KNOWLEDGE, PERCEPTION, BARRIERS, AND UTILIZATION OF CONTRACEPTIVES TOWARD ADOLESCENTS FOR ADOLESCENT'S RESPONSIVE SERVICES OF FAMILY PLANNING IN SURKHET, NEPAL

A Thesis

Submitted to

Faculty of Humanities and Social Science

Central Department of Rural Development, Tribhuvan University

In Partial Fulfillment of the Requirements for the Degree of the Master of Arts (MA) in Rural Development

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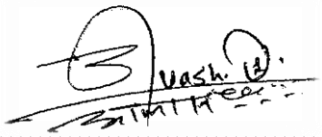
March 2024

DECLARATION

I hereby declare that the thesis titled "Knowledge, Perception, Barriers, And Utilization of Contraceptives Toward Adolescents' Responsive Services of Family Planning in Nepal," submitted to the Central Department of Rural Development, Tribhuvan University, is an original work authored by me. This research was conducted under the guidance and supervision of my assigned supervisor. I have duly acknowledged all ideas and information sourced from various references during the preparation of this thesis. The findings presented in this thesis have not been previously presented or submitted elsewhere for the purpose of obtaining any degree or for any other objectives. I confirm that no part of the thesis content has been published in any form prior to this submission.



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RECOMMENDATION LETTER

The thesis entitled “Knowledge, Perception, Barriers, and Utilization of Contraceptives Toward Adolescents for Adolescents Responsive Services of Family Planning in Nepal” has been prepared by Mr. Satya Raj Upadhayay under my guidance and supervision. I hereby forward this thesis to the evaluation committee for final approval and acceptance.

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ACKNOWLEDGEMENTS

I would like to extend my sincere appreciation to Assistant Prof. Prajwal Pradhan, of the Central Department of Rural Development, for his invaluable guidance, unwavering support, and insightful suggestions throughout the preparation of this thesis. His continuous inspiration and feedback played a pivotal role in shaping this study, and for that, I am truly grateful.

I would also like to express my gratitude to Associate Prof. Bishnu Bahadur Khatri, Head of the Department, and the esteemed teachers and staff at the Central Department of Rural Development for their cooperative assistance, which has left an indelible mark on this research.

Special thanks are due to Samikshya Acharya, whose support in data coding, entry, and analysis was indispensable. I extend my appreciation to Mr. Tej Bahadur Bista, Mr. Ashok Bhandari, and Kusum Shai for their crucial roles in qualitative data collection and participant recruitment. I am equally thankful to the dedicated teachers at Model College, especially Nabin Khadka, for their support during the survey of the study area.

My heartfelt thanks go to my parents, Premjala Devi Upadhayay and Kashi Raj Upadhayay, for their unwavering love and encouragement throughout this thesis. Their constant support and inspiration were instrumental in reaching this milestone.

Lastly, I am indebted to my colleagues for their assistance, inspiration, and cooperation during the entire thesis preparation process. Without the collective support of these individuals and institutions, this research would not have been possible.

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ABSTRACT

Background: This study focuses on adolescent-friendly family planning services in Nepal's Karnali Province, where teenage pregnancy rates are high. Using data from the 2022 Nepal Demographic and Health Survey, it aims to understand obstacles hindering adolescents' access to quality family planning services and their views on service quality. There's limited research on this topic, especially regarding unmarried adolescents. The study aims to fill this gap by identifying barriers and providing insights to improve adolescent reproductive health outcomes.

Objective of the Study: To assess the Knowledge, perceptions, barriers, and utilizations of contraceptives toward adolescent for adolescents' responsive family planning services in Surkhet, Nepal.

Methods: a mixed-method approach, incorporating both qualitative and quantitative methodologies to collect primary data. A cross-sectional explorative design was adopted to comprehensively examine adolescents' barriers, perceptions, and utilization of contraceptive methods in relation to family planning services. Data were gathered through focused group discussions, and self-administered questionnaires to elicit insights into family planning perceptions and key barriers. A semi-structured standard questionnaire was utilized to assess perceptions, barriers, and contraceptive utilization among adolescents accessing family planning services. Quantitative data were obtained using a simple random sampling technique.

Conclusion: This study highlights high awareness of family planning among Nepalese adolescents, yet the utilization rate is only 67.9%, indicating significant barriers. Individual factors like embarrassment, social fears, and lack of awareness of adolescent-friendly services, along with inadequate counseling, cultural taboos, and facility issues, impede use. Demographic factors such as having a boyfriend or girlfriend significantly increase these barriers, with partnered individuals 17 times more likely to face challenges. Qualitative insights point to social media and peer networks as key sources of information, stressing the need for targeted interventions. To improve family planning use among adolescents, tailored awareness campaigns, better counseling, and adolescent-friendly health services are essential.

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ABBREVATION

AFR	: Adolescent Fertility Rate
AGYW	: Adolescent Girl and Young Women
ARCS	: Adolescent Responsive Contraceptives Services
AORs	: Adjusted Odds Ration
BCC	: Behavior Change Communication
CI	: Confidence Interval
COC	: Combine Oral Contraceptives Pills
CPR	: Contraceptives Prevalence Rate
ECP	: Emergency Contraceptives Pills
FGD	: Focus Group Discussion
FP	: Family Planning
HIV	: Human Immunodeficiency Virus
IDI	: In-Depth Interview
IEC	: Information, Education and Communication
IUCD	: Intra Uterine Contraceptive Device
KII	: Key Informant Interview
NDHS	: National Demographic Health Survey
NFHS	: National Fertility Health Survey
LMIC	: Low- and Middle-Income Country
SDM	: Standard Day Method
SRH	: Sexual and Reproductive Health

STI	: Sexually Transmitted Infection
TFR	: Total Fertility Rate
WHO	: World Health Organization

CHAPTER-I: INTRODUCTION

1.1 Background of the Study

According to the World Health Organization (WHO), Family planning allows people to attain their desired number of children, if any, and to determine the spacing of their pregnancies. It is achieved using contraceptive methods and the treatment of infertility. Contraception not only lowers the incidence of unplanned pregnancies but also minimizes the requirement for dangerous abortion procedures and reduces the transmission of HIV from mothers to their babies. Additionally, it can improve the education of girls and enhance women's chances to take an active role in society, including securing paid employment.(Contraception, n.d.).

Adolescent-friendly family planning services refer to reproductive health services that are designed to meet the specific needs and challenges faced by adolescents. These services are typically provided in a confidential and non-judgmental manner and consider the unique physical, emotional, and social needs of this population. The goal of adolescent-friendly family planning services is to empower young people to make informed decisions about their sexual and reproductive health and to access the information, resources, and support they need to stay healthy and protected. World Health Organization. (2012). Adolescent-friendly family planning services typically include a range of services, such as education and counseling on various contraception methods, access to a wide range of contraceptive options, STI testing and treatment, and support for managing menstrual health. These services aim to address the high rates of unintended pregnancy and sexually transmitted infections among adolescents and to help young people delay the onset of sexual activity until they are ready and able to protect themselves(Nath & Garg, 2008).

Globally, 44% of women of reproductive age were using the modern methods of contraceptives(Nations Department of Economic et al., n.d.). The total fertility rate (TFR) has exhibited a consistent downward trend, plummeting from 4.8 births per female in the 1996 national family health Survey (NFHS) to meager 2.1 births per female in the 2022 National Demographic and Health Survey (NDHS). Although the fertility rate remained constant in metropolitan regions, it has significantly reduced in rustic locales. The utilization of any form of family planning methods amidst presently wedded women has surged from 29% in 1996 to a staggering 57% in 2022. In the corresponding period, the adoption of modern contraception experienced an upswing from 26% in 1996 to 44% in 2006, maintaining a constant rate of 43% from 2011 to 2022. A

significant proportion of currently married women, constituting 21%, express an unfulfilled or unmet need for family planning amenities. Conversely, 57% of married women utilize contraception at present, signifying a demand for family planning services in 78% of such women. Thus, if all women who expressed a desire to regulate or space their offspring were to adopt family planning measures, the prevalence of contraceptive usage would escalate from 57% to 78%.(Shah & Kathmandu, n.d.).

Adolescents and youth encounter numerous challenges when it comes to accessing contraceptives services. Some of the obstacles are especially prevalent in developing countries, where individual, interpersonal, community, and cultural factors can have a significant impact on the use of modern contraceptive methods among adolescents. Among adolescent girls there are numerous barriers, including fear, embarrassment, lack of knowledge, high costs of services, all of which hinder their ability to access and utilize these methods effectively. Additionally, some other factors such as the quality and accessibility of health services, as well as age restrictions when seeking family planning services, can also influence the access and use of contraceptives methods among adolescents and youth (Dioubaté et al., 2021a).

The lack of access to family planning leads to unintended pregnancies and underground abortions, which can have significant consequences for both Family health and society. This is a major contributor to maternal and child deaths in countries with low incomes(Nsubuga et al., 2016). Modern contraceptive methods include the pill, injectable, male, and female condoms, emergency contraception, implants, intrauterine contraceptive device (IUCD), female and male sterilization, standard day method (SDM), and lactational amenorrhea method (LAM). The World Health Organization has clarified that modern contraceptive methods are essential for preventing pregnancy-related health risks in women, reducing infant mortality, helping to prevent HIV/AIDS, empowering people, and enhancing education, reducing adolescent pregnancies, and slow population growth(Guta et al., 2021).

1.2 Statement of the Problem

Globally, there were 42 births per 1000 to girls aged 15–19 years in 2021. Each year, developing regions have an approximately 12 million live births from adolescent females aged 15-19 years, and at least 777,000 births from girls below 15 years old. Pregnancy and childbirth-related

complications are major causes of mortality for young women aged 15-19 years worldwide (*Adolescent and Young Adult Health*, n.d.).

According to the WHO report 2019, adolescents aged 15–19 years in low- and middle-income countries (LMICs) had an estimated 21 million pregnancies each year, of which approximately 50% were unintended and which resulted in an estimated 12 million births. Moreover, in LMICs, nearly 55% of unintended pregnancies among adolescent girls aged 15–19 years end in abortions, which are often unsafe in LMICs. Adolescent mothers (aged 10–19 years) face higher risks of eclampsia, puerperal endometritis, and systemic infections than women aged 20–24 years, and babies of adolescent mothers face higher risks of low birth weight, preterm birth, and severe neonatal condition (*Adolescent Pregnancy*, n.d.).

Globally, among women who want to avoid pregnancy, 77 per cent used modern contraceptive methods in 2021. Regions with the highest proportions of modern contraceptive use among women who want to avoid pregnancy are Eastern and South-Eastern Asia (87 per cent), Australia and New Zealand (85 per cent), Latin America and the Caribbean (83 per cent), and Europe and Northern America (80 percent) (United Nations. Department of Economic and Social Affairs & United Nations, n.d.).

Specifically, the number of women with a need for family planning rose from 0.7 billion in 1990 to 1.1 billion in 2021, an increase of 62 percent. This need is increasingly satisfied using modern contraceptive methods. At the same time, total fertility declined globally from 3.3 births per woman in 1990 to 2.3 births per woman in 2021. Consequently, on average, women today live longer periods of their reproductive lives wanting to delay or avoid childbearing (*World Population Prospects 2022 World Population Prospects 2022 Summary of Results*, n.d.).

A significant number of young unmarried individuals face challenges discussing contraception with their parents or healthcare professionals due to the stigma attached to premarital sexual activity. Young people tend to have limited knowledge of contraception compared to adults and are less likely to receive family planning messages from the media or engage in discussions about contraception with healthcare workers, even if they are married. Various factors, such as misinformation about health effects, girls limited decision-making power, and poor access to services, contribute to low contraceptive use. Sociocultural disapproval of premarital sex, legal and regulatory obstacles that prevent unmarried individuals from accessing contraception without

parental or spousal consent, and negative attitudes of healthcare workers are significant obstacles for unmarried young people. Married young women also face barriers, particularly in cultures where there is societal pressure to conceive soon after marriage and prove fertility. In countries like Afghanistan, Bangladesh, India, Maldives, Nepal, Pakistan, Cambodia, Lao PDR, Philippines, Thailand, Viet Nam, Mongolia, PNG, and Vanuatu, more than 50% of adolescent girls rely on short-acting contraceptive methods such as pills and condoms(*UNFPA SHR YP AP_2015 for Web-Final*, n.d.).

The decline in the Total Fertility Rate (TFR) in Nepal over the years is a positive trend i.e., 2.1 births per women in 2022 NDHS, but it is more pronounced in rural areas compared to urban areas. The fact that 14% of women aged 15-19 have been pregnant, with the highest rate in Karnali Province i.e., 21%, is an issue that needs to be addressed. Education also plays a significant role in the age at which women start childbearing, with those with no education being more likely to start early. It is encouraging to note that currently, 57% of married women are using a contraceptive method, but there is still an unmet need for family planning among 21% of currently married women. Addressing this unmet need would help to meet the demand for family planning among 78% of currently married women in Nepal(Shah & Kathmandu, n.d.-b).

