated during Maghe Purnima).

Gurungs celebrate *Ghatu Nach.* Other famous dances in Pyuthan are *Purusunge Nach, Maruni Nach are Madikhole Nach.* Folk songs famous in Pyuthan are *Asare Git, Tij Git, Jhyaure, Bhailo and Dohoris* (DDC, 2066 BS).

Thus, Pyuthan is very rich in ethnic and cultural diversity.

CHAPTER-V

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

In this section, socio-demographic characteristics, viz. age, sex, class, religion, caste/ethnicity, educational status, marital status, employment status and occupational status of the family of the respondents were studied and the findings have been presented by means of different tables.

With the objective of finding out the service utilization and exploring the possible barriers for the sexual and reproductive health service utilization among adolescents, different variables were assessed quantitatively and qualitatively. The findings of the study are being presented here descriptively. Study findings are being presented in to two categories quantitative findings and qualitative findings. Only significant findings from the qualitative information are presented here with the quantitative findings wherever it is suitable as supporting findings of the quantitative data.

5.1 Distribution of Respondents by Age

In this study, adolescents from age 10 to 19 who were studying at the secondary schools were eligible in the study. The survey found that among 412 respondents, many of the respondents were of age 16 (24.8%) followed by age 15 (24.3%). The mean age of the respondents in this survey was 15.89.

Table 5.1: Distribution of Respondents by Age

Age of the respondents	Number (n=412)	Percent
12	5	1.2
13	6	1.5
14	59	14.3
15	100	24.3
16	102	24.8
17	80	19.4
18	48	11.7
19	12	2.9
Total	412	100

Source: Field Survey, 2015

5.2 Sex of the Respondents

Sex is one of the important aspects as it determines the gender role in the society. Students in this survey were selected as per the proportion of males and females in the sampling frame. So, there is almost equal proportion of males and females. In this study, out of total 412 students who participated in the study, males were 50.5% and females were 49.5%.

Table 5.2: Sex of the Respondents

Sex of the respondents	Number (n=412)	Percent
Male	208	50.5
Female	204	49.5
Total	412	100

Source: Field Survey, 2015

5.3 Ethnicity of the Respondents

The caste/ethnicity defines the social roles. Traditionally, due to the caste based social stratification, the lower caste people are found disadvantaged and have lower level of awareness as well as access to to education, health and economic resources.

Table 5.3: Ethnicity of the Respondents

Ethnicity of the respondents	Number (n=373)	Percent
Dalit	40	10.7
Janajati	113	30.3
Brahmin Chhetri	198	53.1
Others	22	5.9
Total	373	100

Source: Field Survey, 2015

In this study, only 373 of the total students responded to their ethnicity. Out of the total 373 respondents, about half of them (53.1%) were from higher castes Brahmin and Chhetri followed by different jannjati castes (30.3%). Only 10.3% of them were from Dalit castes. The data shows that majority number of students was from so called higher castes that are Brahmin Chhetri castes followed by Janajati castes. Only few are from Dalit castes. This finding was due to higher level enrollment and low

drop out of students among higher castes and lower enrollment and high drop out of students from Dalit castes as evident from the ethnicity disaggregated data provided by District Education Office (DEO, 2071 BS). The reason might be due to the multifaced effects of varying level of poverty, literacy, discrimination, social and economic conditions and differences between higher and lower castes since long time as evident in Nepali society.

5.4 Educational Status of the Respondents

The respondents were taken from secondary level (9-12), and thus distribution of the respondents by class may be important to know about the proportional representation.

As per the total proportion of sampling frame, the selected sampled population in this study also contains same proportion of students in class 9 to 12. In class 9 to 10, there were about 67.5 % students while in class 11 and 12, there were 32.5% of the total students. That is the proportion of students in class 9 and 10 to 11 and 12 is 2: 1. The highest number of students was from grade 10 that is about 40% of the total respondents followed by 28% from grade 9.

Table 5.4: Educational Status of the Respondents

Grade	Number (n=412)	Percent
9	114	27.7
10	164	39.8
11	71	17.2
12	63	15.3
Total	412	100

Source: Field Survey, 2015

5.5 Religion of the Respondents

Religion plays important roles in determining various social aspects. Many social beliefs and value systems have greatly been determined by religion.

Table 5.5: Distribution of Respondents by Religion

Religion	Number (n=412)	Percent
Hindu	406	98.5
Buddhist	3	0.7
Christian	3	0.7
Total	412	100

Source: Field Survey, 2015

In this study, among the total respondents, most of the students (98.5%) were Hindus followed by Buddhist and Christians each (0.7%). This finding is line with census data as the distribution of Hindus is the largest in Pyuthan (96.6%) followed by Buddhist (2.81%) and Muslims and Christians 0.26% and 0.24% respectively as evident from the census data (CBS, 2068 BS).

5.6 Permanent Residence of the Respondents

Place of residence is found to have great influence in belief system as varying level of education, awareness and service utilization could be found between the residents living in rural and urban areas.

Table 5.6: Permanent Residence of the Respondents

Address	Number (n=390)	Percent
Pyuthan Municipality	298	76.4
Outside Pyuthan Municipality	92	23.6
Total	390	100

Source: Field Survey, 2015

About three fourth (76.4%) of the respondents were from Pyuthan Municipality while about one fourth (23.6%) were from the villages outside Pyuthan municipality. That means majority respondents were from within the municipality area whereas about one fourth of them were from the other VDCs. The implications of urbanization might be lower in this study as Pyuthan municipality is a recently declared municipality. Except district headquarter and other few clusters where major city markets are located, most of the other parts within municipality area also are of rural setting and share almost similar degree of sociocultural environments as that of rural area.

5.7 Marital Status of the Respondents

Marital status has larger implications in the study of sexual and reproductive health service utilization. In the socio-cultural environments where sexual and reproductive health service utilization practice are mostly welcomed and acceptable after marriage, marital status of the respondents provides the idea about the proportion of population with varying level of service need for various components of sexual and reproductive health.

Table 5.7: Distribution of Respondents by Marital Status

Marital status of respondents	Number (n=409)	Percent
Unmarried	394	96.3
Married and living together	11	2.7
Married and living separately	2	0.5
Divorced	2	0.5
Total	409	100

Source: Field Survey, 2015

Only 409 of the respondents mentioned their marital status. Out of the total respondents, most of the students (96.3%) were unmarried. Only few (3.7%) were ever married. Among them, 2.7% were living together while 0.5% was divorced.

5.8 Age at Marriage

Among the total ever married respondents, only 12 of them revealed their age at marriage. The mean age at marriage was 16.3.

Table 5.8: Age at Marriage of ever married Respondents

Age at marriage of ever married respondents	Number (n=12)	Percent
10	1	8.3
15	2	16.7
16	1	8.3
17	4	33.3
18	4	33.3
Total	12	100

Source: Field Survey, 2015

5.9 Employment Status of the Respondents

Out of the total respondents, most of the students (96.6%) were not employed. However, only few (3.4%) were employed in addition to their regular study.

Table 5.9: Distribution of Respondents by Employment Status

Current employment status of the respondetnts	Number (n=412)	Percent
Not employed	398	96.6
Employed	14	3.4
Total	412	100

Source: Field Survey, 2015

5.10 Major Occupation of the Family

In this study, only 411 respondents revealed their family occupation. Among them, about half of the respondents (53.8%) had agriculture as their major family source of income. It was followed by service (22.6%) and business and daily wasges (8%) each. Considerable (6.8%) number of respondents had foreign employment as their major source of income.

Table 5.10: Major Source of Income of Family

Major source of income of family	Number (n= 411)	Percent
Agriculture	221	53.8
Service	93	22.6
Business	34	8.3
Daily wages	35	8.5
Foreign employment	28	6.8
Total	411	100

Source: Field Survey, 2015

CHAPTER-VI

KNOWLEDGE AND PERCEPTION TOWARDS SEXUAL AND REPRODUCTIVE HEALTH

This section helps to find out the information and knowledge about availability of services, prevailing misconceptions regarding the services availability and existing knowledge gap among respondents on sexual and reproductive health. Also, information from adolescents themselves on actual service utilization and about preferences and perceptions concerning sources is critical for helping determine the types of interventions and policies that could be implemented to improve adolescent sexual and reproductive health.

