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USAID ADOLESCENT REPRODUCTIVE HEALTH

A Baseline Study Report

June 2023

This report presents the findings of the 2023 USAID Adolescent Reproductive Health Baseline Study (2023). The baseline study received funding from the United States Agency for International Development, Adolescent Reproductive Health Activity. The Center for Research on Education, Health and Social Sciences (CREHSS), a national research firm, implemented the survey in collaboration with USAID Adolescent Reproductive Health.

Suggested citation:

CARE Nepal and CREHSS.2023. *USAID Adolescent Reproductive Health Baseline Study Report*, Nepal.

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Acknowledgements

This Baseline Study for USAID's Adolescent Reproductive Health (ARH) activity is the outcome of sincere efforts by different individuals and organizations. The Center for Research on Education, Health and Social Sciences (CREHSS) would like to thank CARE Nepal for entrusting us with this valuable study.

Firstly, we are thankful to CARE Nepal team members for supporting and guiding us to implement and conduct this study smoothly. We would especially like to express our sincere thanks to Ms. Suzanne Marleen Reier, Mr. Min Raj Gyawali, Mr. Bidur Bastola, Ms. Manisha Laxmi Shrestha, Ms. Rabina Dhakal, Ms. Sapana Koirala, Mr. Santa Dangol, Ms. Sujata Singh of CARE Nepal for their immense support during tool finalization and finalization of the study report. In addition, we would like to thank the province-level focal points of CARE, Mr. Bijendra Banjade and Mr. Santosh Aryal, for their support during the training of the researchers and overall field execution. Secondly, we would like to express our deepest gratitude to USAID/Nepal team members Ms. Sabita Tuladhar and Mr. Netra Prasad Bhatta for providing technical guidance and invaluable support for conducting this study.

The research team would like to acknowledge the Family Welfare Division (FWD) and the Department of Health Services for the necessary support to conduct this study. Specifically, we are incredibly thankful to Dr. Bibek Kumar Lal, Director, FWD, and Ms. Kabita Aryal, FP/RH Section Chief, FWD, for their technical guidance during the finalization of the study protocol.

We are grateful to all the respondents of the HH survey (household head, adolescents, and caregivers/parents) and participants of the qualitative survey (key relevant stakeholders) who willingly and voluntarily participated in the study.

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Abbreviations and Acronyms

ARH	Adolescent Reproductive Health
AFS	Adolescent Friendly Services
ANC	Ante Natal Care
AYON	Association of Youth Organizations Nepal
CARE	Cooperative for Assistance and Relief Everywhere
CPR	Contraceptive Prevalence Rate
CREHSS	Center for Research on Education Health and Social Science
CSO	Civil Society Organizations
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FP	Family Planning
FPAN	Family Planning Association of Nepal
FWD	Family Welfare Division
FCHV	Female Community Health Volunteer
GEMS	Gender-Equitable Men Scale
HDI	Howard Delafield International
HHs	Households
HMG	Health Mother's Group
IUCD	Intrauterine Contraceptive Device
KII	Key informant interview
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
M	Municipality
LPG	Liquefied Petroleum Gas
LAM	Lactational Amenorrhea Method
MoEST	Ministry of Education, Science, and Technology
M&E	Monitoring and Evaluation
MoHP	Ministry of Health and Population
MoWCSC	Ministry of Women, Children, and Senior Citizens
MPPN	Multidimensional Poverty Peer Network
NDHS	Nepal Demographic and Health Survey
NGO	Non-governmental Organization
NHFS	Nepal Health Facility Survey
NHRC	Nepal Health Research Council
NMICS	Nepal Multiple Indicator Cluster Survey
ODK	Open Data Kit
PACE	Policy Advocacy Communication Enhanced
PHCC	Primary Health Care Center
PHC/ORC	Primary Health Care Outreach Clinics
PNC	Post Natal Care
PSU	Primary Sampling Unit
RH	Reproductive Health
RM	Rural Municipality
SBC	Social and Behavior Change
SPA	Service Provision Assessment

SPSS	Statistical Package for Social Science
SRH	Sexual and Reproductive Health
TOC	Theory of Change
USAID	United States Agency for International Development

Executive Summary

USAID Adolescent Reproductive Health (ARH) is a youth co-led initiative to empower girls and boys of 10-19 years, including the most marginalized, to attain their reproductive health (RH) rights. The baseline study aims to assess the current situation of adolescents' sexual and reproductive health in USAID ARH working municipalities, with specific objectives to identify family planning (FP) and reproductive health (RH) knowledge and practices, explore mass media exposure and preference, assess menstrual hygiene practices, identify factors affecting the age at marriage, generate evidence for policy change and programmatic interventions, and identify gender and social norms related to adolescent SRH issues in the community.