According to the DOHS, annual report 2020/21, 17% of girls aged 15-19 are already mothers or are expecting their first child, while only 15% of currently married adolescents use modern contraceptives. The Adolescent Fertility Rate (AFR) has been steadily increasing from 81 per 1,000 women aged 15-19 in 2011 to 88 per 1,000 women in 2016. At national and provincial review meetings and during monitoring of adolescent health programs, several concerns were raised, including the low utilization of family planning services resulting in a low Contraceptive Prevalence Rate (CPR) and high unmet needs, inadequate readiness and functionality of adolescent-friendly services, a high prevalence of early marriage and teenage pregnancy, poor integration of ASH services with other programs such as family planning, safe motherhood, and HIV, and insufficient dissemination of IEC/BCC materials to healthcare facilities (*Annual Report*, n.d.).

1.3 Research Questions

1. What is the level of Knowledge and major perceptions of adolescents for adolescent's responsive services of family planning?

2. What are the major key barriers of adolescents for adolescent responsive services of family planning?
3. What is the Utilization practice of Contraception among adolescents and youth from Adolescent responsive services site of family planning?
4. What is the Socio-demographics variables associated with the barriers occurring for Family planning services?

1.4 Objective of the Study

The overreaching objective of the study is to assess the knowledge, barriers, perceptions, and utilizations of contraception towards adolescents for the adolescent responsive family planning services in Surkhet, Nepal.

1. To assess the level of knowledge and perceptions of adolescents for adolescent responsive services of family planning at health facilities.
2. To assess the key barriers of adolescents for adolescent responsive services of family planning.
3. To examine the utilization practice of contraception among adolescents and youths.
4. To assess the association between socio-demographic variables and barriers occurring for family planning services.

1.5 Significance of the Study

- The study addresses the sensitive issue of adolescent-responsive family planning services in Nepal, which has received limited research attention.
- Adolescents face various obstacles in accessing quality family planning services, and their reproductive health is crucial in assessing overall reproductive health progress.
- It aims to identify primary barriers hindering adolescents from accessing quality family planning services and understand their perceptions of service quality.
- The NDHS 2022 key findings report highlights a significant problem with teenage pregnancy rates, particularly in Karnali Province, necessitating attention.
- There is an unmet demand for family planning among currently married women, but information regarding unmarried adolescents and women in Nepal is limited.

- Karnali Province experiences a significant gap in adolescent-responsive family planning services, evidenced by high levels of unmet need, demand for quality family planning, and teenage pregnancy rates.
- Limited research exists on adolescent-responsive family planning services, especially regarding unmarried adolescents.
- The study aims to gain insights into the key barriers to accessing quality family planning services and explore adolescents' perceptions of such services.

1.6 Delimitation of the Study

- Only adolescent responsive family planning services are addressed.
- Constraint time and define Areas only addressed.
- Limited Financial and Human resources.
- Only qualitative data was included for Perceptions toward Adolescents responsive service of Family Planning.

1.7 Organization of the Study

The whole research work has been systematically described in a total of five chapters. Chapter I includes the introductory part that covers background, problem statement and objectives of the study. Chapter II describes about literature review, various literature especially Knowledge, Perception, Barriers, and utilization of contraception among adolescents for adolescent responsive services of Family planning. Chapter III includes methodology adopted to undertake the research work. It consists of research design, and methods of data collection. Chapter IV consists of data analysis and interpretation and explain the brief finding of the study. Chapter V contains the Summary of findings, conclusion, and recommendations regarding the study.

1.8 Operational Definition of the Variables

Adolescents: Adolescence refers to the transitional period between childhood and adulthood, encompassing the ages of approximately 10 to 19 years old. It is a critical developmental stage marked by physical, psychological, and social changes as individuals progress from childhood to becoming independent adults.

Family Planning: Family planning refers to a set of strategies, services, and practices aimed at enabling individuals and couples to make informed decisions about the timing and spacing of pregnancies, as well as the number of children they wish to have. It involves

the use of various methods and techniques to prevent or achieve pregnancy, according to an individual or couple's preferences and reproductive goals.

Responsive Services: In the context of social services, such as healthcare or social welfare, responsive services typically involve recognizing and addressing the unique needs and challenges of individuals or communities. This may include considering factors such as cultural background, language proficiency, socioeconomic status, and individual preferences. The aim is to provide services that are accessible, inclusive, and tailored to the specific needs of the recipients.

Perceptions: Perception refers to the process by which individuals interpret and make sense of sensory information from their environment.

Barriers: refers to a specific and measurable description of the obstacles or impediments that hinder progress, achievement, or desired outcomes in a particular context. It provides clarity and precision in identifying and assessing the nature and extent of barriers.

CHAPTER-II: LITERATURE REVIEW

2.1 Theoretical Literature Review

The social ecological model has a broad perspective on health and considers multiple factors that can affect it. This approach was introduced by the World Health Organization in 1947 and defines health as encompassing physical, mental, and social well-being. According to this model, health is influenced by the interaction between the individual, the group or community, and the physical, social, and political environments. The social ecological model acknowledges the intricate role played by context in the development of health problems and in addressing these issues. Health professionals, researchers, and community leaders can use this model to identify the factors that contribute to poor health at different levels and develop strategies for disease prevention and health promotion that target those levels. Rather than just focusing on individual health behaviors, this approach emphasizes the need to change both the physical and social environments (Community Engagement Key Function Committee Task Force, n.d.).

Thematic analysis is a qualitative research method that involves identifying patterns in the meaning of data to find themes. The process involves carefully examining a set of data to uncover underlying patterns and interpret qualitative data. Thematic analysis is a reflexive process that considers the researcher's subjective experience while analyzing the data. This method is commonly used in qualitative research, and its focus is on identifying, analyzing, and interpreting patterns within qualitative data. Typically, thematic analysis is applied to a group of texts, such as a set of transcripts or interviews. The researcher carefully examines the data to identify common themes, which may include repeated ideas, topics, or ways of expressing thoughts (Castleberry & Nolen, 2018).

2.2 Empirical Literature Review

An exploratory qualitative study was conducted on adolescents and young adults aged 15-24 years residing in Hattimuda village in eastern Nepal. The study utilized a maximum variation sampling method and involved six focus group discussions and 25 in-depth interviews with both male and female participants from the community. The collected data were analyzed using a thematic framework approach. Although many individuals were aware that family planning measures can delay pregnancy, some of the young participants had inadequate knowledge of the available family planning services. Furthermore, some married couples who preferred 'birth spacing' faced criticism

from their family members for not starting a family. The study identified several perceived barriers to the use of family planning services, including lack of knowledge about family planning, fear of the side effects of modern methods, lack of access/affordability due to familial and religious beliefs/myths/misconceptions. Additionally, some couples' hesitant natures also hindered the uptake of family planning measures at the individual level(Bhatt et al., 2021a).

The research study utilized qualitative data collected from in-depth interviews (IDIs) and key informant interviews (KIIs), with results triangulated for accuracy. The study focused on both an urban municipality and a rural municipality in Bara district, Nepal. The sample comprised a total of 60 participants, including 20 married adolescent girls aged 15-19, 20 husbands, and 20 mothers-in-law for IDIs and four healthcare providers, three health coordinators, and three female community health volunteers for KIIs. The research findings revealed that married adolescent girls faced several inter-related barriers at various levels. Patriarchal norms and power imbalances between spouses limited their decision-making power concerning contraception. Societal pressures to conceive early after marriage contributed to the fear of infertility, abandonment, and stigmatization of childless married couples, thereby resulting in a lack of women's autonomy to make decisions about family planning. Mothers-in-law and religious beliefs exerted a considerable influence on couples' decisions regarding contraception. Inadequate access to information about the benefits and methods of family planning led to fear of the side effects of contraceptives and low awareness of the risks involved in adolescent pregnancy(Sekine et al., 2021).

A qualitative study, conducted in five districts of Nepal, 18 women of reproductive age (18-49 years) who regularly accessed family planning services were interviewed over the phone. The data collected were deductively coded based on preexisting themes using a socio-ecological model, which included individual, family, community, and health facility levels. At the individual level, the barriers to family planning included low self-confidence, limited knowledge about COVID-19 and access to family planning, and financial constraints. At the family level, the barriers included lack of partner support, stigma, and communication barriers. Community level barriers included transport issues, insecurity, and privacy violations, while health facility level barriers included limited contraceptive options, long wait times, negative behavior from health workers, and lack of commodities or staff (Sigdel et al., 2023).

A cross-sectional survey was conducted in Bhaktapur district, involving 362 adolescents randomly selected from four village development committees. The study found that approximately 24.7% of respondents had utilized adolescent-friendly services (AFS). Factors positively associated with utilization included being aged 15-19 years, female, awareness of AFS, lack of fear or shyness regarding SRH services, and recognizing the need for SRH services promptly. In a study, a qualitative finding highlighted factors such as lack of awareness, socio-cultural barriers, confidentiality concerns, feasible service hours, and preference for same-sex service providers as influencing utilization (Napit et al., 2020a).

A descriptive cross-sectional study was conducted among 406 adolescent students in grades 11 and 12, selected through simple random sampling from selected higher secondary schools in Kathmandu District. The utilization of sexual and reproductive health (SRH) services was assessed using a validated and pretested semi-structured questionnaire, which covered socio-demographic factors, utilization of SRH services, and sexual behaviors. The overall utilization rate in the past 12 months was 17.2% and was strongly associated with the availability of services within a 30-minute walking distance (p-value=0.001), communication with parents (p-value: 0.02), and recent sexual activity (p-value=0.001). Utilization of SRH services was slightly higher among females (19.8%) compared to males (15.3%). The most utilized services were related to menstrual problems and family planning, including emergency contraceptive pills (ECP). This study concludes that fear of family and societal judgment acts as a barrier to the utilization of SRH services (Pokhrel et al., 2020).

The study was conducted in six communities in southeast Nigeria using in-depth interviews and focus group discussions with policy makers, community leaders, health service providers, and parents of adolescents. The interviews were audio recorded, transcribed in English, and analysed thematically using the socio-ecological model for data synthesis. The study found several barriers to contraceptive access for adolescents. At the individual level, adolescents' lack of awareness, poor knowledge, fear of side effects, low self-esteem, and inability to afford services were identified. At the interpersonal level, poor parent-child communication, and negative parental attitudes towards sexuality education for adolescents were barriers. Health system barriers included lack of privacy and confidentiality, contraceptive stock-outs, judgmental health workers, and insufficient staff skilled in adolescent sexual and reproductive health. Gendered cultural norms, societal shaming, and religious intolerance also prevented adolescents from accessing

contraceptive services. Societal factors such as negative peer and media influences, lack of sexuality education in schools, absence of social networks in communities, and poor economic conditions were also identified as barriers to contraceptive access for adolescents (Ezenwaka et al., 2020).

A quantitative cross-sectional descriptive study design was employed for this research, aiming to investigate the factors influencing the utilization of family planning services. The sample size consisted of 100 women who were selected using a convenient sampling method. Data collection was conducted through a researcher-administered questionnaire. The findings of the study revealed several factors that influenced the utilization of family planning services. Women's knowledge about family planning emerged as a significant factor, along with social factors such as religion and prevalent myths surrounding family planning. Furthermore, the approval of husbands played a role in the utilization of family planning services. In terms of health facility factors, the distance between the place of residence and the health facility was found to be influential. Availability of contraceptives, negative attitudes of health workers, and long waiting hours at the health facility also affected the utilization of family planning services (Robert, n.d.).

A quantitative study design employing a cross-sectional and descriptive approach was used. A group of 400 undergraduate female students was invited to complete a self-administered questionnaire. The participants were selected using a stratified random sampling technique from two campuses. Among the respondents, 74% confirmed their sexual activity, and of those, 79% reported using contraceptives. The prevalent methods of contraception were oral contraceptives, utilized by 38%, and male condoms, used by 25%. In terms of awareness, condoms were recognized by 84% of the participants, while oral contraceptives were familiar to 68% of them. The knowledge regarding condom usage to prevent sexually transmitted diseases was high, with 91% of the participants expressing awareness (Coetzee & Ngunyulu, 2015).

A descriptive cross-sectional household survey conducted amongst young Nepalese men and women living in the urban areas of the Kathmandu valley. We used logistic regression to model the relationship between selected independent variables and outcome variables (use at first sexual intercourse and current use of modern contraception) among 492 ever sexually active youth aged 15–24 years. We found that the key factors associated with current non-use of modern contraceptives among sexually active youth aged 15–24 were young age at first sexual contact and

a relationship with someone other than a spouse, while significant factor associated with current use of contraception was religion, revealing that Hindu youths having lower odds of use compared to young people who belonged to other religions. Half of ever sexually active young people who were not planning a pregnancy had used a modern method of contraception at the time of their first sexual intercourse and of these, the majority (48%) had used condoms (Table 2). Condoms were also the most used method amongst currently sexually active youth, with 66% of participants using a modern contraceptive method (Tamang et al., 2017).