6.1 Source of Information about Sexual and Reproductive Health among the Respondents

From this study, it was found that the major sources of information and knowledge on Sexual and Reproductive Health (SRH) among respondents were school course curriculum (56.3%) followed by teacher (44.2%), health worker (41.5%) and radio and television (38.6%). Significant proportion of respondents has newspaper (9%) and mobile (7.8%) as their source of knowledge about sexual and reproductive health.

Table 6.1 : Source of Knowledge about SRH among the Respondents

Source of knowledge about SRH	Number (n=412)	Percent
Curriculum	232	56.3
Newspaper	37	9.0
Radio and television	159	38.6
Mobile	32	7.8
Peers education	103	25
Teacher	182	44.2
Health worker	171	41.5
Total	412	100

Source: Field Survey, 2015

The data shows that not less than one third of the students are using various sources of information in the society such as school coarse curriculum, radio and television, teachers and health workers as the day to day sources of information for sexual and reproductive health related messages. The number of students who get sexual reproductive health related messages through peers is also notable that is about one fourth. However, the data shows that the access of students to sources such as newpaper and mobile for health information is very low.

6.2 Perception of Respondents as Desired Source of Knowledge on Sexual and Reproductive health

More than one third (38.3%) of the respondents wanted health workers to provide information on reproductive health to them. About one fourth (26.5%) of the respondents desired sexual and reproductive health related information through radio and television while another one fourth (26%) wanted such information from peers. It was followed by curriculum (23.5%). Considerable proportion of respondents perceived teacher (15.8%) as desired source while only about 10% wanted such information through mobile phones.

Table 6.2: Perception of Students as effective Source of Knowledge

Desired source of knowledge about SRH	Number (n=412)	Percent
Curriculum	97	23.5
Newspaper	22	5.3
Radio and television	109	26.5
Mobile	42	10.2
Peers education	107	26
Teacher	65	15.8
Health worker	158	38.3
Total	412	100

Source: Field Survey, 2015

Thus, the data shows that health workers were the most prefered source of knowledge on sexual and reproductive health followed by radio television and peers. This information might be of much value while designing health education programs targeting adolescents in future. This evidence informs that health workers should be

mobilized more while providing targeted awareness programs to adolescents followed by information dissemination through radio and television as well as through the mobilization of peers.

6.3 Knowledge about Availability of Sexual Reproductive Health Services for Adolescents in Health Facilities

Only 409 of the samples responded to this querry and other 3 were non responses. Out of the total number of respondents, only about three fifth (57.9%) had adequate knowledge about the availability of different services for adolescents services while the rest more than one third (38.8%) of the respondents had only partial knowledge about the targeted sexual and reproductive health service components in the adolescent friendly service package for adolescents. About 3% of the respondents do not know about any available services.

Table 6.3: Knowledge about Availability of types of SRH Services

Knowledge about availability of SRH services in nearby health facility	**Number (n=409)**	**Percent**
Family planning	69	16.9
Antenatal Care	55	13.4
Safe abortion	17	4.2
Delivery Service	53	13
STI & HIV/AIDS	64	15.6
Menstural problems and counselling	88	21.5
Counselling and treatment of general health problems	73	17.8
General counselling	46	11.2
All of the above	237	57.9
Don't know	14	3.4
Total	409	100

Source: Field Survey, 2015

6.4 Knowledge about Availability of Adolescent Friendly Health Services

So as to assess the availability of knowledge of students on newly implemented adolescent friendly health service program being implemented by Ministry of Health and Population in in different government health facilities of the district, Pyuthan with the support of different partner agencies since 2012, questions were included about the knowledge of students regarding such health facilities.

Only 403 of the students respondend to this querry. Out of the total responses, about two third (65.5%) knew the availability of adolescent friendly services in nearby health facilities that were targeted services for adolescents. While, still about one third of the respondents (34.5%) do not know about the availability of provision of adolescent friendly services in health facilities which was basically designed for themselves so as to respond to the specific health needs of adolescents.

Table 6.4: Knowledge about Availability of Adolescent Friendly Health Services

Knowledge about availability of Adolescent Friendly Health Services	Number (n=403)	Percent
Yes	264	65.5
No	139	34.5
Total	403	100

Source: Field Survey, 2015

6.5 Knowledge about Place of Availability of Adolescent Friendly Sexual and Reproductive Health Services by type of Health Facility

Only 403 of the students' respondend to this querry related to knowledge about place of availability of adolescent friendly sexual and reproductive health services. Out of the total responses, about three fourth (78.9%) of them responded as government health facility as the adolescent friendly service centre and thus had correct knowledge about the site of availability of adolescent friendly health service. While the rest 29.3% did not have correct knowledge about such program. Among those who did not have correct knowledge, 26.3% had wrong knowledge about the service sites while 3% did not know anything.

Table 6.5: Knowledge about Availability of Adolescent Friendly Health Services by Type of Health Facility

Knowledge about availability of adolescent friendly health services by type of health facility	Number (n=403)	Percent
Government health facility	318	78.9
Private health facility	81	20.1
NGO	25	6.2
Do not know	12	3.0
Total	403	100

Source: Field Survey, 2015

6.6 Knowledge related Barriers in Sexual and Reproductive Health Service Utilization

From this survey, it was found that significant number of students (table 6.1) were found to be regularly getting sexual and reporductive health service related messages from the various day to day communication channels such as school coarse curriculum, teachers, health workers, peers etc of the society, But, still, there was gap in knowledge level especially on the availability of adolescent friendly service sites and sexual and reproductive health related services provided in these service sites.

As only about two third (65.5%) of the adolescents knew about the provision of availability of adolescent friendly service package in nearby health facilities, means, still one third of the population is out of the reach of the information regarding available package of services targeted to the specific need of this population. Similarly, as only about three fifth (57.8%) had adequate knowledge about all the available service components provided under SRH services, the data shows that there was gap in knowledge about information regarding service availability in health facilities. In the same way, as about four fifth of them (78.9%) expressed that the service was available at government health facilities, means, still 20% of the population were having misconceptions or false incorrect knowledge regarding the appropriate site of service delivery.

Thus, it can be concluded that though majority of the school adolescents had knowledge about the availability of adolescent friendly health services in health

facilities still significant proportion of the population did not have the access to information about the availability of service, about availability of various service components and correct knowledge about site of service delivery. Significant population had misconceptions and false knowledge. This finding suggests that knowledge related barriers existed among the population.

CHAPTER VII

SEXUAL REPRODUCTIVE HEALTH SERVICE UTILIZATION AND RELATED BARRIERS

The study also aims to explore the status of adolescent related service use among adolescents as well as the individual, health facility and socio cultural level factors associated with them. So, questions were asked about the use or non use of sexual and reproductive health services, the reasons for use and non use, types of services used and the perception of students on the quality of services provided to them. The findings are presented below with brief descriptions.

7.1 Ever used Sexual and Reproductive Health (SRH) Services from Health Facilities

Only 411 of the total sampled students responded to this question. Out of the total respondents, the survey found that about two third (69.3%) of the respondents had ever used SRH services while the rest about 31% had not used any sexual and reproductive health services related services from any type of health facilities.

Table 7.1: Ever used Sexual and Reproductive Health Services from Health Facilities

Ever used sexual and reproductive health services from health facilities	Number (n=411)	Percent
Yes	285	69.3
No	126	30.7
Total	411	100

Source: Field Survey, 2015

7.2 Reason for not using Sexual and Reproductive Health Services

Reasons for non use of sexual and reproductive health services were asked among the respondents. Among those respondents (126) who did not go to health facility to use sexual and reproductive health service, only 124 of them revealed the reason why they did not go to take the service.