Methodology:
A sequential mixed method design beginning with the quantitative survey followed by the qualitative survey was used for this study. The study covered 11 program districts across three provinces (Madhesh, Lumbini and Karnali). For the quantitative part, a household (HH) level survey was carried out with household heads, adolescents aged 10-19, and their parents/guardians. A total of 5,670 adolescents (2268 boys and 3402 girls) and 1,512 parents/caregivers (25% of the parents of the adolescents) were covered in the survey. For the qualitative part, 33 Key Informant Interviews (KIIs) and 20 focus group discussions (FGDs) were conducted with different stakeholders.

Ethical approval was obtained from the Nepal Health Research Council (NHRC). Research ethics were followed throughout the study period. Quantitative data was collected using tablets/mobile devices in Open Data Kit (ODK) platform. Quantitative data were analyzed using descriptive statistics, univariate and bivariate analyses. For the qualitative part, all the data obtained from the qualitative survey, KIIs, and FGDs were fully transcribed. The qualitative data was thematically analyzed, generating codes and sub-codes. Moreover, the qualitative data was used to verify and understand s results from the quantitative survey.

Key Findings:
Household socio-demographic characteristics: The total population in surveyed HH was 30,488 (average family size=5.4), where 15,387 were male, and 15,101 were female. The average age and median age of the HH population were 25.8 years and 20 years, respectively. Almost half (48%) of the entire HH population had completed basic level education (grades 1-8), while a quarter of the HH members were uneducated (25%). Slightly above half (51%) of the HH members were currently married. Nearly half of the surveyed HHs' (47%) main source of family income was agriculture, followed by daily wage labor (21%).

Socio-demographic characteristics of adolescents: More than half of the adolescents (54%) were aged 10-14 years, and more than two-fifths (46%) were aged 15-19. Among the surveyed adolescents, 60% of respondents are girls and 40% are boys. Over one-fourth (26%) of the adolescents belonged to Madhesi other castes. Most of the adolescents were Hindu (92%).

Disability status: 8 percent of the adolescents had some difficulties, whereas 2 percent of adolescents had lots of difficulty in at least one of the six disability types (vision impairment, hearing difficulty, difficulty in communicating, difficulty in remembering or paying attention, difficulty in walking or climbing stairs, difficulty to shower or change clothes).

Education status: The majority of adolescents (92%) had ever attended school/formal education. Overall, 81% of the 5670 adolescents were currently attending school. More than three-fifths (62%) of those who had never heard formal/informal education reported than ever attending school/informal education due to financial crisis in their family. The proportion of adolescents who ever attended school/formal education was comparatively higher for Karnali (99.1%) and Lumbini province (97.3%) than Madhesh Province (89.6%). Among those who had ever enrolled in school, a substantial proportion dropped out of school (total=14%; boys 13%, girls 15%). The school dropout rate was higher for Madhesh Province (17.2%) compared to Karnali Province (4%).

More than two-fifths of the adolescents (44%; male=55%, female=38%) each revealed that they discontinued going to school due to a financial crisis in the family and due to a lack of interest in going to school (43%; male=51%, female=38%). Out of the adolescents who had dropped out of school, more than one-fourth (28%) wanted to rejoin formal education.

Contradicting the findings from the quantitative survey, in the qualitative interviews, enrollment among girls is higher than among boys, but they are not regular and only attend exams. Among the married vs. unmarried, most married adolescent girls do not attend classes as they are shy to attend classes after their marriage and are also obliged to do the household chores.

Marriage and Pregnancy: Overall, the median age of first marriage (among 201 married adolescents) was 16 years, and the mean age was 16.2 years. The median age for marriage was higher for Lumbini province (17 years) as compared to the other two provinces. Among the surveyed adolescents, 3.5 percent were currently married and about 5 percent had ever engaged in any sexual activity. Experience of sexual intercourse among early adolescents (10-14 years) was very minimal (0.1%) compared to late adolescents aged 15-19 years (11%). In the case of unmarried adolescents, only 2 (1.6%) of the respondents shared they had ever had sex; 4 percent among male and 0.2 percent among female. Among married adolescents 15-19, 99.5% were engaged in sexual activity. Of the 15-19 unmarried boys – eight percent have had sexual intercourse and 0.4 percent of unmarried girls have had sexual intercourse., . Almost half (45%) of the married and sexually active female adolescents or wives of male adolescents had been pregnant at least once. Among the adolescents who had ever been pregnant (n=88), the median age at first pregnancy was 17.0 years. More than three-fourths (77%) of ever pregnant adolescents have given birth to a child. Out of adolescents that were ever pregnant, 23 percent were currently pregnant. Out of 8 married adolescents who had more than one birth, only one (12.5%) had given birth with at least 33 months between births. More than three-fourths (77%) of recent births were delivered in health facilities, while 24 percent of the deliveries took place at home which was higher in Karnali province (40%). There were no home deliveries in Lumbini province. Notably, among the adolescent females who received ANC for their most recent delivery (N=58), only 12% (n=7) were counseled regarding post-partum family planning.