The study involved conducting focus group discussions, facility assessment interviews, and case studies using qualitative methods. Nine focus group discussions were carried out, with each group consisting of 8 to 10 participants from the girls' (10-18 years) age group, community leaders, and adults. The data collected from these discussions was transcribed and analyzed using pattern matching techniques to identify relevant themes for interpretation and analysis. A significant number of healthcare facilities lack skilled service providers who can offer sexual reproductive health services. It also found that girls start engaging in sexual activity as early as 9 to 12 years of age and require services such as education, family planning, and voluntary counseling and testing. However, these services are often inaccessible due to issues such as a lack of privacy and confidentiality, inadequate equipment, and negative attitudes from service providers. In addition, the study identified social-cultural barriers such as initiation ceremonies, early marriages, and gender disparities that hinder access to sexual reproductive health rights(Mbeba et al., 2012).

A qualitative study in the Gedeo zone of South Ethiopia was carried out between December 2020 and April 2021 using the grounded theory method. Six separate schools, two urban and four rural, in the Gedeo zone, participated in the study. Ethiopia's Southern Nations, Nationalities, and Peoples' Region includes the Gedeo zone. 24 in-depth interviews with secondary school students were conducted as part of the study, and 28 key informants were also spoken with, including school counselors, Kebele youth association coordinators, zonal child, adolescent, and youth officers, health professionals, and representatives of non-governmental organizations. The study's conclusions were divided into four main topics that had an impact on the use of contraceptives: difficulties associated with the person, barriers related to the community, barriers related to health services, and difficulties related to the integration of amenities in school. Individual-related barriers included (Wondimagegne et al., 2023).

The study used a qualitative exploratory method to better explore community concepts and opinions about contemporary contraceptive options. Between October 2020 and December 2020, 11 focus groups and 11 in-depth interviews were conducted as part of the study. Discussions in the focus groups included men and women from the neighborhood, including teenagers. The results of the research revealed that female decision-making over the use of contemporary contraceptive methods was hampered by their lack of financial autonomy, limited mobility, discriminatory gender standards, and cultural traditions. In addition, supply-side and facility-level barriers prevented women from using services, such as frequent shortages of contemporary contraceptives and the inability of health professionals to offer effective family planning services and counseling. In addition, supply-side and facility-level obstacles discouraged women from using services, such as a frequent lack of contemporary contraceptives and an absence of health professionals to offer effective family planning services and counseling. The lack of teen-friendly reproductive health facilities and counseling locations was also mentioned in the report as a crucial area for intervention.(Memon et al., 2022)

A review of research studies and program experiences that discuss the needs, challenges, and strategies to enhance access and use of contraception among adolescents in low- and middle-income countries (LMIC). While the sexual activity of adolescents varies based on gender and region, a considerable number of them, both married and unmarried, require contraception. However, adolescents in LMIC face numerous obstacles in accessing and correctly using contraceptives, particularly those who are unmarried. Effective interventions that improve access to and use of contraception among adolescents include implementing laws and policies that require sexuality education and contraceptive services, building community support for contraception provision, providing sexuality education in and outside schools, making health services more adolescent-friendly, integrating contraceptive services with other health services, and offering contraception through various outlets. Recent data suggest that mobile phones and social media may be promising tools to increase contraceptive use among adolescents (Chandra-Mouli et al., 2014).

A mixed-method, cross-sectional design was used in the study, with most of the data obtained from quantitative surveys of randomly chosen households, and the remainder from focus groups, which helped contextualize and shed light on the survey results. The study was carried out in Nakaseke District, and information was gathered via a survey of 250 teenagers between the ages of 15 and

25 from randomly chosen homes to examine the youths' resistance to using VHTs. Three focus group discussions (FGDs) were also used to obtain data. Instead of VHTs, the formal health sector provided FP care to most respondents. Only half of respondents (out of 65%) were aware that VHTs offer free FP services. Many respondents were at ease talking about FP with VHTs, but they were wary of Other typical causes of discomfort included shyness, talking to parents, concern of invasion of privacy, and fear of being judged. The biggest deterrent to FP techniques was concern over adverse effects. According to the survey, it was crucial to have VHTs of the same sex, especially for those who were single and in the youngest age group (Kalyesubula et al., 2021).

The study involved conducting 34 focus group discussions with youth aged 15-24 and parents or legal guardians of female youth in three districts in Malawi. The data obtained from the discussions was analyzed using a thematic framework to identify broader patterns and themes. The study findings revealed that youth participants were motivated to use family planning to protect themselves from sexually transmitted diseases and prevent unwanted pregnancies. Females were concerned about the consequences of unplanned pregnancies and perceived family planning services as being primarily targeted at them, while males thought family planning services were meant for both genders. Youth faced barriers to accessing family planning due to contraception misconceptions, the costs of family planning services, and negative attitudes. Although some parents acknowledged they could support youth, most were hesitant to do so. Participants suggested that improving counseling services, integrating family planning services and education within school curricula, and utilizing youth clubs could enhance family planning services for youth (Self et al., 2018).

The study used qualitative methods, such as in-depth interviews and focus group discussions with 185 adolescent girls and young women (AGYW) aged 15-24 years in five intervention districts in South Africa. The data collected was analyzed thematically using Nvivo 12 software and manual identification of themes and raw data labeling. The findings suggest that many AGYW, especially those in the 15-19 age group, face challenges in accessing contraceptive services at the interpersonal and health service levels. At the interpersonal level, lack of support from parents/caregivers and sexual partners was identified as a significant barrier, while providers' negative attitude was the main barrier at the health service level. Most schools going AGYW believed that bringing contraception and other sexual and reproductive health services to school

premises would make their use more acceptable to parents and overcome some of the health service and structural barriers. However, opinions on school-based provision of contraception services were mixed, with concerns relating to confidentiality (Jonas et al., 2020).

2.3 Summary of Literature Review

Theoretical Literature Review

The social ecological model, introduced by the World Health Organization, provides a comprehensive framework for understanding health, encompassing physical, mental, and social well-being. It emphasizes the interplay between individual, group, and environmental factors in shaping health outcomes, advocating for holistic approaches to health promotion and disease prevention. Thematic analysis, a qualitative research method, offers a systematic approach to identifying patterns and themes within qualitative data, facilitating nuanced interpretations. These frameworks enable researchers and practitioners to delve into the complexities of health issues and develop targeted interventions that address various levels of influence, beyond individual behaviors alone.

Empirical Literature Review

Studies conducted in Nepal shed light on the multifaceted barriers to family planning services among adolescents and young adults. Factors such as limited knowledge, societal pressures, and inadequate access hinder contraceptive uptake, particularly among marginalized groups. Patriarchal norms, religious beliefs, and interpersonal dynamics further complicate decision-making around family planning. These challenges extend beyond individual factors, encompassing community norms, health system deficiencies, and socio-cultural barriers. Despite efforts to improve access and awareness, persistent obstacles underscore the need for comprehensive strategies that address the diverse contexts shaping reproductive health outcomes.

From diverse geographical contexts like Nigeria, Ethiopia, and South Africa, similar themes emerge regarding the complexities of contraceptive access among adolescents. Individual-level challenges such as knowledge gaps and low self-esteem intersect with interpersonal dynamics and societal norms, hindering access to services. Health system deficiencies, including provider attitudes and facility barriers, exacerbate these challenges, highlighting the need for youth-friendly services and comprehensive sexuality education. These findings underscore the importance of

addressing multi-level determinants and promoting youth empowerment to enhance reproductive health outcomes.

Synthesis

The literature review underscores the intricate interplay of individual, interpersonal, and systemic factors shaping contraceptive access among adolescents and young adults across diverse contexts. Challenges such as limited knowledge, social norms, and health system deficiencies intersect to impede access to family planning services. Comprehensive approaches that address these multi-level determinants, including youth-friendly services, community engagement, and comprehensive sexuality education, are crucial for promoting reproductive health and rights. Insights from theoretical frameworks like the social ecological model and thematic analysis guide research and interventions, emphasizing the need for holistic approaches that consider the complex interplay of factors influencing reproductive health outcomes.

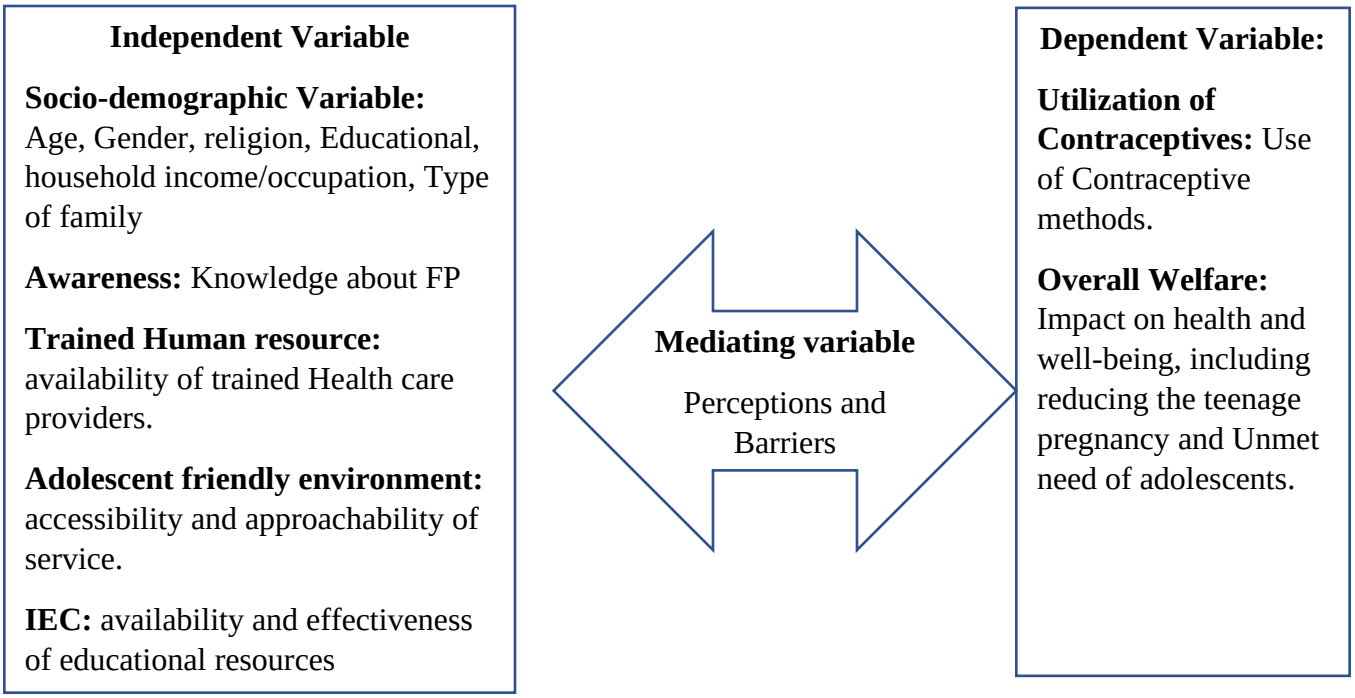
2.4 Research Gaps

1. Integration of Social Ecological Model and Thematic Analysis: Existing literature lacks studies that integrate the social ecological model with thematic analysis to provide a comprehensive understanding of health behaviors and contextual factors.
2. Thematic Analysis of Structural Barriers: There is a gap in literature regarding the use of thematic analysis to explore systemic obstacles to healthcare access, particularly in the context of family planning services.
3. Gendered Perspectives in Family Planning Barriers: Research has yet to extensively examine family planning barriers through a gender lens using thematic analysis, which could reveal nuanced insights into how gender dynamics impact contraceptive use.
4. Comprehensive Examination of Barriers: Studies often focus on individual or interpersonal barriers to contraceptive use, overlooking systemic factors. There is a need for research that comprehensively examines how these different levels of barriers interact and influence contraceptive access.
5. Cultural and Contextual Factors in Thematic Analysis: Literature lacks in-depth exploration of cultural and contextual influences on health behaviors using thematic analysis, limiting our understanding of how these factors shape contraceptive utilization.

6. Adolescent Perspectives on Family Planning Access: Limited research has directly explored adolescents' perspectives on improving access to family planning services. Future studies could fill this gap by engaging adolescents in the research process to identify potential solutions.
7. Effectiveness of Adolescent-Friendly Services: While adolescent-friendly services have been implemented in various settings, there is a lack of comprehensive research evaluating their impact on contraceptive uptake among adolescents.
8. Longitudinal Studies on Contraceptive Utilization: There is a need for longitudinal studies that track changes in contraceptive use among adolescents over time to understand patterns and factors influencing contraceptive behavior.
9. Innovative Approaches to Overcoming Structural Barriers: Existing literature lacks exploration of novel interventions to address structural barriers to contraceptive access. Future research could focus on developing and testing innovative approaches in diverse settings.
10. Intersectionality in Contraceptive Access: Research often overlooks the intersectionality of social identities in shaping contraceptive access among adolescents. There is a need for studies that consider how factors such as race, ethnicity, socioeconomic status, and gender identity intersect to influence contraceptive utilization.

2.5 Conceptual Framework

Figure 1:Conceptual Framework



In this research investigation, the independent variables encompass socio-demographic factors and influential elements such as awareness regarding family planning services, the presence of an adolescent-friendly environment, trained human resources, and the availability of informational, educational, and communication materials. These factors play a crucial role in shaping the perceptions of adolescents, acting as both facilitators and barriers to accessing contraception, thereby impacting the overall welfare of the population.