Among them, while exploring the reason for non use of service, 56% of the respondents revealed that they did not feel any sexual and reproductive health related problem that needed counselling and treatment from health facility so they did not go to health facility. That means this 56% did not feel the need to go. That means rest of the 44% of 124 respondents had felt need but did not use the service due to various reasons.

Similarly, other reasons found for the non use were 23% of the respondents feeling shy to share such issues to health worker, 12% of the respondents feeling fear of others knowing such problems, about 7% of the respondents feeling lack of time to go to health facility while 6% of the total respondents depicted as lack of knowledge did not know about where the available services were so they did not go to health facilities to use the service.

Table 7.2: Reasons for not using Sexual Reproductive Health Services

Reason for not using sexual and reproductive health services	**Number (n=124)**	**Percent**
Did not feel need for any SRH related services from health facility	70	56
Shyness (*laaj*) and difficulty to share private things with health workers	28	23
Fear of others knowing private issues	15	12
Financial problems	2	1.6
Health facility being far	3	2.4
Lack of information	6	4.8
Lack of time	7	5.6
Others	5	4
Total	124	100

Source: Field Survey, 2015

Thus, from the above two tables, it is clear that significant percentage of adolescents who had need for sexual and reproductive health services but were not using the service due to various barriers such as shyness (*laaj*) and difficulty to share, fear of others knowing private issues, financial problems, inaccessibility of health facilities due to distance and lack of information along with various other reasons.

7.3 Type of Sexual Reproductive Health Services used last Time in Health Center

Only 260 of the respondents responded on this querry. Out of the total responses, about 30% of the respondents had been to adolescent sexual and reproductive health learning centre to read and collect adolescent related information. About 25% of the respondents had taken general health treatment and counselling services, 15% had taken treatment services for infections on genital parts, 15% had menstrual problems related counselling and treatment and 8% had taken family planning services from the health facility. About 3% of the respondents had taken abortion services while the proportion of respondents who had taken antenatal care was very low as there was very small proportion o married population..

Table 7.3: Type of Sexual Reproductive Health Services used last Time

Type of SRH services used last time in health facilities	Number (n=260)	Percent
Family Planning	23	8.1
Antenatal Care	3	1.1
Safe Abortion	8	2.8
Delivery Service	1	0.4
Treatment of the infections of the genital parts	44	15.5
Menstrual problems counseling and treatment	42	14.8
General health problems treatment and counselling services	70	24.6
Study in the adolescent learning centre of health facility	86	30.3
Others	7	2.5
Total	284	100

Source: Field Survey, 2015

Thus, from the table above, it was clear that mostly utilized service among students was use of adolescent health learning centre in health facility followed by general health check up and counselling. Other services used by notable proportion of students besides them were treatment of infections of genital parts, treatment of menstruation related problems and use of family planning service. The proportion of students using

abortion service was also notable though the sample had very few of the married adolescents.

7.4 Type of Health Facility where Reproductive Health Service was taken

Only 281 students mentioned the type of service delivery point where they have received the service last time. Out of the total respondents, majority (62%) had taken the sexual and reproductive health services from the government health facilities. There was significant number of service users from non government sector as well. That is about one fourth (27%) had taken the service from private sources followed by 6% who had taken such services from NGO clinics. While, 5% of them had taken services from other sources.

Table 7.4: Sexual Reproductive Health Service Use last Time by Type of Health Facility

Type of health facilility	Number (n=281)	Percent
Government	175	62.3
Private	75	26.7
NGO	17	6
Others	14	5
Total	281	100

Source: Field Survey, 2015

7.5 Satisfaction with the Service Received

Satisfaction status of respondents who used the service was assessed in order to find out whether the received service quality was as per the expectation of the service users so that there would be tendency to reuse the services.

Out of the total respondents, only 267 expressed their views over the satisfaction status. It was found that about 83% of the respondents expressed satisfaction to the service they had received which was quiet encouraging finding. However, about 17% of them did not find the available service as per their expectation.

Table 7.5: Satisfaction Status of Respondents on the Service used

Satisfied with the service used	Number (n=267)	Percent
Yes	221	82.8
No	46	17.2
Total	267	100

Source: Field Survey, 2015

7.6 Perceived Good aspects of Health Facility among Respondents who took Service

Only 181 students responded to this question and gave their views regarding good aspects of health facility. It was found that 22% of the respondents felt they got the desired information from the health facility about adolescents. While about 17% of the respondents felt the behaviour of health workers in the health facility was friendly and respectful. Similarly, 15% of the respondents felt the suggestions given by health workers as good aspect of health facility. Similarly, 14% of the respondents felt privacy as the reason for satisfaction in health facility while receiving the service. It was followed by the other views such as better service provided (10%), open interaction with health worker (6%) and got required medicine and supplies (5%).

Table 7.6: Perceived reasons for Satisfaction from Health Service Received

Reasons for satisfaction	Number (n=181)	Percent
Got adequate privacy/provision of privacy rights in health facility	25	14
Good behaviour of HW/dealt with respect and friendly manner	30	17
Got good suggestion	27	15
Provision of equal and friendly treatment to all in HF	5	2.8
Got required medicines and supplies free of cost	10	5.5
Got desired information on sexual and reproductive health of adolescents	40	22
Opportunity to directly share with HW/had open discussions	12	6.6
Got desired health service	18	9.9
Others	14	7.7
Total	181	100

Source: Field Survey, 2015

7.7 Perceived Reasons for Dissatisfaction for the Service Received from Health Facility

Under this section, potential barriers for health service utilization as experienced by the respondents were explored. There were only 45 responses regarding the dissatisfaction for the service received. The findings are presented below (table 7.7).

Table 7.7: Perceived Reasons for Dissatisfaction from the Service Received

Reasons for dissatisfaction	Number (n=45)	Percent
Unavailability of health worker in health facility	16	35.6
Misbehaviour by health worker	9	20
Lack of confidentiality in health facility	5	11.1
Difficulty to share private things with health worker openly	5	11.1
Health worker not taking seriously	9	20
Shyness *(Laaj)* and fear to share	4	8.9
Not getting the required medicines and commodity in health facility	10	22.2
Long waiting time to take service in health facility	4	8.9
Health facility opening time unsuitable	1	2.2
Not getting the required Information and Educational material in health facility	9	20
Total	45	100

Source: Field Survey, 2015

About one third (35.6%) of them felt the unavailability of health workers and (22%), not getting the desired medicines and supplies as the major source of dissatisfaction. Similarly, another one fifth (20%) did not feel the behaviour of health worker good and felt misbehaved. Similarly, other reasons felt by the respondents were health workers not taking seriously adolescents' issues (20%), and not getting the desired health information (20%). Other potential barriers explored were lack of confidentiality in health facility, shyness or fear, difficulty to open up and long waiting hours in health facility.

7.8 Waiting Time to receive Service in Health Facility

Prompt service is one of the indicators of quality service provided. The more is the waiting time, the more it creates barrier to service use resulting into lesser satisfaction among service users and less chances of coming back again to take the service.

Table 7.8: Waiting Time to receive Service in Health Facility

Waiting time taken (in minutes)	Number (n=214)	Percent
Less than 15 minutes	19	8.9
15-30 minutes	33	15.4
30-60 minutes	74	34.6
Greater than 60 minutes	88	41.1
Total	214	100.0

Source: Field Survey, 2015

In total, 214 respondents revealed the waiting time taken to receive the service from health facilities. The mean waiting time was found to be 59.6 minutes which was much higher than the government commitment to provide health service to all people within 30 minutes time. Only, about 9% of the respondents had required services within 15 minutes of time. While, about 50% respondents reported having waiting time more than 15 minutes and less than 60 minutes. And, about 41% of the respondents had waiting time more than 60 minutes.

7.9 Suitability of Health Facility Opening Time

Suitable health facility opening time leads to greater service utilization and vice versa. So, respondents were asked whether they felt their nearby health facility opening time was suitable to them or not.