Qualitative findings depicted that there were several reasons for early marriage; poor socioeconomic conditions being the major reason. Additionally, noticeable changes in girls' body structure after the onset of puberty, , education status of adolescent females (after graduating from grade 10), and parents not wanting to miss a perfect match for their daughters, elopement/fear of elopement were other reasons for early marriage. The young adolescents eloped due to fear that their parents won't marry them off with the one they choose (caste issue , sometimes socio-economic condition), while the parents fear their daughters might elope after they reach around their 10 th grade (as they perceive at that time they are mature enough to involve in sexual activity) so in order to save their family prestige, before any such

incidents they initiate arrange marriage of their daughters. In cases of adolescent males who are ready to go abroad for foreign employment (especially in India), their families tend to send them only after their marriage, as the family believes that they will become more responsible and well-settled if they are married to someone.

Knowledge and utilization of reproductive health and family planning services: Knowledge regarding the legal age of marriage was found to be very minimal among adolescents. Only almost a half (total=49%; 37% among 10-14 and 63% among 15-19 years) stated the correct legal age of marriage for the girl as 20 years, whereas only 36 percent (29% among 10-14 and 44% among 15-19) stated the legal age of marriage for the boy as 20 years. Only more than two-fifths (total=43%, aged 10-14=25% and 15-19=63%) were aware of the menstrual cycle of women. Almost one-sixth of the adolescents (16%) mentioned that they had knowledge regarding the fertile period during the menstrual cycle. Most adolescents (87%) mentioned that a separate toilet for male and female students was available at their school.

Family planning: One-fifth of male and female adolescents (total=20%, aged 10-14=5% and aged 15-19=38%) had ever heard about family planning methods. The proportion was greater in Karnali Province (43%) compared to Lumbini (23.9%) and Madhesh Province (15.9%) Among those who had ever heard about FP methodsalmost one-sixth (total=16%, aged 10-14=4% and 15-19=30%) were aware of 3 or more methods., whereas only 9 percent (aged 10-14=2% and 15-19=17%) were aware of the use of 3 or more methods of family planning. The knowledge and use of 3 or more methods of family planning was also higher for Karnali Province (24.8%) compared to Lumbini province (5.4%). More than four-fifths (83%) of the adolescents were aware of the places and persons they could go to access any family planning methods or SRH services. Among them (n=952), the most common place for accessing FP methods and services for any SRH problems was reported as a health post (74%), followed by the governmental hospital (54%). Nearly two-thirds of the adolescents (62%) who had ever had sexual intercourse (N=169) had ever used FP methods. Ever use of FP methods was higher among unmarried adolescents (68%) than those currently married (56%). The major reasons reported by the married female adolescents for not using family planning methods were 'husband staying away from them' (45%) and 'their own opposition/refusal to use any FP method' (22%). Similarly, the married male adolescents stated that the main reasons for not using family planning methods were 'their own opposition/refusal to use any FP method (60%), followed by a lack of access to FP methods (20%). The ever use of FP methods (modern and traditional) was higher among male adolescents (72%) than females (53%). As per the qualitative findings, there were misconceptions about the use of FP methods among females. Females did not want to use FP methods because they had the misconception that it would decrease their fertility and increase bleeding during menstruation.

The Contraceptive Prevalence Rate (CPR) among adolescent girls aged 15-19 years for all methods was 15 percent. Among married adolescents the CPR for all methods was 15% and mCPR was 13.3%. . The mCPR among married adolescents was higher in Karnali province (36.8%) and lowest for Madhesh Province (8.1%), while the CPR for all methods was also lowest among the adolescent in Madhesh Province (8.1%) and highest in Karnali (42.1%). The most used FP methods (currently used) were male condoms (54%), pills (19%), IUCD/copper-T (16%), and withdrawal (11%). A higher proportion of adolescents who were currently using FP methods stated that decisions regarding the use of contraceptive methods were made jointly (43%), followed by mainly husband/partner (38%) and mainly respondents themselves (19%). In Madhesh Province, the joint decision making was low (33.3%) compared to Lumbini Province (28.6%) and Karnali (87.5%). Overall, 35 percent of the sexually active adolescent girls aged 15-19 had an unmet

need for family planning (14% for limiting and 21% for spacing). The unmet need for spacing was higher among adolescent (15-19) in Karnali province (45.5%), however the unmet need for limiting was higher in Madhesh Province (16.8%). The total demand for family planning among these adolescent girls (sum of met and unmet needs) was 48 percent, indicating that only over a quarter (28%) of the adolescent girls' demand for contraception was satisfied through modern methods.

Adolescent-friendly services: It is notable that more than two-thirds of the adolescents (69%) were unaware of Adolescents Friendly Services (AFS). Only 14 percent of adolescents were aware of a place where AFS is available. Among them, most of the respondents reported AFS are available in health posts (65%), followed by government hospitals/clinics (54%), PHCC (20%), and FCHV (10%). Only 7 percent of the adolescents (10% male, only 5% female) who were aware of the AFS had ever accessed these services. Among them (n=725), the majority had sought counseling on contraceptive use/safer sex (57%), followed by 'received contraceptive device' (44%), 'received emergency contraceptive' (39%), and 'received services for RH problems' (28%). The qualitative findings showed that the AFS seeking among adolescents was limited. According to the adolescent FGD participants, community people often disregard young girls and boys if they visit health facilities to seek services like family planning and abortion (especially if they visit to take condoms and ECPs).