CHAPTER-III: RESEARCH METHODOLOGY

3.1 Research Design

The cross-sectional and an explorative design was used to gather detailed information of the Knowledge, perception, barriers, and utilization of contraceptives toward adolescents' responsive services of family planning. Focused group discussion and self-administered questionnaire was used to gather information about FP perception and its key barriers.

3.2 Rational of Study Areas Selections

- The NDHS 2022 key findings report highlights a significant problem with teenage pregnancy rates i.e., 21% particularly in Karnali Province, necessitating attention.
- Surkhet district, situated at the core of the Karnali province, accommodates a varied populace embodying the core values of Karnali across a spectrum of health metrics.
- Fortunately, two out of the nine local levels, namely Birendranagar and Bheriganga, were randomly selected. These municipalities effectively uphold the comprehensive representation of Surkhet as well.
- Karnali Province experiences a significant gap in adolescent-responsive family planning services, evidenced by high levels of unmet need, demand for quality family planning, and teenage pregnancy rates.

3.3 Nature and Source of Data

This study employs a mixed-method approach, incorporating both qualitative and quantitative data collection methods. Primary data was gathered through a combination of qualitative techniques, such as focus groups, and quantitative approaches, including self-administered surveys. This dual methodology allows for a comprehensive understanding of the research topic by capturing both rich, narrative-based insights and quantifiable data points. By triangulating evidence from multiple sources, this study aims to enhance the validity and depth of its findings.

3.4 Universe, Sampling Procedure and Sample Size

This study was conducted with Adolescents and newly married couples from urban areas of Birendranagar municipality and Bheriganga Municipality of Surkhet District. These areas are the highly populated site and have a huge number of government and private Health facilities including Government Health Facilities (like Hospital, PHCC, HP, BHSU and other) and Private

Health facilities (like; Hospital, polyclinic, clinic, and Pharmacy). They are serving the large scale of Family planning commodities or contraceptives.

In the qualitative survey, A total of two FGD was conducted, male group had 10 participants and female group had 12 participants which was homogeneous participants in the discussion, which was selected as a Purposive Sampling method. A representative group of adolescents and newly married youth from diverse backgrounds was selected who could provide credible information about the key barriers and factors affecting adolescent's responsive services of family planning.

In the quantitative survey, data collection involved the use of a semi-structured self-administered questionnaire. Colleges were selected through simple random sampling, while a multistage cluster sampling method was employed to select specific classes. During the quantitative survey segment, the researcher clarified each question individually with participants during the survey administration. Extensive efforts were made to ensure thorough data collection. Prior to commencement, both the self-administered questionnaire and the focus group discussion (FGD) guide underwent rigorous pretesting. Any identified issues during pretesting were promptly addressed through modification, with the pretest data excluded from the study findings.

In the FGD sessions, participants were coded anonymously as F1 to F22, with the entirety of the discussion recorded. Additionally, male and female note takers were present to support respective gender groups during the FGDs. The researcher facilitated the discussions, probing participants and adhering to the FGD interview guide throughout.

Sample Size

This study considers 95% CI with the assumption of 5% margin of error. According to NDHS report 2022, the contraceptive prevalence rate is 57%. Sample size of the study is calculated by using cross-sectional formula for infinite population.

$n = (Z_{\alpha/2}^2 pq \div d^2)$

here,

n = Sample size

$Z\alpha/_2$= confidence interval (1-α) (95%=CI)

p= Prevalence FP contraceptives 57%

d= allowable error (5%)

$n = \{(1.962)^2 \times 0.57 \times 0.43\} \div (0.05)^2$

$=377$

Sample size is 377.

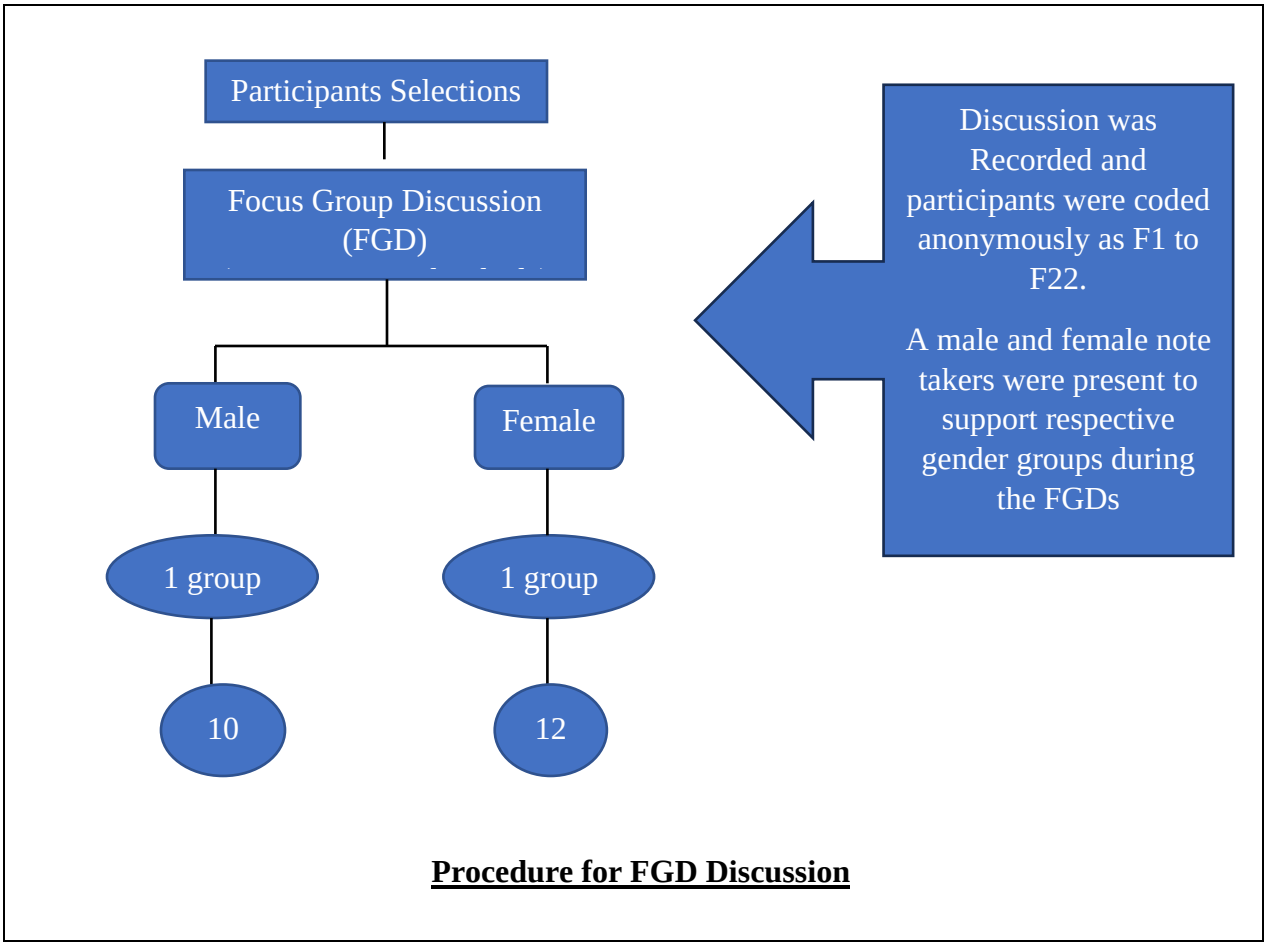


Figure 2Data Collection procedure for FGD.

3.5 Data Collection Methods, Techniques and Tools

This research adopts a mixed-method approach, incorporating qualitative and quantitative data collection techniques. Primary data was obtained through a blend of qualitative methods, such as focus groups, and quantitative approaches, including self-administered surveys.

For quantitative data collection, colleges were selected via simple random sampling, with a multistage cluster sampling technique used to select specific classes. The study focused on adolescents and youths enrolled in Model College and Sarada Higher Secondary School in Birendranagar and Bheriganga municipalities. A standardized semi-structured questionnaire,

translated into Nepali, was utilized. The researcher provided clarification for each questionnaire item to participants, ensuring effective data collection.

Qualitative data were gathered through focused group discussions (FGDs) to explore knowledge, perceptions, and barriers related to adolescent responsive service of Family Planning. FGDs were conducted separately for adolescents and newly married youth couples, with gender-segregated groups to facilitate open discussion of sensitive topics. Participants were anonymously coded as F1 to F22, and the entire discussions were recorded. Male and female note takers were present to support respective gender groups during FGDs. The researcher guided the discussions, prompting participants and adhering to the FGD interview guide.

3.6 Methods of Data Analysis and Interpretation

A framework method of thematic analysis was used for qualitative information. The analysis included stages of transcription, familiarization with the interview, coding, developing a working analytical framework, applying the analytical framework, charting the data into the framework matrix, and interpretation of the data. The notes taken were used as a guide to segregate the responses by different respondents during the discussion.

The Chi-square test and multivariate regression analysis was used to test the association between sociodemographic and socio-economic factors with the Knowledge, perception, barriers, and utilization of adolescent's contraception toward adolescent responsive service of Family planning. The data was analyzed using SPSS version 25 and MS excel 20.

In the study, translation of questionnaire was done to Nepali language and each filled questionnaire was rechecked just after completing questionnaire for the completeness of the questionnaire. The collected data was checked for error and emission on the same day and the consistency of the data will be maintained. The researcher collected the data himself with support of public health expertise and the study was conducted with continuous guidance of the research supervisor.

3.7 Ethical Consideration

- The ethical considerations were taken from the Central Department of Rural Development (CDRD).
- The approval letter was taken from the local authority before the Survey.
- Informed written consent was obtained from each participant prior to interview.
- Confidentiality was maintained of all participants and identity was revealed.

- The right to withdraw from the study at any time was ensured.

CHAPTER-IV: DATA ANALYSIS AND INTERPRETATION

4.1 Sociodemographic Profile

In the demographic profile, the predominant age group among respondents was 15-19 years, constituted 76% of the study, with a mean age of 18.37±1.7. Females represent 58.4%, while males account for 41.6% of the participant pool. The gender dynamics reveal a slightly higher female representation, highlighted the importance of considering gender-specific perspectives.

The marital status breakdown sheds light on the predominant unmarried status at 92.3%, aligning with the youthful age demographic. Additionally, the presence of married people at 6.9% and a small percentage of widowed at 0.5% and divorced individuals at 0.3%, emphasizes the need to recognize diverse life experiences within the studied population.

Ethnically, respondents were most commonly Brahmin/Chhetri (56.8%), followed by Janajati (19.6%), Dalit (17.8%), Muslim (1.1%), and Madesi (0.8%). In terms of religion, the majority were Hindu (93.6%), followed by Christian (4.8%), Muslim (0.8%), Buddhist (0.5%), and other religions (0.3%). Educationally, respondents range from Class 9 to higher education, with 50.7% holding a bachelor's degree, 45.1% in Class 12, 3.7% in Class 11, and 0.3% each in Class 10 and Class 9.

The research also focuses on household decision-making roles and indicates a significant paternal influence i.e., fathers lead in final decision-making (66.0%), followed by mothers (27.1%), the respondents themselves (4.0%), brothers (2.1%), and others family member (0.8%) in decision-making underlines the complex familial dynamics that influence household activities.

The research Showed that the Occupationally, fathers were involved in diverse sectors, reflecting the varied economic landscape of the community which reflect that the primary sectors of the father were agriculture (25.5%), government services (24.4%), business (22.0%), foreign employment (19.9%), daily labor (1.3%), and other occupations (4.2%). Mothers were predominantly homemakers (44.6%), followed by those in agriculture (32.1%), government services (8.8%), daily labor (4.2%), foreign employment (3.2%), NGO/INGOs (1.6%), and other occupations (5.6%), showcasing the multifaceted roles they play.

Regarding income distribution, a considerable percentage of households (59.2%) earn below fifty thousand, while 27.6% fall within the fifty to eighty thousand range. A smaller yet noteworthy fraction (13.3%) earns above eighty thousand monthly. This insight was vital for understanding the financial context in which the surveyed individuals navigate their lives.

Table 1: Socio-demographic variables (n=377)

Characteristics	**Categories**	**Frequency(n)**	**Percentage (%)**
1.Age (in years)	< 15 years	3	0.3
	15 – 19 years	286	75.9
	20 – 29 years	88	23.3
Age in years: Mean ±SD		18.37±1.7	
2. Gender of respondent	Male	157	41.6
	Female	220	58.4
3. Marital status of respondent	Married	26	6.9
	Unmarried	348	92.3
	Widow	2	0.5
	Divorced	1	0.3
4. Ethnicity	Dalit	67	17.8
	Janjati	74	19.6
	Madesi	3	0.8
	Muslim	4	1.1
	Brahmin/Chhetri	214	56.8
	Others	15	4.0
5. Religion	Hindu	353	93.6
	Buddhist	2	0.5

	Muslim	3	0.8
	Christian	18	4.8
	Others	1	0.3
6. Educational status of respondent	Class 9	1	0.3
	Class 10	1	0.3
	Class 11	14	3.7
	Class 12	170	45.1
	Higher Education	191	50.7
7. Head of household	Father	249	66.0
	Mother	102	27.1
	Brother	8	2.1
	Self	15	4.0
	Others	3	0.8
8. Occupation of Father	Business	83	22.0
	Agriculture	96	25.5
	Gov.Service	92	24.4
	NGO/INGOs	10	2.7
	Foreign Employment	75	19.9
	Daily labour	5	1.3
	Others	16	4.2
9. Occupation of mother	Homemaker	168	44.6
	Agriculture	121	32.1
	Gov.service	33	8.8

	NGO/INGOs	6	1.6
	Foreign employment	12	3.2
	Daily Labor	16	4.2
	Others	21	5.6
10. Average Family monthly income	<50,000	223	59.2
	50,000 – 80 ,000	104	27.6
	>80,000	50	13.3

Source: Field Survey 2024

4.2 Knowledge level of Family Planning

Regarding awareness of family planning, a predominant 96% of the respondents were knowledgeable about Family Planning, while 96.3% heard about family planning contraception. Notably, the primary sources of information were social media, accounting for 75.4%, followed by books at 64.9%, friend's circles at 56.6%, Google search at 43.6%, newspapers at 40.1%, parents at 29.9%, and other sources at 22.9%.