Table 7.9: Suitability of Health Facility Opening Time to the Respondents

Suitability of health facility opening time	Number (n=278)	Percent
Yes	197	70.9
No	81	29.1
Total	278	100

Source: Field Survey, 2015

In this survey, it was found that about 71% (197) of the respondents told that the health facility opening time was suitable to them which was little bit unexpected finding. However, remaining 29% (81) of the respondents felt the health facility opening time was not suitable to them.

7.10 Perception of Respondents on Suitable Health Facility Opening Time

Generally schools open at 10 am in the morning and close at 4 pm in the afternoon. Similarly, government health facilities opening time is 10 am in the morning and 2 pm in the afternoon. Thus, the time to take the service by school students from such facilities overlaps with their school hours. So, the respondents were asked about their preferred health facility opening time.

Table 7.10: Suitable Health Facility Opening Time

Suitabile Health Facility Opening Time	Number (n=81)	Percent
10 -5	20	29
All the time (24 hours)	10	14
Morning hours before 10	5	7.1
Beyond office time in morning and evening	25	36
Saturdays and holidays	10	14
Total	70	100

Source: Field Survey, 2015

In this survey, only 81 of the respondents responded about the suitable opening time for health facility. It was found that about one third (36%) of the respondents wanted health facilities to be opened in the morning and evening hours beyond office time. Similarly, 29% of the respondents wanted health facilities to be opened till 5 in the evening. While 14 % of them wanted the health facilities to be opened 24 hrs a day. Similarly, another 14% wanted health facilities to be opened on Saturdays and holidays.

This view was supported by the participants in focus group discussion as well as by the key informant interviewees during indepth interviews.

CHAPTER VIII

FAMILY AND SOCIETY LEVEL BARRIERS IN SEXUAL AND REPRODUCTIVE HEALTH SERVICE UTILIZATION

Sexual and reproductive health related matter is a taboo in many societies and cultures. Individuals, families and societies hesitate to talk with each other and openly in such matters. Thus, such issues are not encouraged to share with each other and are not given concern in many traditional societies and cultures. This chapter explores such barriers in family, social and cultural level about the utilization of sexual and reproductive health.

8.1 Sharing Practices with Family

Family is a place where individual share their day to day knowledge, perceptions and experiences. Family provides a environment in which individuals share their problems with each other, discuss, interact and find a way out for the solution. Such interactions provide emotional attachment as well as sense of security and satisfaction with each other among family members. Many problems are solved at the family level itself.

8.1.1 Sharing of Sexual and Reproductive Health Related Problems

In this survey, out of the total 370 responses on this querry, majority of them (56.2%) did not share their sexual and reproductive health problems with their family. Only about 43% of the respondents shared their sexual and reproductive health problems with family.

Table 8.1: Sharing of Sexual and Reproductive Health Related Problems

Shared with family	Number (n=370)	Percent
Yes	162	43.8
No	208	56.2
Total	370	100

Source: Field Survey, 2015

The findings suggest that less than half of the adolescent had practices of sharing their sexual and reproductive health related problems with their family. So, still more than

half of them hesitated to share such issues with their family. It means as adolescence is a highly vulnerable period with multiple risk behaviour, not sharing with family means there was likelihood of lacking proper guidance and support from family in matters of health and well being of them. Such practice could provide risk for negative sexual and reproductive health behaviour. The large proportion of adolescents not sharing their problems with their family might be due to traditional cultural patterns and misconceptions existing in traditional society where issues related to sex were taboo and forbidden things to talk with each other.

8.1.2 Sharing of Sexual and Reproductive Health Problems with Family Members

Out of the total respondents who shared their problems with their family, 145 respondend the person to whom they have shared the problems.

Table 8.2: Person Shared Sexual and Reproductive Health Problems Last Time

Person shared SRH problems last time	Number	Percent
Parents (Father or mother)	111	76.6
Siblings (brothers or sisters)	34	23.4
Total	145	100

Source: Field Survey, 2015

It was found that; majority 111 (76%) of the respondents shared their problems with parents while only 34 (23%) of the respondents shared their problems with brothers and sisters. This data showed that even though the proportion of population who shared their sexual and reproductive health related problems with family was less, the good practice found among them was that the majority of them directly shared their problems with their parents. These finding show, significant number of adolescents of today's generation living in neo-urban areas have encouraging practices of sharing their problems with their families.

8.1.3 Reasons for not Sharing Sexual and Reproductive Health Related Problems with Family

Reason for not sharing the sexual and reproductive health problems with family was explored among those who did not share with their family members. Only 137 of them responded. Out of them, 51% of the respondents felt that they did not have such

problems till now. While, 18% shared that they shared it with female community health volunteers and health workers but did not share with family. About 18% expressed that they consulted friends for easiness. About 3% of the respondents felt that family was not conducive and positive to them to talk for such problems.

Table 8.3: Perceived Barriers to share SRH Related Problem with Family

Barriers in problem sharing	**Number (n=137)**	**Percent**
Shyness (*Laaj)*	20	15
SRH related problem not occuring till now	70	51
Got sharing with health workers/female community heath volunteers	25	18
Difficult to share with family, consulted friends for easiness	25	18
Family do not listen and understand so no need to share	4	2.9
Being away from home	6	4.4
Others	5	3.6
Total	137	100

Source: Field Survey, 2015

Thus, the major perceived barriers seen among those who actually felt the problem were of psychological nature especially inability to express the sexual reproductive issues due to shyness and difficulty to share with family due to traditional family and cultural norms. Similarly, the data also revealed that family was also hesitating to openly talk such issues with their children.

Majority of the adolescents in focus group discussion as well did not share their problems at first with their families. The reasons provided were factors such as socio-cultural unacceptance, lack of concern of family on such issues, shyness to share and friends being the easier option to talk on sexual and reproductive health. First of all, most of them shared it with friends. However, practice of sharing menstruation related problems were found among girls with their family members especially mothers or sisters. It was found that most boys did not talk such issues with family.

Key informants also accepted the larger gap between parents and children regarding their knowledge and perception on sexual and reproductive health. This gap has remained the major and key barrier in the utilization of sexual and reproductive health services. Lack of sharing practices between parents and children on sexual

reproductive health was found as a major barrier during both key informant interviews as well as focus group discussions. Still, parents hesitate to inform as well as counsel their children on such issues due to the deeply rooted underlying socio-cultural norms and values. However, among certain portion of educated urban parents, healthy practice of sharing with each other was also found during discussion sessions.

8.2 Family Involvement while accessing the Service

This variable wanted to study the level of support the respondents received from someone nearer to them in the family or from outside the family while accessing sexual and reproductive health related information and service.

Table 8.4: Accompanied or not while taking the service Last time

Accompanied or not	Number (n=238)	Percent
Yes	140	58.8
No	98	41.2
Total	238	100

Source: Field Survey, 2015

Table 8.5: Person who accompanied the Respondent while going to Health Facility

Person who accompanied	Number (n=140)	Percent
Parents (Father or mother)	21	15
husband or wife	5	3.6
friends	108	77.1
other family members	3	2.1
others	3	2.1
Total	140	100

Source: Field Survey, 2015

It was explored whether the respondent was supported by anyone while receiving sexual and reproductive health related services. In total, 238 respondents responded to this question. It was found that about 59% were accompanied while taking the health services by someone nearer to them. While, 41% of them were not accompanied by anyone and had gone to receive health service alone. Only 140 of them responded the person who accompanied them while receiving the service. About 77% told that they

went to health facility with friends. Only as high as 20% of them went with their parents.

Thus, the findings suggest that, there was less degree of involvement of family to receive sexual reproductive health service. So, such practice was likely to contribute to the risk of negative results due to a bad company. This data shows that the low degree of sharing practice with family followed by low degree of family support and involvement in the sexual and reproductive health utilization issues of adolescents.