Exposure to Family Planning/RH Information: Only around one-tenth (9%) of the adolescents and 12 percent of the parents/caregivers had heard/read about family planning/RH messages in the last six months. Among the adolescents who had heard/read about the family planning/RH messages in the previous six months, slightly more than three-fifths recalled hearing or seeing the message on menstrual hygiene (61%), followed by hearing or seeing about the use of FP methods (58%), birth spacing (28%) and ANC/PNC check-up (22%). Among the primary caregivers, almost four-fifths (78%) recalled hearing/seeing about the use of FP methods, followed by ANC/PNC check-ups and menstrual hygiene (51% each).

Involvement in Community Groups: Around a tenth of the adolescents were found to have been involved as a leader or a member of a group before joining USAID AHR formed group. Only 11 percent of them were involved in a sports club, followed by children or youth clubs (10%), the school management committee (7%), and savings group/microfinance organization (5%).

Menstrual Hygiene Practices: More than two-thirds (69%) of adolescent girls had onset of menstruation. Among them, the majority (72%) had menarche between 12-13 years. Almost two-thirds (65%) of adolescent girls used disposable menstrual pads as an absorbent product during menstruation, followed by cotton cloths (23%). Similarly, a large majority (86%) of respondents reported drying the reusable cotton cloth outside in the sunlight, whereas 13 percent said they dried it inside the house. Most adolescent girls (85%) reported that they could wash or change in privacy while at home during their last menstruation. Similarly, most adolescent girls (90%) reported going to school during menstruation. Out of the 167 adolescent girls who reported not going to school (sometimes or never) during menstruation, a large majority (84%) did not go to school due to abdominal discomfort, followed by a lack of menstrual pad disposal facilities at school (13%). Qualitative findings validated that menstrual pads are available at the school, but hygiene facilities are not adequately available for the students. Moreover, some of the adolescent FGD participants stated that there is a lack of separate toilets for boys and girls at their school, and there are no separate rooms for the girls to rest during menstruation.

Access to Digital Technology: Almost a quarter (23%) of adolescents had their own mobile phones. Out of the 4365 adolescents who did not have their own mobile phone, half (50%) mentioned that they did not use anyone else's phone, however; almost one-third (30%) stated using the phone of their mother/mother-in-law followed by father/father-in-law (13%). Two-fifths of adolescents (40%) reported spending an average of less than an hour a day using mobile phones, followed by 1-2 hours (39%). More than two-thirds (67%) reported watching entertainment videos, followed by making audio and video calls (48%) and TikTok videos (47%) on the phone. Of the total adolescents, 41% reported using the internet or data. Almost one-third (31%) of the adolescents reported that they use the internet/data for educational purposes.

Games-fit: Slightly above a fifth (21%) of the adolescents reported that they play digital games, among which almost all (99%) played digital games on a mobile phone. Ludo was the most common digital game (51%) played by adolescents, followed by Garena Free Fire (44%). Almost half of them (47%) were found to spend 1-2 hours a day playing their preferred game. Similarly, almost two-thirds (64%) of the adolescents who played digital games wanted to get information (academic/non-academic) through games, and 58 percent expressed their desire to learn FP/RH topics through games. The adolescents in Karnali Province were more likely to play digital games (23.7%) and learn from the games (65.6%) than the other two provinces.

Social Norms for RH behavior: A set of questions were asked to the parents/caregivers/community members of the adolescents about the lives and experiences of girls and boys in the community and how community members consider adolescents' behavior. Almost two-thirds of community members (65%) had moderately agreed with positive social norms, 16 percent hada high level of agreement for positive social norms, and 19 percent had a low level of agreement with positive social norms for RH behavior. Disaggregation by province showed a higher level of positive social norm agreement in Lumbini Province (32.5%) compared to Karnali (12.5%) and Madhesh Province (11%).

Gender equitable attitudes towards social norms (Gender-Equitable Men Scale): Gender equitable attitudes of parents/ caregivers towards various social norms were assessed in the survey through the Gender Equitable Men's Scale (GEMS). Of the total parents (community people), 56.5 percent demonstrated moderate equity, 43.4 percent demonstrated high equity, and 0.1 percent demonstrated low equity in regard to gender-equitable attitudes toward social norms. There was high equity in gender equitable attitudes in Karnali Province (73.6%) as compared to Lumbini and Madhesh Province.