Regarding contraceptive methods, the respondents demonstrated varying levels of awareness: 97.5% were familiar with condoms, 82.4% with Emergency Contraceptive Pills (ECP), 71.1% with oral contraceptive pills, 71.1% with Depo-Provera/Sangini, 43.5% with implants, 43.5% with Intrauterine Contraceptive Devices (IUCD), 36.6% with permanent methods, and 32.5% with natural methods.

T*able 2: Knowledge of family planning (n=377)*

Characteristics	Categories	Frequency(n)	Percentage (%)
11. Ever Heard of Family Planning?	Yes	362	96
	No	15	4
12. Ever Heard of contraceptives?	Yes	363	96.3
	No	14	3.7

13. Source of Information (Multiple response)	Newspaper	145	40.1
	Social media	273	75.4
	Google	158	43.6
	Friends	205	56.6
	Parents	106	29.3
	Books	235	64.9
	Others	83	22.9
14. Know about contraceptives (Multiple response)	Condom	354	97.5
	ECP	299	82.4
	Pills	258	71.1
	Depo-Provera	258	71.1
	Implant	158	43.5
	IUCD	158	43.5
	Permanent method	133	36.6
	Natural method	118	32.5

Source: Field Survey 2024

4.3 Utilization of Family Planning

Among the respondents, 71.1% reported having a boyfriend or girlfriend, while 66.31% acknowledged engaging in sexual intercourse. Notably, the majority (60%) of those who had sexual intercourse experienced it for the first time between the ages of 15-19 years, with 36.4% reporting an initial experience below the age of 15 years, and a smaller percentage (3.6%) indicating an age range of 20 to 29 years. The mean age of first sexual intercourse was calculated at 16.68±2.014 years.

The current user of contraception among the respondents stands at 67.9%. Notably, 81.2% respondents used condoms, 53.6% utilized emergency contraceptive pills, 17.2% used oral contraceptive pills, 4.8% opted for Depo-Provera/Sangini, 0.4% chose implants, and 11.2%

practiced natural methods. Among contraceptive users, the majority (79.2%) obtained contraception from pharmacies or medical halls, while 8.8% accessed it from health posts, 4.8% accessed from private hospitals, and government hospitals. Additionally, 1.2% sourced contraception from Primary Health Centers (PHC), 0.8% from clinics/polyclinics, and 0.4% from Marie Stopes.

Among the 250 respondents, 85.6% found it convenient to access services from the private sector. The primary factors contributing to this ease included privacy maintenance (92.1%), accessibility (50.5%), effective counseling (39.3%), provider trust (35%), service delivery point's opening and closing times (31.3%), the variety of contraception options (27.6%), quality services (26.2%), and awareness and promotion (9.8%). Additionally, 9.3% appreciated the services being provided free of cost.

Conversely, out of 36 respondents, 85.6% expressed ease in obtaining services from government facilities. The main reasons cited were the provision of free services (66.7%), quality counseling (47.2%), privacy (47.2%), trained providers (25%), awareness and promotion (8.3%), provider trust (30.6%), accessibility (22.2%), the range of contraception options (5.6%), and the operating hours of the service delivery point (5.6%).

A mere 72% of service providers engage in discussions about family planning services. Notably, 60.8% inform clients about contraceptive choices, 51.6% discuss the potential side effects and risks associated with contraceptive methods, 29.2% provide guidance on actions to take in the event of experiencing side effects or issues related to contraceptive use, and 34.4% convey information about the possibility of transitioning to an alternative contraceptive method in case of severe effects.

T*able 3: Utilization of family planning (n=377)*

Characteristics	Categories	Frequency(n)	Percentage (%)
15.Have Gf/Bf	Yes	268	71.1
	No	109	28.9
	Yes	250	66.3

16. Have had sexual intercourse	No	127	33.7
17. Age of first sexual intercourse (in years) (n=149)	<15	91	36.4
	15 – 19	150	60
	20 – 29	9	3.6
Age in years: Mean ±SD 16.68 ±2.014			
18. Currently using any method to delay or avoid getting pregnant'?	Yes	250	67.9
	No	118	32.1
19. Used FP method (Multiple response)	Condom	203	81.2
	ECP	134	53.6
	Pills	43	17.2
	Depo-Provera	12	4.8
	Implant	1	0.4
	Natural method	28	11.2
20. Facility to get the contraception(n=250)	Medical/Pharmacy	198	79.2
	Health post	22	8.8
	Clinic/Polyclinic	2	0.8
	PHC	3	1.2
	Private hospital	12	4.8
	Government hospital	12	4.8
	Meri Stopes	1	0.4
21. Easy getting the private services? (n=250)	Yes	214	85.6
	No	36	14.4
	Privacy	197	92.1

22. Easy/difficult aspects of private services(n=250) (Multiple response)	Counselling	84	39.3
	Trust of Provider	75	35
	Accessibility	108	50.5
	Free of cost	20	9.3
	Quality services	56	26.2
	Trained provider	18	8.4
	Awareness and promotion	21	9.8
	Range of contraception option	59	27.6
	Time (opening and closing)	67	31.3
23. Easy getting the government services? (n=250)	Yes	36	14.4
	No	214	85.6
24. Easy/difficult aspects of government services(n=36) (Multiple response)	Privacy	17	47.2
	Counselling	17	47.2
	Trust of provider	11	30.6
	Accessibility	8	22.2
	Free of cost	24	66.7
	Quality services	6	16.7
	Trained provider	9	25
	Awareness and promotion	3	8.3
	Range of contraception option	2	5.6
	Time (opening and closing)	2	5.6

25. Did any staff member in the health facility share information about family planning methods? (n=250)	Yes	180	72
	No	70	28
26. Were you informed about side effects or problems you might have with the method? (n=250)	Yes	129	51.6
	No	121	48.4
27. Were you informed about what to do if you experienced side effects or problems? (n=250)	Yes	73	29.2
	No	177	70.8
28. Were you informed about the other method of family planning? (n=250)	Yes	152	60.8
	No	98	39.2
29. Were you informed about the possibility of switching to another method of contraception? (n=250)	Yes	86	34.4
	No	164	65.6

Source: Field Survey 2024

4.4 Barriers to utilization of family planning

The majority 86.8% of respondents reported discomfort during or before using contraception, and among them, 97.7% identified individual barriers. The key individual barriers included embarrassment/shyness (81.1%), lack of awareness of adolescent-friendly health services (32.1%), pressure to have a child after marriage (11.3%), fear of infertility due to contraceptive use (12.2%), and other reasons (5.2%). Social or family-related barriers affected 88.9% of respondents, encompassing fear of parents (63.9%), judgmental attitudes (49%), disapproval from community leaders/gatekeepers (17%), family pressure to have children or not use contraception (8.2%), and son preference (4.1%).

At the service provider level, 90.8% of respondents encountered barriers, including difficulties due to inadequate counseling (70.6%), reluctance to provide contraceptive services (36%), bias (20.3%), and cultural taboos (4.1%). Health facility-related barriers were reported by 84.8% of respondents, citing poor physical access (18.4%), high costs of services and transportation (14.6%), lack of privacy (47%), long waiting times (21.1%), inconvenient opening hours (11.4%), commodity stockouts (10.3%), and the absence of female providers (30.8%) as notable challenges.

Table 4: Barriers to utilization of family planning (n=250)

Characteristics	Categories	Frequency(n)	Percentage (%)
30.Barrier/Discomfort during or before using contraception?	Yes	217	86.8
	No	33	13.2
31. Individual barrier? (n=217)	Yes	212	97.7
	No	5	2.3
31.a. Individual barrier aspects (Multiple response)	Embarrassment/shyness	172	81.1
	Lack of awareness of adolescent friendly health services	68	32.1
	Pressure to have child after marriage	24	11.3
	Fear of infertility due to use of contraceptives	26	12.3
	Other reason	11	5.2
32. Social or Family barrier? (n=217)	Yes	193	88.9
	No	24	11.1
32.a. Family barrier aspects (Multiple response)	Fear of parents	123	64.1
	Judgemental attitudes	94	49.0
	Disapproval of community/gatekeepers	33	17.2

	Family pressure to have children/not to use a method	15	7.8
	Son preference	8	4.2
33. Service provider Barrier? (n=217)	Yes	197	90.8
	No	20	9.2
33.a. Service provider barrier aspects (multiple response)	Inadequate counselling	140	70.7
	Reluctance to provide contraceptive services	71	35.9
	Biasedness	40	20.2
	Cultural taboos	8	4.0
34. Health facility barrier? (n=217)	Yes	190	87.6
	No	27	12.4
34.a. Health facility barrier aspects (multiple response)	Poor physical access	34	17.9
	Cost of services and transport	27	14.2
	Lack of privacy	90	47.4
	Long waiting time	40	21.1
	Inconvenient opening hours	23	12.1
	Stock out of commodities	22	11.6
	Lack of Female providers	60	31.6

Source: Field Survey 2024

4.5: Association of the barriers of the family planning use with socio-demographic variables and other factors (Bi-variate analysis)

The table 5 summarizes the bivariate association between the predictor variable and barriers while using family planning methods that is the dependent variable. The association of utilization of modern contraceptives was assessed with socio-demographic variables, having bf/gf, history of sexual intercourse and utilization of family planning methods.

The analysis of bivariate associations between the predictor variable and barriers to using family planning methods revealed significant findings across various socio-demographic variables. Notably, gender demonstrated a strong association with barriers to family planning utilization, with a p-value of less than 0.001. This suggests that gender plays a significant role in influencing the challenges individuals face in adopting family planning practices, emphasizing the need for gender-specific interventions to enhance contraceptive utilization.

Ethnicity was found to be statistically associated with barriers to family planning utilization, with a p-value of 0.021. These results imply that individuals from different ethnic backgrounds may encounter varying levels of challenges in accessing and using family planning methods, highlighting the importance of tailoring interventions to address ethnic-specific factors.

Religion also showed a notable association with barriers to family planning utilization, with a p-value of 0.019. This indicates that religious beliefs may impact decisions regarding family planning, emphasizing the need to consider and understand the influence of religious factors in the development of culturally sensitive strategies to address obstacles to contraceptive use.

Having a boyfriend or girlfriend (bf/gf) was significantly associated with barriers to family planning utilization, with a p-value of less than 0.001. This suggests that interpersonal relationships may influence the challenges individuals face in adopting family planning practices, and interventions and educational programs may benefit from recognizing the impact of romantic relationships on barriers to contraceptive use.

A strong association was observed between a history of sexual intercourse and barriers to family planning utilization, with a p-value of less than 0.001. This emphasizes the crucial link between sexual behavior and challenges related to family planning practices, highlighting the need for targeted interventions addressing obstacles to contraceptive needs among those with a history of sexual activity.

It was found that there was a strong association between current users of family planning and barriers to family planning methods utilization ($p < 0.001$). Therefore, the crucial link emphasizes the importance of addressing obstacles to contraceptive use among individuals already engaged in family planning.

Furthermore, another significant association was observed between barriers to family planning methods utilization among the people who have heard about family planning devices ($p < 0.001$). Therefore, this highlights the critical need to tackle challenges in accessing family planning services among those who are knowledgeable about available options.