8.3 Perceived Barriers faced by Respondents in the Society while going to Health Facility or during receiving Treatment in Health Facility

In total, 304 students responded to this question. About one third (37%) felt difficulty to express sexual and reproductive health problems with health workers of opposite sex. Similarly, about one fourth (24%) of the respondents felt ashamed of in front of health workers to express their problems. About 16% felt misbehaved in the health facility, 13% had fear of other people knowing about their problems and taking negative of them. While 13% felt lack of privacy in helath facility. About 9% also feared of health worker sharing their private issues with other people.

Table 8.6: Problems faced while receiving Sexual and Reproductive Health Service from Health Faclity

Types of problems faced	Number (n=304)	Percent
Fear of family knowing	16	5.3
Fear of other people knowing or thinking negatively	41	13.5
Fear of health worker sharing private things with other people	27	8.9
laaj with health worker	72	23.7
Difficult to share sexual problems with health worker of opposite sex	114	37.4
Misbehavior by health worker in health facility	48	15.8
Lack of privacy in health facility	39	12.8
Others	18	5.9
Total	304	100

Source: Field Survey, 2015

Thus the finding shows that most of the problems faced are of psychological origin and related to social norms and beliefs on sex and reproduction.

8.4 Ever felt Discrimination in Health Facility while taking Service based on Sex or Caste

In total, 359 respondents answered to this question. Among them, 89% did not feel any type discrimination in health facility while receiving health service. However, 11% felt some type of discrimination in health facility based on sex or caste. The data showed that there was still significant discrimination in health facility based on gender and caste.

Table 8.7: Ever felt Discrimination in Health Facility based on Sex or Caste

Ever felt discrimination in health facility	Number (n=359)	Percent
Yes	40	11.1
No	319	88.9
Total	359	100

Source: Field Survey, 2015

From this evidence, we may hypothesize that discrimination based in social stratification by sex and caste is existent in health service institutions as well among the educated professional people which might have its roots in the deep social and cultural belief systems of society.

8.5 Suggestions for Better Sexual and Reproductive Health Services for Adolescents

At the end of the survey, way out for making sexual and reproductive health services better was asked among the targed respondents. Out of total 290 responses, about one fourth (26%) of the respondents suggested for the provision of separate male and female health workers in health facility for counselling and treatment purpose. Similarly, 12% of them suggested for regular health education sessions in school by health workers. About 10% expressed need for village focussed awareness programms so as to change the deep rooted traditional cultural misconceptions and attitude of community people towards sexual and reproductive health. About 8% each

demanded for privacy in health facility. Other 8% suggested establishing more adolescent friendly health facilities at the community level. Some 7% of the respondents demanded for the availability of service providers of young age having similar thinking to them with whom they can freely share their problems. Other suggestions received are given below in the table.

Table 8.8 : Suggestions for better sexual and reproductive health services

Suggestions	**Number (n= 290)**	**Percent**
Equal treatment to all without discrimination	9	3
Regular school health education on SRH by health workers	36	12
Create environment without laaj and fear for better service utilization	15	5
More adolescent friendly service at many places	23	8
Friendly and supportive behaviour of HWs	21	7
SRH information education through media	15	5
Provision of male and female health workers for male and females	75	26
More awareness programs on SRH at community/society level	30	10
Train volunteers to support adolescents	3	1
Keep privacy in health facility	22	8
Provision of adequate medicine and supplies in health facility	9	3
Habit of sharing problems and going to HFs	6	2
adolescent friendly clinics in separate days	7	2
Provide condoms freely	8	3
Provision of service from equal friends	19	7
Form child clubs and provide information	4	1
System for providing information through mobile	13	4
Train at least one teacher in each school for adolescent information	9	3
Others	36	12
Total	15	5

Source: Field Survey, 2015

Thus, majorities strongly advocated for gender friendly health services with specific request for provisions of female health service providers as counsellors, health educators as well as treatment providers. Some major suggestions among other many were to conduct regular health education classes in school as well as in community, expansion of adolescent targeted health services and information centres into communities and provision of young adolescents and club members as health educators and change agents.

8.6 Case Studies

The researcher carried out case studies with randomly selected ten participants. Five of them have been presented here in the boxes. They have been presented because of the uniqueness in their stories.

Case 01

Case Study of Rita

Gender Friendly Health Services

I am Rita (name changed) Pokhrel, a 15 years old girl from Dakhaquadi VDC of Pyuthan. Three months ago, I had menstruation related problems. I had repeated bleedings and lower abdominial pain. At first, I did not share with anyone. Later, I shared it with my friends. One day, we went to a nearby health facility to check up for the problem. I got checked by a male "doctor" there. Though there was a separate room for check up, I could not tell all the things to the doctor openly because I felt shy. The doctor listened to me and prescribed medicines. Such problems had occurred to me earlier as well. So, I actually wanted to ask the reasons behind it in detail. I wanted to ask the health service provider more about it. However, I did not feel easier to talk in detail. So, I left the facility as soon as the doctor prescribed the medicine. But my querries remained as it were. So, even though I got the medicine, I did not get satisfied with the health service provider. If there was a female doctor, I would have learned more about it. So, a female doctor should be available at health facility all the time.

Case 02

Case Study of Subin

Need For A Young Service Provider in Health Facility

Subin (name changed) Shrestha was from Khalanga, 15 years old male. He lived with his parents and a sister in the district headquarters Khalaga. He had a habit of doing masturbation quiet often. He was very much worried with this habit of him as his friends told him that regular masturbation would make his genitals curved and he will be weak after all. Hearing such things in the school made him worried but he could not give up the habit easily even though he said he tried a lot. He did not know whom to consult. Finally, one day, by collecting strength, he went to the nearby hospital (PHCC) and met a male health service provider there. The health worker was a man of his fathers' age. After he went to the OPD room, he could not say his problems to him. Anxiously, he told him that he was having a headache and needed cetamol. The "doctor" quickly gave him cetamol and he ran away from there. With this type of problem, he could not consult anyone except friends who kept on saying many things to him. He finally got his problems solved after few weeks when he met a young peer educator working in a local NGO. The peer educator explained him that such feeling among adolescents is normal and a part of physical, mental and psychological changes during adolescence.

Thus, he now thinks that if there would have been provision of a young service provider similar to his age, it would have been quiet easier to him to share such problems.

Case 03

Case Study of Aashish

Health Facility Opening Time is Not Suitable

I am Aashish (name changed) Acharya, a 17 years male, from Khaira, Pyuthan. I am now studying in class 10. I am also a trained peer educator. I support my friends whenever they have such problems. I have time and again discussed with my friends on such issues. Friends listen to me interestingly when I share sexual and reproductive health related issues to them. I have told friends to go to the adolescent learning centre in the nearby sub health post. However, we are not satisfied with the health facility opening time. We have to come to the school at 10 AM and school leaves at 4 PM. Exactly what happens is the health post opens at 10 am in the morning and closes at 2 PM. In between these hours also, the classes are tight. So, the only available time to us is during the break times. That small break time is not sufficient to go to the health post, share our problems to the health workers and get counseling and treatment. At the same time, there are other patients as well. So, we have to wait to get our turn. The health facility opening hours do not match to us. So, we want the use of adolescent friendly service if the time is not suitable to us. In my view, the clinic should open on either Fridays till late ours or during the holiday time. Many of the friends (adolescents) have not been there due to lack of time. So, the time needs to be adjusted at first to make this program better.

Case 4

Case Study of Sub Health Post Incharge

Lack of Communication between Parents and Adolescents on Sexual and Reproductive Health is a key problem

I am Prakash Shrestha, incharge of Khaira SHP. Adolescent Friendly Health Service is running in Khaira Health Post. We have separate room for counseling; all the staffs in our sub health are trained on adolescent sexual and reproductive health. Regarding the health services provided, the sub health post has provided all the services under sexual and reproductive health guideline except safe abortion. We have tried our best to make the facility adolescent friendly. However, still, I am not satisfied with this. Actually, we have decided and minuted to conduct adolescent clinic every Friday after 1 PM. However, this has not come into implementation level during various problems.