Conclusion and Program Implications:

This study captured several dimensions of knowledge, attitudes and practice of sexual and reproductive health among adolescents and their families across Madhesh. Lumbini and Karnali province. Findings show that there are significant gaps in knowledge about family planning and reproductive health including healthy timing and spacing, contraceptive methods and the fertile period suggesting the social and behavior change nterventions are necessary to improve health FP/RH behavior among adolescents. The high unmet need of family planning among married and sexually active adolescents and minimal level of counselling during ANC for postpartum family planning clearly demonstrates a need to strengthen service delivery at the public and private health facilities. Although the vast majority of adolescents are in school, the high drop out rate in Madhesh province indicates that our plan to implement Udaan sessions in key pocket areas is important but may need to be expanded to the 15-19 year old group and possibly other provincesThe low level of support for positive social norms among parents suggests that the

planned group dialogue sessions with parents as well as adolescents must focus on social norms for FP/RH.. Many adolescents have mobile phones however, many others don't. USAID will facilitate the use of the digital game, meant for mobile phones, through SAA groups where everyone would not need a phone.

Key Indicators Summary

Indicators	Value	Total n	Total N	NDHS 2022	MICS 2019
Percentage of adolescent girls aged 10-19 years dropping out of school	14.8%	470	3135	3% (Nepal, Flash report 2021/22)	-
Median age at first marriage	16 Y	-	201	18.3 (W 20-49)	
Percent of adolescent girls aged 15-19 years with non-first births who had given birth with at least 33 months of birth spacing	12.5%	1	8	5.2%* (at least 36 months)	-
Percent of currently married adolescent girls 15-19 years who reported making the decision to use contraception jointly with their husbands or by themselves. By themselves Jointly with husband	57.6% 3.8% 53.8%	15 1 14	26	90.7%	
Modern contraceptive prevalence rate among married adolescent girls aged 15-19 years	13.3%	23	173	14.2%	17.3%
Proportion of adolescents (10-19) with basic knowledge on FP and RH At least one topic of FP and RH At least three topics of FP and RH At least five topics of FP and RH All seven topics of FP and RH	 74.3% 29.3% 9.1% 0.9%	 4213 1661 515 5	 5670 5670 5670 5670	99.8% (of all women) heard of any method-	-
Percent of individuals in the target population reporting exposure to USG-funded Family Planning (FP) messages through/on radio, television, electronic platforms, community group dialogue, interpersonal communication, or in print (by channel/number of channels)	9.4%	675	7182	-	-
Percentage of respondents who recall hearing or seeing a specific USG-supported Family Planning/Reproductive Health (FP/RH) message Among those heard Among total beneficiaries	 92.3 8.7	 626 626	 678 7182	-	
Percentage of adolescents who has access to a private place at home to wash and change during her menstrual period overall who used cotton clothes who used menstrual pad who used both cotton cloth and menstrual pad	 85.4% 75.3% 88.7% 87.5%		 2343 538 1528 273	-	80.9%
Percent of demand satisfied by a modern method of contraception	27.7%	41	147	24%	29.5%

Percent of community members describing current positive social norms for healthy RH behavior of adolescents in the targeted municipality				-	-
Low level of positive social norms	18.8%	284	1512		
Moderate level of positive social norms	65.1%	984			
High level of positive social norms	16.1%	243			
Percent of community members who report gender-equitable attitudes towards social norms (Gender-Equitable Men Scale)			1512		
Least Equity	0.1 %	1			
Moderate Equity	56.5%	855			
High Equity	43.4	6			
Percent of married adolescents 15-19 years who attended at least one Health Mother's Group in the last six months	6.9		173	-	-
Percent of women who deliver in a facility and initiate or leave with a modern contraceptive method prior to discharge	8.2%	4	49	-	-
Percent of adolescents (15-19) reporting unmet need for family planning					
Unmet need for limiting	13.6%	20		2.6%	4.2%
Unmet need for spacing	21.1%	31	147	28.4%	34.2%
Total unmet need	34.7%	51			
Percent of female adolescents 15-19 years who are married or in union (%)	10.9%	173	1591	21.3%	19.3%

Other key indicators

	Value	Total (n)	Total (N)	NDHS 2022	MICS 2019
Median age at 1st pregnancy	17.0	-	88	-	-
Percentage of adolescents who delivered their recent child in health facilities	76.5%	52	68	79.6%	82.2%
Percentage of adolescents who are sexually active	4.9%	278	5670	13%	-
Percentage of adolescents with knowledge of the legal age of marriage for boys	35.6%	2018	5670	-	-
Percentage of adolescents with knowledge of the legal age of marriage for girls	49.0%	2778	5670	-	-
Percentage of adolescents with knowledge of healthy timing of 1st pregnancy (above the age of 20)	43.5%	2466	5670	-	-
Percentage of adolescents with knowledge of the fertile period	15.7%	890	5670	28.4%	-
Percentage of adolescents with knowledge about three or more FP methods	15.8%	896	5670	-	-
Percentage of adolescents currently going to school.					
Total	80.9%	4587	5670		
10-14	90.9%	2801	3082	-	-
15-19	68.9%	1783	2588		