Table 5: Association of the barriers of the family planning use with socio-demographic variables and other factors (Bi-variate analysis) (n=377)

Characteristics	**Categories**	**Barriers while using Family planning methods. (n (%))**		**p-value**
		Yes	No	
1.Age of Respondent	≤19	2(66.7)	1(33.3)	1.000[b]
	>19	215(57.5)	159(42.5)	
2.Gender of Respondent	Male	107(68.2)	50(31.8)	**<0.001**
	Female	110(50.0)	110(50.0)	
3.Marital status of respondent	Married	20(76.9)	6(23.1)	0.080[b]
	Unmarried	195(56.0)	153(44.0)	
	Widow	1(50.0)	1(50.0)	
	Divorced	1(100.0)	0	
4.Ethnicity	Brahmin/Chhetri	47(70.1)	20(29.9)	**0.021**
	Other than Brahmin/Chhetri	170(54.8)	140(45.2)	
5.Religion	Hindu	197(56.0)	155(44.0)	**0.019**
	Non-Hindu	20(80.0)	5(20.0)	
6.Education of respondent	Class 9-12	1(100.0)	0	1.000[b]
	Higher Education	216(57.4)	160(42.6)	
7.Head of family in decision making	Father	148(59.4)	101(40.6)	0.303
	Mother	69(53.9)	59(46.1)	
	Others	22(84.6)	4(15.4)	
	Engaged in work	51(61.4)	32(38.6)	0.417

8. Father's occupation	Foreign employment	166(56.5)	128(43.5)	
9. Mother's occupation	Homemaker	98(58.3)	70(41.7)	0.785
	Other than homemaker	119(56.9)	90(43.1)	
10. Average Family Income	<50,000	129(57.8)	94(42.2)	0.875
	50,000 – 80 ,000	58(55.8)	46(44.2)	
	>80,000	30(60.0)	20(40.0)	
11. Have bf/gf	Yes	215(80.2)	53(19.8)	**<0.001**
	No	2(1.8)	107(98.2)	
12. Have sexual intercourse	Yes	217(86.8)	33(13.2)	**<0.001**
	No	0	127(100.0)	
13. Current user of family planning	Yes	217(86.8)	33(13.2)	**<0.001**
	No	0	127(100.0)	
14. Ever Heard of family planning	Yes	217(59.9)	145(40.1)	**<0.001**
	No	0	15(100.0)	

[b]*fisher exact test, Significant at p-value<0.05*

Source: Field Survey 2024

4.6 Barriers of family planning methods and its' associated factors (Multivariate analysis)

Binary logistic regression was used to analyze the relationship between the dependent variable and explanatory factors. The findings were interpreted using adjusted odds ratios (AORs) along with a 95% confidence interval (CI). In the multivariate analysis, variables demonstrating significant associations in the bivariate analysis (CI 95%, P<0.2) were considered. The results from the multivariate analysis revealed that users having bf/gf showed statistically significant relationships with barriers to utilizing family planning methods. Conversely, factors such as gender, religion, ethnicity, current users of FP and users hearing about FP methods did not show statistically significant associations in the multivariate analysis.

Concerning having bf/gf, individuals who had bf/gf were 17 times more likely (AOR=17.491; 95% CI: 3.038-100.709) to encounter barriers in using family planning methods compared to those who

didn't have bf/gf. Thus, having bf/gf emerged as a pivotal factor in the obstacles to family planning utilization.

Table 6: Barriers of family planning methods and its' associated factors (Multivariate analysis)

Variables	Categories	β-coefficient	p-value	AOR	95% CI
Gender	Male	Ref			
	Female	-0.183	0.660	0.833	(0.369-1.879)
Ethnicity	Brahmin/Chhetri	Ref.			
	Other than Brahmin/Chhetri	-1.914	0.067	0.147	(0.019-1.139)
Religion	Hindu	Ref.			
	Non-Hindu	0.444	0.680	1.558	(0.190-12.792)
Have bf/gf	No	Ref.			
	Yes	2.862	**0.001**	17.491	(3.038-100.709)
Have sexual intercourse	No	Ref.			
	Yes	21.982	0.994	35211	0
Heard about Family Planning	No	Ref.			
	Yes	17.208	0.998	29731	0

Significant at p-value<0.05
Source: Field Survey 2024

4.7 Focus Group Discussion (FGD Results)

Two distinct gender-based Focus Group Discussions (FGDs) were successfully conducted in Birendranagar Municipality, involving participants from both genders, including adolescents aged 15-19 years and young adults aged 20-29 years, encompassing both married and unmarried individuals. The male FGD comprised a total of 10 participants, while the female FGD involved

12 participants, predominantly from Chaudhari groups and other diverse areas such as slums, rural, and urban settings. The discussions were audio-recorded, with a note-taker documenting key points. The researcher facilitated and probed the FGD guide, employing local language and terminology to create a conducive environment for participants to openly express their thoughts and concerns regarding family planning.

Table 5: Focus Group Discussion Results

Knowledge and Source of Information	F4. - Family planning encompasses decisions about the number of children to conceive and the healthful spacing between childbirths. I've obtained information on contraceptive methods like condoms and pills mainly through FM radio broadcasts. F7. -In the initial instance, I gained insights into engaging in intimate activities with a partner, and subsequently, my siblings imparted knowledge about the use and benefits of condoms. F3. -Utilizing condoms serves as a protective measure against unintended pregnancies and sexually transmitted diseases. This awareness was acquired through information shared on social media, particularly on platforms such as Facebook reels. F1. -While accompanying my nurse mother to the hospital, I learned about family planning and condoms related information during her health education sessions for other clients. In a lighthearted moment, I playfully blew up a condom as if it were a balloon. F9. -In the Seventh grade, I studied Reproductive Health and Family Planning commodities. However, the course was briefly omitted by my teacher due to her reticence. F8. -I gained awareness about condoms and their role in preventing unintended pregnancies and sexually transmitted diseases through a YouTube advertisement.

	F10. -I first heard about the FP device from friends, but discussing my sexual concerns with them was difficult at the time due to teasing practices in our classroom. F2. -I learned how to use condoms by reading the instructions on the packaging and guide, and then used them correctly.
Perception about Family Planning	F3. -Utilize this contraceptive measure to alleviate the financial strain on households and create opportunities for gainful employment through the effective implementation of Family Planning. F5. -The efficacy of Family Planning is notably higher for females in comparison to males, given the myriad choices of contraception available to women that are user-friendly and facilitate effective birth spacing. While options like male condoms and vasectomy exist, I personally dismiss the use of condoms due to diminished pleasure and their limited duration. Consequently, I endorse female contraception as a more viable means of controlling unwanted births. F2. -Our choices are limited to condoms, which may rupture, and vasectomy, a permanent option, both posing challenges for consistent use. The optimal solution, particularly for effective contraception, lies in the utilization of Family Planning methods designed for females. F7. -Due to the widespread engagement of men in various external activities and involvement with multiple sexual partners, it is crucial for them to prioritize protection by consistently using condoms. This precautionary measure significantly enhances their defense against sexually transmitted diseases. F1. -Hormonal methods like pills and Sangini injections are ideal for those with multiple children seeking to prevent additional pregnancies. However, these methods may delay conception and

	pose a risk of infertility. Hence, condoms remain a viable option for males at any time. F3. -For heightened pleasure, consider transitioning from condoms to regular use of Emergency Contraceptive pills (E-con) as a more satisfying contraception option for both males and females.
Decision Making role for Family Planning within a Partner	F5. -In my perspective, girls should take an active role in determining the most effective contraception method for themselves, ensuring that boys do not influence the choice of contraceptive. The entire credit for method selection should be attributed to the female. F13. - I am aware of Emergency Contraceptive Pills (ECP) and have been using them regularly at my husband's urging, maintaining a three-day interval. However, the irregularities in my menstrual cycle are causing significant concern about my fertility. Despite these concerns, my husband is opposed to switching to an alternative contraception method, and I am encountering challenges in seeking assistance from health facilities due to shyness. F10. -Abortion-related health risks primarily impact women, especially when contraception is neglected or influenced by male coercion. Thus, the availability of contraception empowers women to proactively manage and safeguard their health. F9. -Boys are direct involvement in purchasing contraception and openly discussing sexual concerns with service providers enhances their decision-making in family planning and contributing to its overall effectiveness for male decision. F1. In my Girl friend case, she experienced feelings of shyness when it came to family planning and other matters related to sexual activities. Consequently, I assumed the responsibility of making decisions regarding our contraception methods.

	F2. In the pharmacy setting, most of the providers are male, enabling me to autonomously procure and use contraception based on my personal decision. F4. Regarding hormonal methods like pills and Depo, my wife independently chooses and administers It, while I handle the procurement of condoms. The choice of contraceptive method is a result of mutual understanding and agreement between both partners. F3. As I am Unmarried, my contraceptive choice is limited to condoms, which I can easily acquire and use in a straightforward manner. F6. My girlfriend autonomously chose a contraceptive and comfortably purchased it from a pharmacy where a female service provider assisted her in the selection process and make a favorable environment to share her concerns as well. F7. My girlfriend insists on the use of contraception, particularly condoms, while I prefer not to use one for my sexual pleasure. The decision ultimately rests with my girlfriend.
Supply Side Barrier (Barrier from Health Facilities and Service provider)	F3. -Certain service providers exhibit bias against adolescents under 18, refusing to provide contraception based on age. In emergency situations, we resort to seeking assistance from auto drivers or other young individuals to procure contraception. F5. I feel at ease purchasing contraception from pharmacies, where transactions are simple without the need for personal information. Conversely, government Health Posts' inquiries into personal and irrelevant details raise concerns about privacy and confidentiality. F2. -Expressing concerns about contraception with service providers poses challenges, despite the numerous issues involved. Creating a conducive environment where service providers openly

	share information and address concerns in a friendly manner would greatly benefit individuals, making it easier to access and utilize services. F7. -At times, health facilities experience prolonged patient queues, making it challenging for individuals to wait in line for contraception services. This situation often prompts individuals to explore alternative health facilities for more efficient service delivery. F8. -At times, age-related discrimination from providers occurs, implying that being under 18 is too young for seeking sexual health services, akin to breastfeeding. Such comments are inappropriate and dismiss the right to access relevant information and support. F4. -Covering contraception items like condoms, ECP, and pills with paper can safeguard privacy in busy health facilities. Not doing so may raise fears of recognition by relatives, compromising my privacy anywhere and anytime.
Demand Side Barrier	F20. -I am apprehensive about the potential breach of my privacy, particularly concerning the disclosure of my personal relationship details and decisions regarding contraception to my family. F22. -During my initial encounter with contraception, I grappled with the challenge of choosing the most appropriate method for myself. Over time, I have gained a better understanding and confidence in making decisions related to contraception. F2. -In the pharmacy, encountering a female service provider posed challenges for me as a male. Feeling uncomfortable, I opted to purchase paracetamol instead of an ECP. F21. -I visited a health post to obtain a Dipo injection but encountered a male service provider during my visit. Due to my personal shyness, I chose to forgo the Dipo injection and returned

	home, inadvertently leading to another unintended pregnancy. Consequently, I find myself facing the prospect of raising an additional unwanted child due to this decision. F15. - During the initial stages of my first pregnancy, I lacked awareness regarding contraception methods. Subsequently, within four months after giving birth, I found myself pregnant again, leading to the decision to undergo an abortion due to our limited knowledge about contraception. This experience served as a catalyst for educating myself about various contraceptive options. As a result, I am now informed about the choices available and am prepared to incorporate the use of Depo-Provera in my upcoming menstrual cycle. F16. - I experience unease in utilizing government facilities due to multiple providers in a single service site requesting irrelevant personal information. Consequently, I have chosen to recommend a friend to seek services from a private pharmacy. F17- My husband, employed as an auto driver, believes that condoms diminish his pleasure and, as a result, opposes their use. Consequently, I have taken it upon myself to consistently use contraceptive pills obtained from a pharmacy. F3. - I equip myself with a helmet, mask, and black goggles before heading to a distant health facility to acquire condoms. This precautionary measure is taken to ensure that I go unrecognized, particularly by family members and others. F4- I choose to acquire contraception during the evening hours to minimize visibility during the purchase, prioritizing privacy. Additionally, I travel to health facilities located at a distance to further ensure both my safety and confidentiality.

Source: Field Survey 2024 (FGD)

CHAPTER-V: SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Summary of the Findings

In this research, Among the respondents, 71.1% reported having a boyfriend or girlfriend, while 66.31% acknowledged engaging in sexual intercourse. Notably, the majority (60%) of those who had sexual intercourse experienced it for the first time between the ages of 15-19 years, with 36.4% reporting an initial experience below the age of 15 years, and a smaller percentage (3.6%) indicating an age range of 20 to 29 years. The mean age of first sexual intercourse was calculated at 16.68±2.014 years. The current user of contraception among the respondents stands at 67.9%. Notably, 81.2% respondents used condoms, 53.6% utilized emergency contraceptive pills, 17.2% used oral contraceptive pills, 4.8% opted for Depo-Provera/Sangini, 0.4% chose implants, and 11.2% practiced natural methods. A Study conducted in Jhapa district shows that 69.1% respondents used the family planning method during their premarital sex. Among the boys 77.8% and among the girls 38.9% used the family planning method. The study showed that in villages of Nepal, among the sexually active boys 42% used Condom during their last sexual intercourse. (Nand Bhatta et al., 2013)

In this study, A significant majority (86.8%) of respondents expressed discomfort with contraception, with individual hurdles such as embarrassment (81.1%) and limited awareness (32.1%) of adolescent-friendly health services. Social and familial factors also played a significant role, impacting 88.9% of respondents, including fear of parental disapproval (63.9%) and societal judgment (49%). At the service provider level, barriers were encountered by 90.8% of respondents, notably stemming from inadequate counseling (70.6%) and reluctance to provide contraceptive services (36%). Additionally, health facility-related challenges were widespread, affecting 84.8% of respondents, with issues like poor physical access (18.4%), long waiting times (21.1%), and lack of privacy (47%) presenting notable hurdles. The other study shows that participants identified fear of side effects, infertility, cost, and misinformation as significant individual barriers to using modern contraceptives. Concerns about health risks and consequences, especially for girls, were seen as limiting factors. Additionally, some individuals, including parents or relatives, may perceive users of family planning methods as leading a "promiscuous life.(Dioubaté et al., 2021b) A another study show that a fear of society and family members was identified as the barrier for

services utilization in contrast to the similar study in which lack of confidentiality was described as a barrier to SRH services utilization.(Pokhrel et al., 2020).