About 40% of the patients of the sub health post are adolescents. Adolescents do rarely come with their parents for taking the service. Mostly they come in groups and they stay for a short time period. This group is very mobile, very unstable and difficult to retain in health facility. One reason is that the health facility opening time is not suitable to them. They utilize their breaks for coming here. They do not stay here as long as 15 minutes as well. So, it's very difficult for this group to retain here, to counsel on their health problems, to prepare them to open up. They come in a hurry and go in a very short time. There is one legal problem associated with them. They share their issues with us. We counsel and provide solutions.We know what happened to them. However, in what track their children are going is not known to their parents. Neither can we tell them (parents). Actually the problem is here. This gap (between parents and children) needs to be broken if we are trying to improve adolescent sexual and reproductive health. Untill and unless, the community, the society does not start from their level, the actual problem is not going to be addressed. If any NGO or government takes programs with them, the community perceives it not as a program for them, but as a program for the outsider and they only have attention on money. So, so as to address the barriers, first of all, the gap in understanding between parents and children should be broken. Envioronment should be created to facilitate discussions between them. Health worker should be allowed to share the positive feedbacks to parents if something is found problematic during counseling these adolescents in health facilities.

Case 5

Case Study of Sunita

Family is Very Conservative on Sexual and Reproductive Health issues

I am Sunita (name changed) Pun, 19 years old, from a nearby village Jumrikanda VDC. I study in class 11 in education faculty. We have three sisters and two brothers. My parents stay in the nearby village. They are not educated and work in the agriculture. Rest of the time they work for daily wages.

The health facility is far away from our locality about 2 hours distance. So, it is better to come to Bijuwar in district hospital. I have heard about adolescent friendly health service being available at health facility in the school during health education classes from teachers. Sometimes, "doctors" from hospital come and take classes. We are hearing about it from various sources. The service is available at health posts. But I have not been to them till now. The reason is shyness. I don't talk such things even with my parents. I sometimes talk with sisters and most of the time talks with friends. The reason why I don't talk with the parents is they do not give much attention to it. They do not take it seriously. They are illiterate, conservative and do not know about it. They hesitate to talk on such issues. We feel shame to talk on sexual issues. We have never done so. I sometimes share my menstrual related problems with mother and sister. But, talking about such things is very difficult. It is taken as unpleasant and negatively. We have to share it with them. But, we feel very shy. Also, they (parents) don't want to discuss. Here as we are of same age, we can talk on such issues. But, we can't talk in front of our brothers and parents. Many times, we share issues with friends. Female doctors available for health education would be so easy to understand as well as to question. But, with male doctors, the problem is similar. The health post should make trained female doctors available for health education classes as well as for regular check up.

CHAPTER IX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

9.1 Summary

The major objective of this study was to find out the barriers at individual, social and health facility levels for the utilization of sexual and reproductive health services among adolescent school students. The specific objectives were to explore the socio demographic variables, knowledge and perception related to sexual and reproductive health service use, service utilization practice; individual, social and health service related reasons for use and non use of health services and explore way out for further steps towards making the services more adolescent friendly and effective.

The study area was Pyuthan municipality. Study design was cross sectional descriptive study. Study type was mainly quantitative supplemented by qualitative studies. The sampling technique used for selecting district and municipality was purposive while three schools were chosed randomly. Students studying in classes 9 to 12 were selected randomly and proportionately as per their sex and class composition. Data collection technique used were self admininstered questionnaire, key informant interview, focus group discussions, observations and case studies.

This study documented and explored key findings in sexual and reproductive health service utilization. The mean age of the students involved in this study was 15.89. There was almost equal proportion of male (50.5%) and females (49.5%) in the total population selected for the study. More than half of them (53.1%) were from Brahmin and Chhetri castes followed by Janajati castes (30.3%) and Dalits (10.3%). The proportion of students selected in class 9 to 10 and 11 to 12 was almost equal to 2:1. Almost all of them (98.5%) were Hindus by religion. About three fourth (76.4%) of the respondents were from Pyuthan Municipality. Out of the total respondents, most of the students (96.3%) were unmarried and not employed (96.6%). About half of the respondents (53.8%) had agriculture as their major family source of income.

Regarding knowledge related variables, it was found that the major sources of information and knowledge on SRH among respondents were curriculum (56.3%) followed by teacher (44.2%), health worker (41.5%) and radio and television (38.6%). The data shows that students were receiving SRH related messages from the major day to day common sources of the society. The data also shows that among adolescents, health workers were the first preference (38.3%) as source of knowledge about SRH followed by radio television (26.5%) and peers (26%). Out of the 409 respondents, only about three fifth (57.8%) had correct knowledge about the availability of different services for adolescents under SRH services. Out of the 403 responses, about two third (65.5%) knew about the provision of availability of adolescent friendly services in nearby health facilities and while about three fourth of them (78.9%) expressed that the service might be available at government health facilities and were correct to their knowledge.

While trying to explore the service use in the health facility, the survey found that about two third (69.3%) of the respondents had ever used SRH services. While the rest about 31% had not used any sexual and reproductive health related services from any type of health facilities till now. Among those respondents who did not go to health facility to use sexual and reproductive health service till now, 56% of the respondents revealed that they did not feel any sexual and reproductive health related problem so they did not have need for it. While the rest 23% of the respondents among those who did not go to the health facility to use service felt ashamed to share with health worker and rest 12% of the respondents felt fear of others knowing such problems if they shared it with anyone. The data shows that significant percentage of adolescents who had need for sexual and reproductive health services were not using the service due to various barriers such as shyness (*laaj)*, difficulty to open up, fear, financial problems, and inaccessibility of health facilities and lack of information along with other reasons. Among the respondents who felt dissatisfaction for the service, about one third (35.6%) of them felt the unavailability of health worker as the major source of dissatisfaction. Similarly, another one fifth (20%) did not feel the behaviour of health worker good and felt misbehaved. Similarly other reasons felt were health workers not taking seriously their issues (20%), not getting the desired medicines and supplies in health facility (20%) and not getting the desired health information at health facility (20%). The other potential barriers explored were lack of

confidentiality, shyness or fear, difficulty to open up and long waiting hours in health facility.

In this survey, the mean waiting time was found to be 59.6 minutes which was much higher compared to the government commitment to provide health service to all people within 30 minutes time. Here, 29% of the respondents felt the health facility opening time was not suitable to them. The major reason was the overlap between school opening hours and health facility opening hours. This finding was supported from FGD as well as key informant interview.

Out of the total 370 responses, majority of them (56.2%) did not share their sexual and reproductive health problems with their family during the last time when they felt SRH related problem. This shows the traditional cultural patterns and misconceptions of Nepali society related to sex as taboo and forbidden things to talk with each other within family. While exploring the level of family support while receiving treatment, about 77% told that they went to health facility with friends and only as high as 20% of them went with their parents. The findings show that the sharing practice with family is low and not encouraging.

The study also tried to explore the perceived barriers for service utilization for adolescents at individual, family and community level both from survey and qualitative data. The findings suggest that about one third (37%) felt difficulty to express sexual and reproductive health related problems with health workers of opposite sex. Similarly, about one fourth (24%) of the respondents felt embarrassed in front of health workers to express their problems. About 16% felt misbehaved in the health facility, 13% had fear of other people knowing about their problems and taking negative of them. While 13% felt lack of privacy in helath facility. About 9% also feared of health worker sharing their private issues with other people. Thus, it shows that most of the problems faced were of psychological origin related to social norms and beliefs on sex and reproduction. Similarly, while exploring sex and caste based discrimination in health facility, 11% still felt some type of discrimination in health facility based on sex or caste which is challenging barrier for better service utilization.