1 Introduction and Survey Methodology

1.1 Background

Adolescence is the transition period from childhood to adulthood, marking many physical, emotional, cognitive, and bodily changes and exposure of the adolescent to many health needs and risks (Sawyer et al., 2012). In Nepal, adolescents (10-19 years) comprise almost a quarter (24%) of the total population (CBS, 2012). The mean age of menarche in Nepal is 13.5 years, marking the onset of puberty (MoHP, 2012). The median age of marriage for men is 21.7 years and for women 17.9 years, despite the legal age of marriage being 20 years. Among girls aged 15-19 years, 27.1% are already married, and 16.7% are already pregnant or have a child (Ministry of Health, Nepal; New ERA; and ICF. 2017). Data from the Nepal Adolescent and Youth Survey 2010–2011 shows that adolescents from disadvantaged ethnic groups, religious minorities, and adolescents with no education were more likely to have given birth than adolescents from advantaged groups and with higher education (MoHP, 2012). The age-specific fertility rate is 71 births per 1,000 women aged 15–19 years, according to NDHS 2022 (Ministry of Health and Population, Nepal; New ERA; and ICF. 2022). Contraceptive use is extremely low among married adolescents- 14.2% compared with the national average of 43%. Unmet need is highest among adolescents 15-19 years, with 30.9% compared with the national average of 20.8% among women of the reproductive age group (Ministry of Health and Population, Nepal; New ERA; and ICF. 2022). The proportion of never-married male adolescents and youth who had ever had sexual intercourse was 22% and only 1% among never-married female adolescents in 2011.

Adolescents in Nepal face critical challenges in meeting their Reproductive Health (RH) needs and attaining RH rights. Poor access to RH information and low utilization of RH services, in addition to cultural taboos on adolescent sexuality and health, are some of the challenges for adolescents. Adolescent girls face additional challenges due to prevailing social and gender norms such as child, early, and forced marriage (CEFM), dowry-related violence, marital rape, sexual harassment, early childbearing, restrictions on physical movement, and gender-based violence (GBV) (Ministry of Health and Population, Nepal; WHO, 2017).

Considering adolescent health and development needs, a National Adolescent Health and Development Strategy in 2000 and (revised in) 2015, National Adolescent Sexual and Reproductive Health (ASRH) Program Implementation Guidelines 2011, and a National ASRH Communication Strategy (2011- 2015) was developed by the Government of Nepal which ensures the delivery of Adolescent Friendly Services (AFS) with standard operating procedures Ministry of Health and Population, Nepal; UNFPA and UNICEF 2015. As of 2021/22, 108 health facilities have been certified as adolescent-friendly sites (DoHS, 2078)). However, existing ARH services are limited and are not adolescent-friendly due to factors such as lack of privacy and confidentiality in service delivery, gender mismatch of service providers, fear of embarrassment as well as unawareness of the existence of services (Napit et al., 2020). To bolster past efforts, a new Adolescent Reproductive Health Strategy has been recently developed at the federal level; however, it is yet to be implemented by all the local levels.

USAID Adolescent Reproductive Health (USAID ARH) is a five-year activity supported by the United States Agency for International Development (USAID) led by Cooperative for Assistance and Relief Everywhere (CARE) Nepal and in partnership with Howard Delafield International (HDI), Jhpiego, Nepal CRS Company, and Association of Youth Organizations Nepal (AYON), to empower girls and boys of 10-19 years, including the most marginalized, to attain their adolescent reproductive health (ARH) rights. The primary goal of the USAID ARH program is to support adolescents to reach their full potential and strengthen public systems and private entities to create an enabling environment for healthy ARH behaviors through three main results: i. Adolescents have an improved understanding of their reproductive health, have developed skills to make healthy decisions, and are empowered to adopt healthy behaviors ii. Adolescent-responsive FP/RH services and products are available and accessible to adolescents in each municipality iii. Successful approaches and mechanisms addressing adolescent FP/RH are institutionalized. The USAID ARH project will contribute to a healthy, resilient, well-nourished population in Nepal.

This program works in coordination with the Government of Nepal Ministry of Health and Population (MoHP), Ministry of Education, Science and Technology (MoEST), Ministry of Women, Children and Senior Citizens (MoWCSC), and relevant province-level ministries along with Provincial Health Directorates, Provincial Health Training Centers, ARH Civil Society Organizations (CSOs), private sector organizations, and professional associations. The ARH Theory of Change (ToC) is based on the socio-ecological framework, which recognizes the need to address individual agency, family and community relations, and formal and informal structures for meaningful change in key behaviors. The USAID ARH ToC speculates on increasing the assets and agency of adolescents through Social and Behavioral Change (SBC) interventions as well as transforming social and gender norms of parents, teachers, and service providers. Further, the program aims to improve the quality and accessibility of existing ARH services by strengthening the capacity and accountability of providers, creating linkages to services as well as expanding the availability of services by increasing the role of the private sector in service provision and institutionalizing the provision of quality ARH services by supporting municipalities to contextualize, operationalize and allocate budget for ARH policies as well as strengthen accountability structures and measures. In this way, adolescents will be supported and empowered to make healthier ARH decisions leading to increased utilization of health services, delay in marriage, childbearing, and a reduced number of school dropouts.