The research findings indicate a robust correlation between various demographic factors and the presence of barriers in the utilization of family planning methods. Specifically, age, gender, and the role of the head of the family in decision-making exhibited a significant association with these barriers. Furthermore, a strong connection was observed between barriers and additional utilization variables, such as having a boyfriend or girlfriend, engaging in sexual intercourse, and being a current user of family planning. The religious and ethnic background of the respondents also demonstrated an association with obstacles encountered in the use of family planning methods. These insights underscore the multifaceted nature of factors influencing the adoption of family planning and emphasize the need for targeted interventions to address barriers within specific demographic and contextual contexts. However other studies showed that there was a notable correlation (p-value: 0.001) between recent sexual activity within the past 12 months and service utilization. However, it is noteworthy that enabling factors, including age, gender, religion, ethnicity, as well as the occupational, educational, and living status of both fathers and mothers, did not demonstrate statistically significant associations. These findings suggest that while recent sexual activity appears to influence service utilization, other enabling factors examined in this study do not exhibit a statistically significant relationship with the utilization of services (Pokhrel et al., 2020).

The study results from the multivariate analysis revealed that the results from the multivariate analysis revealed that users having bf/gf showed statistically significant relationships with barriers to utilizing family planning methods. Conversely, factors such as gender, religion, ethnicity, current users of FP and users hearing about FP methods did not show statistically significant associations in the multivariate analysis. Concerning having bf/gf, individuals who had bf/gf were 17 times more likely (AOR=17.491; 95% CI: 3.038-100.709) to encounter barriers in using family planning methods compared to those who didn't have bf/gf. Thus, having bf/gf emerged as a pivotal factor in the obstacles to family planning utilization. A study conducted in Kathmandu shows that the multivariate analysis, significant factors associated with Adolescent-Friendly Services (AFS) utilization included age (15-19 vs. 10-14), with a more than twenty-twofold increase, and being female, with five times higher odds. Awareness of AFS raised the likelihood

by over thirty times. Sociocultural factors, such as lack of shyness, increased AFS utilization by nine times. Fear of being seen while receiving services doubled the likelihood, and a perceived need for SRH services upon illness development resulted in an elevenfold increase in AFS utilization. (Napit et al., 2020b)

The qualitative insights from this study highlight adolescents' nuanced awareness of family planning methods, particularly their familiarity with condoms, emergency contraceptive pills (ECP), and Depo contraception. Information dissemination predominantly occurs through social media and peer networks. The perception of contraceptive options leans toward more choices for women, creating a belief in female-centric responsibility. Decision-making roles are perceived as shared, yet females express heightened consciousness in contraceptive selection. Supply-side barriers encompass biases against adolescents, concerns about confidentiality breaches, limited contraceptive information from providers, crowded facilities leading to rushed services, and a lack of awareness about adolescent-responsive family planning services. On the demand side, challenges include choosing the most suitable method, facing provider-related obstacles such as gender preferences, encountering multiple providers seeking irrelevant personal information, and navigating issues of personal shyness and privacy. These findings provide a rich understanding of the complex dynamics surrounding adolescent perspectives on family planning in the study context. A qualitative investigation delves into the nuanced perspectives and comprehension of youth in Eastern Nepal concerning family planning (FP). The study unravels insights into the knowledge and perceptions of FP methods among rural residents, shedding light on decision-making processes and preferences. Additionally, the research unveils obstacles on both the supply and demand sides concerning FP utilization, proposing potential measures to enhance usage. The findings also highlight the distinctive role of youth in expanding FP coverage. Although a majority of participants demonstrated familiarity with FP, a notable number of female participants exhibited a complete lack of awareness. Divergent opinions emerged among participants, with some advocating for universal FP adoption by married couples, while certain unmarried males asserted that FP measures should exclusively pertain to women, expressing a willingness to consider them only post-marriage. The study underscores the current limited choices for men in FP methods, emphasizing coitus-dependent or permanent options, which may contribute to misconceptions regarding the predominantly female-oriented nature of contraceptives.(Bhatt et al., 2021b)

5.2 Conclusion

The research highlights a commendable level of awareness about family planning among adolescents in Nepal, with a significant majority being knowledgeable about various contraceptive methods. However, the utilization rate remains at 67.9%, indicating existing challenges. Condoms are the most widely used method, and the majority of users access contraception from pharmacies or medical halls.

Individual barriers, such as embarrassment and lack of awareness of adolescent-friendly health services, significantly impact contraceptive use. Social and family-related barriers, including fear of parents and judgmental attitudes, are prevalent. Service provider-level challenges, such as inadequate counseling and cultural taboos, contribute to barriers, along with health facility-related issues like poor physical access and commodity stockouts.

Demographic factors such as gender, ethnicity, religions, having BF/GF, Age of first sexual intercourse, Current Use of FP contraception and Knowledge of contraception exhibit significant associations with barriers, emphasizing the need for targeted interventions. Multivariate analysis underscores the significant associations observed between barriers to utilizing family planning methods and the presence of a boyfriend or girlfriend. Individuals with a partner were 17 times more likely to encounter these barriers compared to those without. Surprisingly, factors such as gender, religion, ethnicity, current use of family planning, and awareness of family planning methods did not show statistically significant associations. Therefore, the presence of a romantic partner emerged as a critical factor affecting the challenges in family planning utilization.

Qualitative insights reveal nuanced awareness and information dissemination through social media and peer networks. Female-centric responsibility and shared decision-making roles emerge, with challenges on both the supply and demand sides, emphasizing the need for adolescent-responsive family planning services.

This study underscores the need for targeted interventions to enhance the utilization of family planning methods among adolescents in Nepal. While a high level of awareness exists, persistent individual, social, and systemic barriers hinder optimal usage. Tailored awareness campaigns, improved counseling, and adolescent-friendly health services are recommended to address these challenges and promote a more inclusive and effective approach to family planning in this demographic.

5.3 Recommendations

5.3.1 General Recommendation

To address the challenges in promoting family planning among adolescents in Nepal, a comprehensive and multifaceted approach is recommended:

Awareness Campaigns: Targeted awareness campaigns should utilize social media platforms and peer networks to foster open communication and reduce the stigma surrounding family planning.

Health Education Programs: These programs must focus on dispelling myths that contribute to discomfort and embarrassment regarding family planning.

Training for Service Providers: Comprehensive training is crucial to overcome biases against unmarried adolescents, enhance counseling, and ensure confidential and adolescent-responsive services.

Policy Initiatives: Increased funding aligned with Sustainable Development Goals is essential for significant advancements. This financial investment can address key concerns and promote sustainable development in the family planning sector.

Accessibility Improvements: Enhance physical access to health facilities, reduce costs, eliminate the requirement for personal details in recording systems, and address commodity stockouts. Incorporating adolescent-friendly features, such as flexible hours and female providers, will create a more supportive environment for family planning services.

5.3.2 Recommendations for Further Study

Effectiveness of Awareness Campaigns: Research should focus on evaluating the impact of social media and peer network campaigns in changing attitudes and behaviors regarding family planning among adolescents.

Community-Specific Myths and Misconceptions: Studies should explore the specific myths and misconceptions prevalent in different communities to tailor education programs more effectively.

Service Provider Training Impact: Investigate the effects of service provider training on the quality of counseling and service delivery for unmarried adolescents to identify best practices.

Policy Implementation and Funding Utilization: Research into the implementation of policies, particularly the allocation and utilization of increased funding, can help identify gaps and areas for improvement.

Adolescent-Friendly Health Facilities: Examine the feasibility and outcomes of incorporating adolescent-friendly features in health facilities to better support young people's reproductive health needs.

Barriers to Service Utilization: Conduct studies on the individual, social, and systemic barriers that prevent adolescents from utilizing family planning services effectively.

Long-Term Impact Assessment: Longitudinal studies assessing the long-term impact of improved family planning services on adolescent health and well-being in Nepal can provide valuable insights for ongoing policy and program adjustments.

By pursuing these research avenues, stakeholders can develop more informed, effective, and sustainable strategies to enhance family planning services for adolescents in Nepal.

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APPENDICES

Annex-I: Quantitative Questionnaire

Sociodemographic Status:

1. Age of Respondent (उमेर)……
2. Gender लिगं
   a. Male पुरुष b. Female महिला c. other अन्य
3. Marital Status (वैवाहित अवस्ता)
   a. Married बिवाहित b. Unmarried अबिवाहित c. Widower/Widow (एकल महिला/एकल पुरुष) d. Divorced/Separated (छोडपत्र वा छुटिएको)
4. Ethnicity जातियत
   a. Dalit दलित b. Janjati जनजाती c. Madhesi मदेसी d. Muslim मुस्लिम e. Bhramin/Chhetri ब्राह्मण/क्षेत्री f. Other अन्य
5. Religion धर्म

a. Hindu हिन्दु b. Buddist बौदिष्टc. Muslim मुस्लिम d. Christian क्रिश्चियन

e. Other अन्य……..

6. Education Status of Respondent शिक्षा स्थिति
7. Class 10 b. Class 11 c. Class 12 d. Bachelor Student
8. Head of your household for decision making? परिवारको निर्णय लिने प्रमुख भुमिका कस्को छ?
   a. Father बुबा b. Mother आमा c. Brother दाजु-भाई d. Sister दिदि-बैनि
   e. Self आफै

   f. Other अरु कोहि…….
9. Occupation of Father बुबाको पेशा
   a. Business व्यापार b. Farmer किसान c. Gov. Service सरकारी सेवा d. NGO/INGOs सरकारी ग्रैहसरकारी संध संस्थाहरु e. foreign employee बैदेशिक रोजगार

   f. Daily Labor दैनिक श्रम g. Other specific अन्य (……)

10. Occupation of Mother आमाको पेशा

a. Housewife गृहणी b. Agriculture कृषि c. Gov. Service सरकारी सेवा d. NGO/INGOs सरकारी ग्रैहसरकारी संध संस्थाहरु e. foreign employee बैदेशिक रोजगार

f. Daily Labor दैनिक श्रम g. Other specific अन्य (…….)

10. Average monthly Income of Family मासिक पारिवारिक आम्दानी

a. Below 10000 b. 10000 to 30000 c. 30000 to 60000 d. 60000 to 90000
e. Above 90000

Utilization of Family Planning services परिवार नियोजनका साधनहरुको उपयोग

1. Do you Have a BF/GF? तपाईको बोइफ्रइन्ड वा गलफ्रइन्ड छ?

Yes छ No छैन

2. Have you ever had sexual intercourse? के तपाईले कहिल्यै यौनसम्पर्क गर्नुभएको छ?

Yes छ No छैन

3. Age at First sexual Intercourse पहिलो पटक यौनसम्प्रक गर्दाको उमेर …….
4. Have you ever heard of about Family Planning? तपाइले परिवार योजनाको बारेमा सुन्नु भएको छ?

Yes छ No छैन

5. Have You ever heard about the contraceptives? तपाइले गर्भनिरोधक साधनहरुको बारेमा सुन्नु भएको छ?

Yes छ No छैन

6. If yes, how did you Know about the Contraception? यदि सुन्नु भएको छ भने, कसरी थाहा पाउनु भयो?

New paper पत्रपत्रिका social media (Facebook, TikTok, YouTube) सामाजिक सञ्जाल

Google गुगोल Friend (साथिहरु) Parents अभिभावक Others अन्य

7. Are you or your partner currently doing something or using any method to delay or avoid getting pregnant? तपाइँ वा तपाइँको पार्टनरले हाल केहि गरिरहनु भएको छ वा गर्भवती हुन ढिलाइ वा गर्भवती हुन वाट बच्नको लागि कुनै परिवार योजनाको साधन प्रयोग गरिरहनु भएको छ?

Yes छ No छैन

8. Which method are you using? कुन परिवार योजनाको साधन प्रयोग गर्नु भएको छ?

Female Sterilization (महिला बन्ध्याकरण) Male Sterilization (पुरुष बन्ध्याकरण)

IUCD (कपर टि) Injectables (डिपो सुई) Implants (इम्पलान्ट) Pill (पिल्स चक्कि)

Condom (कण्डम) Emergency Contraception (आकस्मिक गर्भनिरोधक चक्कि)

Lactational Amenorrhea Method (स्तनपान बिधी) Rhythm Method (क्यालेनडर बिधी)

Withdrawal (बाह्य स्खलन विधि)

9. Where do you get the contraception? परिवार योजनाका साधनहारु कहां वाट लिनु हुन्छ?

Gov. Hospital (सरकारी अस्पताल) Gov. Health Post (स्वास्थ्य चौकी) Gov. PHC (प्राथामिक स्वास्थ्य केन्द्र)

NGO/INGO (FPAN) (गैरसरकारी सँघसस्था) Meri Stop (मेरी स्टोप)

Private Hospital (निजी अस्पताल) Clinic/Polyclinic (क्लिनिक पोलिक्लिनिक)

Medical/Pharmacy (मेडिकल फार्मेसी) Other specific (अन्य…….)