At the end of the survey, way out for making sexual and reproductive health services better was asked among the targeted respondents. Comparatively large number of

suggestions came in favour of gender friendly health services with specific request for provisions of female health service providers as counsellors, as health educators as well as treatment providers. Some major suggestions among other many were making arrangements for regular health education classes in school, health education and trainings to community people, expansion of adolescent targeted health services and information centres into communities, provision of young adolescents and club members as health educators and change agents. Out of total 290 responses, about one fourth (26%) of the respondents suggested for the provision of separate male and female health workers in health facility for counselling and treatment purpose. Similarly, 12% of them suggested for regular health education sessions in school by health workers. About 10% expressed need for village focussed awareness programms so as to change the deep rooted traditional cultural misconceptions and attitude of community people towards sexual and reproductive health. About 8% each demanded for privacy in health facility. Other 8% suggested establishing more adolescent friendly health facilities at the community level. Some 7% of the respondents demanded for service provider of young age having similar thinking to them with which they can freely share their problems.

Now let's consider the linkage of the findings with the theortical framework on which this study is based. This study was based on the Anderson and Newman's framework for health service utilization. The evidence generated in the study found that predisposing factors related with societal determinants such as social norms, belief systems, family perception towards sexual and reproductive health were found having deeply linked with service utilization. Similarly, predisposing factors related with individual determinants such as perceived need for service by respondents, respondent's health beliefs including knowledge towards sexual and reproductive health service was also found associated with health service utilization which is also a component that is individual determinant in the model. However, barriers related to psychological origin that were found to be less focused in the Anderson and Newman model such as fear, hesitation, shyness and difficulties in communication of the health problems were also found linked with health service utilization.

Similarly, sharing practices with family , family support and involvement in the counseling and treatment process termed as enabling factors in the model were also

found having linkages with health service utilization. However, economic factors such as income (that were termed as enabling factors and found linked with health service utilization in that framework) were not relevant in this study as most sexual and reproductive health services targeted for the adolescents were free of cost in nearby government health facilities.

Similarly, health system related factors termed as enabling factors in the original framework such as availability of health workers and facilities, gender friendly health services, behavior of health worker, confidentiality in health facility, misbehavior and discrimination in health facility, health facility opening hours and waiting time to take the service were also found associated with health service utilization in this study.

Thus, most of the findings in this study are in accordance with the theoretical framework proposed by Anderson and Newman. These factors have been explained in the framework under predisposing, enabling and need factors in the model. As psychological factors of individuals were given less importance in the framework, these were found much more linked with health service utilization in this study.

9.2 Conclusion

The findings suggest that only two third of the adolescents are aware of targeted adolescent sexual and reproductive health services being available to them free of cost in government health facilities in Pyuthan Municipality. So, there is knowledge gap to rest one third adolescents about a specifically target service package basically designed to address the health needs of this vulnerable population. This might be one important barrier to service utilization and one important issue to be addressed by health education and awareness programs.

Regarding the findings related to service utilization, about two third had ever used sexual and reproductive health services. Among those who had not used the service, 44% had need for service but are unable to use it due to various barriers. This shows that, though the service has covered majority of the targeted populations, there is still need to reduce various psychological barriers so as to increase service utilization.

The major barriers explored for non utilization of health services were of psychological origin that is feeling of shamed off to share sexual and reproductive health related issues to health workers and feeling of fear of others knowing it.

Service quality related barriers in health instititution were unavailability of health worker in health facility, feeling of misbehaved and discriminated by health worker, not getting the desired medicines and supplies and not getting the desired health information. Likewise, other potential barriers explored were lack of confidentiality in health facility, laaj or fear, difficulty to open up to health workers, unsuitable health facility opening hours and long waiting hours in health facility.

Barriers found at the family and society was also explored in this survey. The key barriers found at family level were shyness (*laaj)* to express with family members about sexual reproductive health issues, less family concern and encouragement to talk and share on such issues and easiness to talk with friends, health workers or female community health volunteers in comparision with family members. Similarly, barriers found at societal level were fear of others knowing about personal SRH problems, difficulty to share and present personal problems with health workers of opposite sex, misbehavior and caste sex based discrimination at health facility by health workers and lack of confidentiality arrangements in health facilities.

9.3 Recommendation

Based on the study findings, recommendations could be given to various stakeholders to respond to various barriers among this group of population such as district and village health authorities, schools, local bodies and community people including guardians themselves.

- Provide education and interaction classes focussing adolescents at regular intervals at school level to reduce deeply rooted psychological barriers.
- District health office and concerned health facilities should strictly implement the provisions mentioned in adolescent friendly health service guideline to make the health facility adolescent friendly. More specifically, health authorities and other responsible partners working in this sector need to train and make available at least one female health service provider in health facility to provide adolescent

sexual and reproductive health counselling and treatment services to make it gender friendly.

- In response to much more privacy concern of students in health facility, there should be separate counseling and treatment room in health facilities for adolescents.

- Similarly, at family and community level, to reduce the gap between adolescents and their gudardians, stakeholders (in coordination with social organizations such as child clubs, women's groups, teachers, social workers and health volunteers) should organize regular interaction programmes sitting together and talking freely about the sexual and reproductive health problems of adolescents and probable solutions to address them

9.4 Directions for Future Research

It was found that much research has been done at the health system level and targeted interventions programs were also going on mainly to address the health facility level barriers. Similarly, the study also found that, at individual level, psychological factors such as fear, shyness, hesitation and difficulties in communication were the common barriers among others which had its roots in socio-cultural norms and health beliefs related to sexual health. Current intervention programs were at health facility (chiefly through counselling and treatment services) and school level (through reproductive health education programs via different sources). However, during the coarse of this study, the very important dimension; the social dimension of this problem, that is the guardians, the families, the community, the social networks and the societal organizations have found to be poorly reached or no reached at all through current intervention programs. But this level was found to be that base of all the barriers which contributed to the root causes of inadequate sexual and reproductive health services utilization, that is the fear, the shyness, the lack of communication between generations, the lack of concern and the lack of openness on sexual and reproductive health issues as well as the misleading traditional beliefs and the taboos related with sexual health, that were deeply rooted under the brains community people.

So, it is recommended to carry out further research on community and social barriers. It is also suggested that studies in future explore innovative intervention modalities to address the community and social level barriers that adolescents are facing at the true social settings. Such studies would then be helpful in designing innovative socio-culturally acceptable intervention models to promote sexual and reproductive health service utilization in future.

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Annex I

SELF ADMINISTERED QUESTIONNAIRE

Name of the School: Address of School:

Date of Data Collection:

I. Socio-Demographic Variables

S.N.	Questions	Possible Responses	Code	Skip Questions
1.	Sex	Male female	1 2	
2.	Age of the respondent	..... Years		
3.	Ethnicity	Dalit Janajati Madhesi Muslim Brahmin Chhetri Others	1 2 3 4 5 6	
4.	Educational Status	Grade.....(now studying)		
5.	Religion	Hindu Bouddha Islam Christian Others (Specify).....	1 2 3 4	
6.	Permanent residence	.....		
7.	Marital Status	Single Married Separated Divorced widowed	1 2 3 4 5	
8.	If married, age at marriage	.....(Specify)		
9.	Are you employed	Not employed Employed Others (Specify).....	1 2	If not employed, go to Q 11
10.	Major source of family income	Agriculture service Business Daily Wages Foreign employment Others (specify).....	1 2 3 4 5	

Part II: Knowledge and Perceptions of adolescents towards Sexual and Reproductive Health

S. N.	Questions	Possible Responses	Coding	Skip questions
11	Source of information about sexual and reproductive health	Class curriculum Newpapers Radio and television Mobile Peer education Teacher Health worker Others	1 2 3 4 5 6 7	
12	Desired source of information for sexual and reproductive health in future	Class curriculum Newpapers Radio and television Mobile Peer education Teacher Health worker Others	1 2 3 4 5 6 7	
13	Do you know specific health services are being provided for Adolescents under the name Adolescent Friendly Health Services?	Yes No	1 2	
14	Which of the following Sexual and Reproductive Health Services are provided in health facilities for the Adolescents?	Family Planning Antenatal Care Safe Abortion Service Institutional Delivery Infection of the Genitals, RTI and HIV/AIDS Mensuration related problems General Health Check up Counselling All of the above Other (specify).....	1 2 3 4 5 6 7 8 9	
15	What type of facility is providing Sexual and Reproductive Health Services targeted for adolescents?	Government institutions (Distirct Hospital/PHCC/HP/ SHP) Private Health Facilities NGO Do not Know Other (specify).....	1 2 3 4	

16	Have you ever been to your nearby health facility to take adolescent sexual and reproductive health related service or information?	Yes No	1 2	If yes, go to 19
17	If not ever been there, what is the probable reason for not going to health facility ?	.....		Go to Q 26
18	Which service did you receive there the last time when you have been there?	Family Planning Antenatal Care, Iron tablet and TT immunization Safe Abortion Service Delivery Service Reproductive Tract Infection Mensuration related problems General Health Check up and Counselling Take information in the adolescent heatlh learning centre All of the above Other (specify).....	1 2 3 4 5 6 7 8 9	
19.	Where did you receive that service?	Government institutions (Distirct Hospital/PHCC/HP/ SHP) PrivateHealth Facilities NGO Do not Know Other (specify).....	1 2 3 4	
20	Were you satisfied with the service	Yes No	1 2	If no, go to Q 22
21	Reason for satisfaction if satisfied	.....		

22	If not satisfied, what is the reason?	1) The desired service provider was not available at the HF 2) Health worker did not behave well with me 3) Lack of confidentiality in health facilities 4) I could not share my problem openly with the service provider 5) The service provider did not adequately respond to my problem 6) I felt shy to share my private issues 7) I could not get medicines and other necessary supplies in health facilities 8) Not getting the required health information in health facility 9) Long waiting hours in the health facility to take service 10) Health facility opening time unsuitable	1 2 3 4 5 6 7 8 9 10	
23	How much time did it take to receive service in health facility	.....minutes		
24	Is the nearby health facility opening hour suitable to you?	Yes No	1 2	If yes, go to Q 26
25	If not, what might be the suitable opening hour?	.....		

Part IV : Family and society related barriers associated with Sexual and Reproductive health Services

26	Did you share with any of the family members when you had any of the following problems related with sexual and reproductive health? (Family Planning, Antenatal Care, Iron tablet and Tetanus Toxoid Immunization, Safe Abortion Service, Delivery Service Reproductive Tract Infection Mensuration related problems, General Health Check up and Counselling)	Yes No	1 2	If no, go to 28
27	If shared with any of the family members, whom did you share with?	**.....**		
28	If not shared with anyone, what was the reason ?	**.....**		
29	Did anyone accompany you the last time you went to health facility to take the service?	Yes No	1 2	**If no, go to 31**
30	If Yes, who accompanied you to the health facility ?	**.....**		
31	What type of problems do you usually face when you need to go to health facility for the consultation treatment of sexual and reproductive health problems?	**.....**		
32	Did you ever felt discrimination in health facility based on gender or caste while taking the service?	Yes No	1 2	
33	What suggestion do you give for the better sexual and reproductive health services to adolescents ?	.....		

Annex II

FGD GUIDELINES

Hello, Namaskar. You are requested to participate in the Focus group discussion as a respondent.I (MA student from Prithvi Narayan Multiple Campus, Pokhara) am conducting a study about **'Utilization of Sexual and Reproductive Health Services among Adolescent School Students in Pyuthan District of Mid Western Nepal '**. I would appreciate your participation very much in this study. It will take about 45 minutes to complete the conversation. All of the answers that you give will be confidential. Participation in the survey is voluntary. If any issue comes to you that you don't want to speak, you can enjoy your freedom or you can stop process at any time. However, I hope you will participate in the study since your views and opinions are important for this study.

Guidelines for the discussion

- Introduction and objective sharing by the researcher
- Basic background information of the participants
- Knowledge about the availability of sexual and reproductive health services provided in the health facilities
- Why specific health services are needed to be provided to adolescents?
- What is meant by adolescent friendly health services?
- Have you ever used Sexual and reproductive health services?
- Details about the service used last time: type of health facility, type of service use
- Views about received health service and its quality: behaviour of health workers, quality of service received, satisfaction from the service, confidentiality, waiting time, distance
- Interesting,/unforgettable /unique experiences that you want to share while occurring sexual reproductive health related problems and service utilization
- Barriers related to service use (Probe)
  - **Difficulties and problems faced at individual level**- fear, anxiety, shame, distance, others (probe)
  - **Difficulties and problems faced due to Socio-cultural reasons**- social norms and values related to service utilization by adolescents, lack of information about the service, lack of permision and support from the family, others (probe)
  - **Difficulties and problems faced at the service delivery point** : behaviour of health workers, quality of service received, satisfaction from the service, confidentiality, waiting time, distance, and others (probe)
- Suggestions for improvement of adolescent friendly health services

ANNEX III

KEY INFORMANT INTERVIEW GUIDELINE

- Introduction and objective of the interview
- Background information of the Health Facility and service providers regarding adolescent friendly health services, infrastructures, training status of health workers, provisions on adolescent friendly guidelines implemented or not
- Available adolescent sexual and reproductive health services in the health facilities,
- Positive aspects/areas of improvement in health facility
- Health service utilization status of adolescents
- Knowledge, perception and practice of adolescents towards sexual and reproductive health services
- Knowledge, perception and practice of family members towards sexual and reproductive health services
- Knowledge, perception and practice of community people towards sexual and reproductive health services
- Interesting,unforgettable and unique findings related with adolescents during the utilization of sexual and reproductive health services
- Problems/ difficulties encountered while providing Adolescent sexual and reproductive health services : individual level, family and community level, health facility level
- Suggestions for better service utilization by adolescents
- Suggestions for reducing barriers of sexual and reproductive health service utilization

ANNEX IV

Total number of students studying from class 9 to 12 in different secondary schools of Pyuthan Municipality

Name	Ward	Location	Grade 9			Grade 10			Grade 9-10			Grade 11			Grade 12			Grade 11-12			Grade 9-12		
			G	B	T	G	B	T	G	B	T	G	B	T	G	B	T	G	B	T	G	B	T
Mukti H Ss	3	Ratamata	49	38	87	72	61	133	121	99	220	74	94	168	49	80	129				244	273	517
Bijubar	4	Punya Khola	39	46	85	23	46	69	62	92	154	2	16	18	8	16	24				72	124	196
Chhatra Bikash Ma Vi	4	Punya Khola	26	16	42	14	21	35	40	37	77										40	37	77
Dakhanwadi	5	Chitikhola	55	72	127	54	46	100	109	118	227										109	118	227
Janaki Ma Vi	5	Chitikhola	26	26	52	34	16	50	60	42	102										60	42	102
Janata Uchha Ma V	1	Bagdula	80	92	172	44	46	90	124	138	262	48	22	70	58	38	96	106	60	166	230	198	428
Bhubaneshwori H S S Khaira	6	Sulikharka	35	35	70	21	19	40	56	54	110	10	8	18	9	4	13	19	12	31	75	66	141
Bal Bidya Ma V	2	Maranthana	33	36	69	19	29	48	52	65	117							0	0	0	52	65	117
Pyuthan Khalanga	4	Shivalaya Tol	61	57	118	46	58	104	107	115	222	26	19	45	28	29	57	54	48	102	161	163	324
Jana Jagartji Ma Vi Kesari	1	Kaseri	17	21	38	17	18	35	34	39	73							0	0	0	34	39	73
Mahendra Uchha Ma V	4	Shivalaya Tol	44	36	80	29	40	69	73	76	149	26	19	45	28	29	57	54	48	102	127	124	251
Total			**662**	**676**	**1338**	**529**	**555**	**1084**	**1191**	**1231**	**2422**	**318**	**302**	**620**	**296**	**318**	**614**	**614**	**620**	**1234**	**1805**	**1851**	**3656**

Source: District Education Office, Pyuthan, 2015