10. If click to Gov. HFs, Why Did you feel easy to get contraceptives from Gov. HFs? के तपाइलाई सरकारी स्वास्थ्य संस्थावाट परिवार नियोजनका साधनको सेवा लिनकालागि सजिलो महसुस गर्नु भएको छ?

Yes छ No छैन

11. If yes, why did you feel it? यदि छ भने, किन सजिलो लाग्छ?

a. Privacy/Confidential गोपनियता b. Counseling परामर्श c. Trust of the provider बिश्वासिलो सेवाप्रदायक d. Convenience/accessibility नजिकैको सेवा e. Free of Cost निःशुल्क सेवा f. Quality services गुणस्तरिय सेवा g. Trained provider तालिम प्राप्त सेवाप्रदायक h. Awareness and promotion उचित जानकारि र प्रवन्धन i. Range of contraception option गर्भनिरोधकको छनौटका लागि वैकल्पिक दायरा j. Time (Open and close time of HFs) उपयुक्त समय

12. If click to Private HFs, Why Did you feel easy to get contraception from Private health facility? के तपाइलाई सरकारी स्वास्थ्य संस्थावाट परिवार नियोजनका साधनको सेवा लिनकालागि सजिलो महसुस गर्नु भएको छ?

a. Privacy/Confidential गोपनियता b. Counseling परामर्श c. Trust of the provider बिश्वासिलो सेवाप्रदायक d. Convenience/accessibility नजिकैको सेवा e. Free of Cost निशुल्क सेवा f. Quality services गुणस्तरिय सेवा g. Trained provider तालिम प्राप्त सेवाप्रदायक h. Awareness and promotion उचित जानकारि र प्रवन्धन i. Range of contraception option गर्भनिरोधकको छनौटका लागि वैकल्पिक दायरा j. Time (Open and close time of HFs) उपयुक्त समय

13. Did any staff member at the health facility speak to you about family planning methods? के तपाइ स्वास्थ्य संस्थामा सेवा लिन जादा कुनै सेवाप्रदायकले परिवार योजनाका बिधिहरु बारेमा केहि भन्नु भएको छ?

Yes छ No छैन

14. Were you informed about the other method of family planning? के तपाईलाइ अन्य परिवार योजनाका बिधिहरु बारेमा जानकारी दिनु भएको छ?

Yes छ No छैन

15. At that time, were you informed about side effects or problems you might have with the method? के तपाईलाइ रोजेको/छनौवट गरको साधन वाट हुन सक्ने सामान्य असर वा समस्याहरु बारेमा थाहा/जानकारी दिनु भएको छ?

Yes छ No छैन

16. Were you informed about what to do if you experienced side effects or problems? के तपाईलाइ सेवा वाट हुन सक्ने सामान्य असर वा समस्याहरुलाई कम गर्न के गर्ने भन्ने कुरामा पुर्व जानकारी दिनु भएको छ?

Yes छ No छैन

17. Were You informed about the possibility of switching to another method of contraception? के तपाईलाइ प्रयोग गर्नु भएको साधन फापेन वा तपाईलाइ राम्रो नगरेको खण्डमा अर्को बिधी पनि प्रयोग गर्न सकिन्छ भन्ने कुरामा पुर्व जानकारी दिइएको छ?

Yes छ No छैन

Barrier Related Questionnaire:

1. Did you feel any discomfort from taking contraception? के तपाईले गर्भनिरोधक साधन प्रयोग गर्दा वा गर्न खोज्दा कुनै अप्ठ्यारो महसुस गर्नुभएको छ?

Yes छ No छैन

2. Why did you feel discomfort for taking contraception from Health Facilities? यदि छ भने के कारण ले अप्ठ्यारो महसुस गर्नुभएको हो?

A. Individuals Barrier (व्यक्तिगत बाधाहरु)

Embarrassment/shyness लाज Yes हो No होइन

Lack of awareness of adolescent friendly health services किशोरकिशोरि मैत्री स्वास्थ्य सेवा चेतनाको अभाव

Yes हो No होइन Pressure to have child after marriage विवाह पछि सन्तान जन्माउने दबावले

Yes, हो No होइन

Fear of infertility due to use of contraceptives गर्भनिरोधकले बाजोपन हुन्छ भन्ने डरले

Yes, हो No होइन

B. Family member/society barriers (पारिवारिक वा सामाजिक बाधाहरु)

Fear of parents आमाबुबाको डरले Yes हो No होइन

Judgmental attitudes निर्णयात्मक मनोवृतिले Yes हो No होइन

Disapproval of community gatekeepers समुदायका अघुवाहरुको अस्विकारले Yes हो No होइन

Family pressure to have children/not to use a method सन्तान जन्माउनको लागि कुनै पनि साधनको प्रयोग नगर्न दबाव

Yes हो No होइन

Son preference छोरा जन्माउने कुराको प्रथमिकता Yes हो No होइन

C. Service provider barriers सेवा प्रदायक वाट हुने बाधाहरु

Inadequate counseling पर्याप्त परामर्श नहुदा Yes हो No होइन

Reluctance to provide contraceptive services गर्भनिरोधकका सेवाहरु दिन नचाहनाले.

Yes हो No होइन

Biasedness पक्षपात Yes हो No होइन

Cultural taboos सास्कृतिक निषेधहरु Yes हो No होइन

D. Health facility location and service-related barriers स्वास्थ्य सुबिधा, स्थान र सेवा सम्बन्धी अवरोधहरु

Poor physical access कम्जोर भौतिक संरचना Yes हो No होइन

Cost of services and transport सेवा शुल्क र यातायात खर्चले Yes हो No होइन

Lack of privacy गोपनियाताको कमिले Yes हो No होइन

Long waiting time लामो समय कुर्न पर्ने Yes हो No होइन

Inconvenient opening hours उपयुक्त समयमा संथा नखुल्ने Yes हो No होइन

Stock out of commodities प्रयाप्त साधन नहुनाले/भण्डार नभएकाले Yes हो No होइन

Lack of female providers महिला स्वास्थ्यकर्मिको अभावले Yes हो No होइन

Annex-II: FGD questionnaire

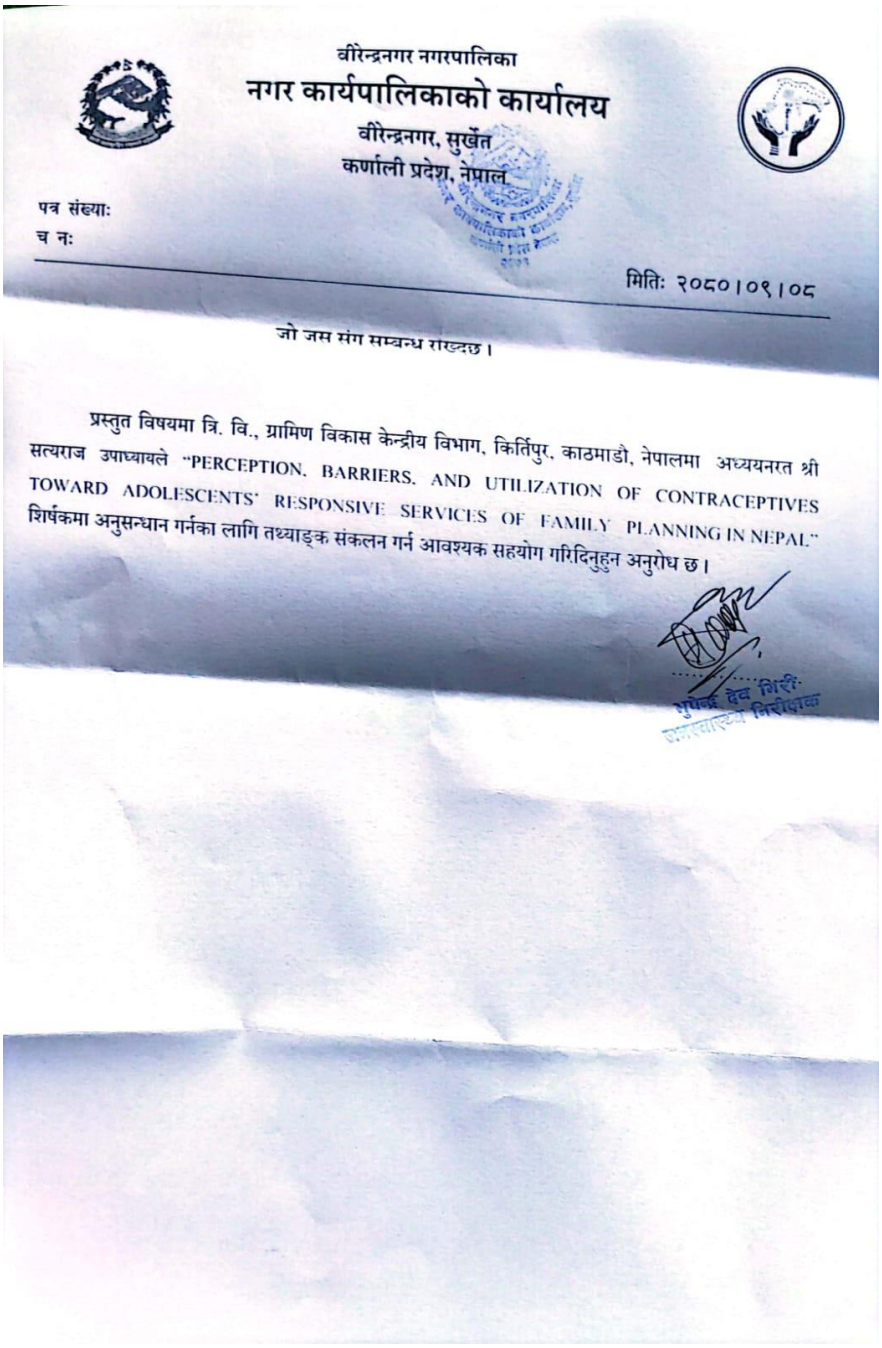
INTERVIEW GUIDE

Interview Guide for Focus Group Discussion

1. Concept of family planning
2. Primary source of family planning information
3. Societal perception on family planning
4. Religious or social stigma related to family planning.
5. Reasons for female contraception preference among men
6. Perceived side effects experienced by women after Contraception.
7. Decision making about family planning in the family.
8. Informative and awareness programs about family planning by the Government/Family Planning Association of Nepal/ District (Public) Health Office/ Non-governmental organizations
9. Role of male/female youths in strengthening the FP services in your community
10. Adequacy of family planning education in high school curriculum
11. Youth led social activities in the community about family planning.
12. Interview Guide for Focus Group Discussion in Nepali

1. परिवार नियोजनबारे तपाईँको अवधारणा
2. परिवार नियोजनबारे जानकारीको मूख्य स्रोत
3. परिवार नियोजनबारे समाजको धारणा
4. परिवार नियोजनबारे व्याप्त धार्मिक तथा सामाजिक अन्धविश्वास
5. पुरुष भन्दा महिला बन्ध्याकरणलाई प्राथमिकता दिनुका कारणहरू
6. बन्ध्याकरण गरिसकेपछि महिलामा हुने असरहरू बारे बुझाइ
7. परिवार नियोजन बारेमा तपाईँको परिवारको निर्णायक मान्छे
8. परिवार नियोजन सम्बन्धी नेपाल सरकार/नेपाल परिवार नियोजन संघ/जिल्ला (जन)स्वास्थ्य कार्यालय/गैरसरकारी संस्थाहरूले गर्ने जनचेतनामूलक एवं जानकारीमूलक कार्यक्रम
9. समुदायमा परिवार नियोजनका सुविधाहरूको सुदृढीकरणमा युवाहरूको भूमिका
10. उच्च माध्यमिक विद्यालयको पाठ्यक्रममा परिवार नियोजनबारेको शिक्षा
11. परिवार नियोजनबारे युवाहरूले समुदायमा गरेका सामाजिक कार्यहरू

Annex-III: Acceptance letter from Local Municipal level



वीरेन्द्रनगर नगरपालिका

नगर कार्यपालिकाको कार्यालय

वीरेन्द्रनगर, सुर्खेत

कर्णाली प्रदेश, नेपाल

पत्र संख्या:

च नः

मितिः २०८०।०९।०८

जो जस संग सम्बन्ध राख्दछ।

प्रस्तुत विषयमा त्रि. वि., ग्रामिण विकास केन्द्रीय विभाग, किर्तिपुर, काठमाडौ, नेपालमा अध्ययनरत श्री सत्यराज उपाध्यायले "PERCEPTION, BARRIERS, AND UTILIZATION OF CONTRACEPTIVES TOWARD ADOLESCENTS' RESPONSIVE SERVICES OF FAMILY PLANNING IN NEPAL" शिर्षकमा अनुसन्धान गर्नका लागि तथ्याङ्क संकलन गर्न आवश्यक सहयोग गरिदिनुहुन अनुरोध छ।

गुरुदेव गिरी

प्रशासकीय निरीक्षक