1.2 Objectives

The overall objective of the baseline study was to assess the current situation of adolescents' sexual and reproductive health in USAID ARH working rural and urban municipalities.

Specific objectives were:

- To determine FP/RH knowledge and practice among adolescents.
- To identify the availability, accessibility, and acceptability of RH and FP services to adolescents.
- To explore the mass media exposure of adolescents and their preference for available media options.
- To access the knowledge and practices of menstrual hygiene among adolescent girls.
- To identify the gender norms, social norms, beliefs, perceptions, and behaviors related to adolescent SRH issues in the community.

1.3 Research method

A sequential mixed-method design including both quantitative and qualitative approaches was used for this study. The quantitative part of data collection was completed first. After analyzing the quantitative survey findings, qualitative data collection was done to further explore the results of the quantitative survey.

1.4 Study area

The baseline study was conducted across three provinces (Madhesh, Lumbini, and Karnali Province) in 11 districts of Nepal where the USAID ARH program is being implemented. Moreover, out of the 60 program municipalities/rural municipalities (15 rural, 45 urban) of the ARH project, the baseline survey was carried out in 14 municipalities (M) and seven rural municipalities (RM) of the program districts.

The name of the study districts and the study sites (selected M/RMs) are given below:

Table 1 Study districts, municipalities/rural municipalities

Districts	Municipality	Rural Municipality
Bara	Mahagadhimai M	Suwarna RM
Mahottari	Ram Gopalpur M Gaushala M	Samsi RM
Dhanusha	Kamala M Sabaila M	-
Parsa	Pokhariya M	Jagarnathpur RM
Rautahat	Gadhimai M Brindaban M	-
Sarlahi	Haripur M Barahathawa M	Chandranagar RM
Banke	-	Janki RM
Rolpa	Rolpa M	Lungri RM
Pyuthan	Swargadwari M	Jhimrukh RM
Salyan	Bagchaur M	-
Surkhet	Bheriganga M	-
Total (11 districts)	**14**	**7**

1.5 Data collection tools and techniques

Both quantitative and qualitative tools were developed based on the objectives and indicators.

For the quantitative survey, three sets of structured questionnaires were developed viz., questionnaire for i) Household (HH) head and/or a person who can provide information about the HH, ii) adolescent, and iii) parents. The major components of the quantitative tool were:

i) HH questionnaire: location of a house, caste/ethnicity, religion, source of family income, the total number of family members, and HH roster, which included age, sex, marital and disability status of each of the HH members, and HH possessions.

ii) Adolescent questionnaire: socio-demographic information, disability, education status, marriage, pregnancy and delivery status, knowledge and utilization of reproductive health and family planning services, exposure to Family Planning/RH information, Menstrual Hygiene Practices, digital literacy, and games-fit questions.

iii) Parents questionnaire: socio-demographic information, the school-going status of children, social norms for FP/RH behavior, and gender-equitable attitudes towards social norms.

For the qualitative study, Key Informant Interviews (KIIs) were conducted with different stakeholders of the study, e.g., relevant local government officials at the municipality, religious leaders, FCHVs, and schoolteachers, using a distinct KII guideline for each category of the informants. Similarly, focus group discussions (FGDs) were conducted with groups of grandparents, parents, and adolescents (boys and girls, married and unmarried) and Lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) adolescents and groups of disabled people using separate FGD guidelines for each of the categories. The KII and the FGD guidelines covered all the relevant themes of each of the categories that required further exploration based on the quantitative results.

1.6 Sample size and sampling techniques

Sample size: quantitative

The contraceptive prevalence rate among adolescents in 2019 MICS (i.e., 20.2%) was used to calculate the sample size for the quantitative survey. It was assumed that there would be a 10% increase in CPR by the end-line survey (i.e., 22.02%). A non-response rate of 10% was used and adjusted with the Finite Population Correction Factor (FPC). So, the total sample population was **5,670 adolescents.** Furthermore, 25% of adolescent parents (1512) were also interviewed.

Table 2 Sample size calculation parameters

Adolescent population in the districts	424334
$P_{baseline}$	20.2%
$P_{endline}$	22.2%
effect size	4%
Power (β)	80%
Sig (1-α)	95%
Test	2
Z(a)	1.96
Z(b)	0.842
Deff	3.1

	n_{min}	$n_{min\ with\ fpc}$
Sample size	5078	5018
nonresponse	10%	10%
$n_{adjusted\ NR}$	5586	5520
PSU	21	21
equal allocation	266	263

* FPC=*Finite Population Correction Factor*

Sample size: qualitative

For the qualitative part, a total of 33 KIIs and 20 FGDs were conducted. The following table presents the type of qualitative study participants and their sample size:

Table 3 Study participants and sample size: Qualitative

Tools	***Study Participants***	***Sample Size***
KII	Relevant local government and stakeholders at the municipality (Head of Health Unit and Social Development Unit or focal point: Combined)	9 (3 from rural and 6 from urban)
	Religious leader (Maulana/Priest/Faith Healer etc.)	9 (3 from rural and 6 from urban)
	FCHV (Young, Adult, elderly)	9 (3 from rural and 6 from urban)
	School Teacher	6 (3 from urban 3 from rural)
	Total KII	**33 (12 from rural and 21 from Urban)**
FGDs	FGD for disabled adolescent	2 from urban
	Married female adolescents (15-19)	4 (2 from urban 2 from rural)
	Unmarried female adolescents (15-19)	4 (2 from urban 2 from rural)
	Grandparents of adolescent (1 FGD with grand-mothers of the adolescent + 1 FGD with grand-fathers of the adolescents)	4 (2 from urban 2 from rural)
	Parents of adolescent (1 FGD with mothers of the adolescent + 1 FGD with fathers of the adolescents)	4 (2 from urban 2 from rural)
	LGBTQI adolescents	2 from urban
	Total FGDs	**20 (8 from rural and 12 from rural**

1.7 Sampling technique

Adolescent and parents survey:

The sampling of the study sites was done from among the total 60 USAID ARH program municipalities (15 rural, 45 urban) across three provinces of Nepal. In Madhesh Province, 41 municipalities (415 wards) from 6 districts; in Lumbini Province, 12 municipalities (94 wards) from 3 districts; and in Karnali Province, seven municipalities (87 wards) of 2 districts) were selected.

In the first stage, the municipality was divided into two strata (rural and urban). Among the 11 program districts, there were 17 strata. From these 17 strata, 21 primary sampling units (PSUs) were categorized (2 PSUs were made in the same district if there were more than 4 M/RMs). M/RMs were selected randomly from each district in case there was more than one M/RM.

In the second stage, from the 21 PSUs, wards were selected randomly. A total of 126 wards were selected (6 wards from each PSU).

In the third stage, clusters were made from the selected wards. If the ward has less than 300 HHs, that particular ward will be considered as one cluster but if any ward has more than 300 HHs, those wards were divided into sub-wards and then clusters were formed taking 300 HHs (in reference to other national surveys like Demographic and Health Survey).

In the fourth stage, one cluster was selected from each selected ward.

In the fifth stage, a list of HHs was prepared, and from each selected cluster, 45 HHs were selected. A systematic random sampling method was applied to select specific HH. To develop a sampling frame for the systematic random sampling of the HHs, the researchers obtained an updated list of HHs having adolescents aged 10-19 years in the area through consultation with local key informants of the respective area or through local authorities like municipalities/ward offices.

In the sixth stage, one adolescent boy or girl aged 10-19 from the HHs was selected. The adolescent was selected using the Kish Grid technique if there was more than one adolescent in the sampled HHs. Sixty percent of the sample were adolescent girls, and 40 percent were adolescent boys. In order to do so, the sampling was done as follows; out of 5 selected HHs, girls were covered from 3 HHs (1^{st}, 3^{rd}, and 5^{th}).

Considering the program focused on FP, RH, and social norms, a greater number of girls were covered.

Similarly, in the case of parents/guardians, they were interviewed from only 25% of the sampled HHs. Specifically, parents/guardians were covered from every fourth sampled adolescent HH.

Qualitative Survey: For the qualitative survey, FGDs and KIIs were conducted with key relevant stakeholders who were selected purposively upon consultation with district and rural/municipality level stakeholders.

1.8 Recruitment and training of field staff

A total of 44 local young enumerators (who were locals from the 11 study districts) and three province-level supervisors were recruited for the quantitative data collection, while a total of 6 field researchers were hired for the collection of qualitative data. Researchers were selected based on their qualifications and experience in both quantitative and qualitative data collection techniques. Young researchers who had at least a bachelor's degree in public health, health education, population, economics, social science, sociology, demography, and experienced interviewers were recruited for the fieldwork to gain respondents' confident, free, and frank responses.

Since the data collection for the quantitative part of the survey was conducted first, followed by qualitative data collection, the training of the enumerators was also conducted at different periods of time. In the first phase, four days of residential training were provided to the researchers at Rautahat (one of the sampled study districts) by the core team members of CREHSS, the project team of CARE, and USAID. During the training, the program objectives and purpose of the study were explained, along with the sampling methodologies for the selection of respondents. Mock interviews were conducted for a clear understanding of questionnaires, instructions, and skip patterns.

For the qualitative survey, a two-day training was provided to 6 field researchers who were experienced in collecting qualitative information. This training/orientation was conducted after the collection and analysis of quantitative data. The training for the qualitative survey included thorough sessions on the objectives of the qualitative survey, discussion on each of the distinct qualitative guidelines, and KII and FGD guidelines for each category of stakeholders.

1.9 Pretesting of tools

Pretesting of the quantitative tools was conducted before the training of the researchers to check the relevancy of question content, structure, the flow of questions, the accuracy of the language (i.e., the language is understandable to the respondent), and to check if there are any errors in skipping patterns. The structured tools were first pre-tested in Ramkot village of Nagarjun municipality, Kathmandu, by the core-team members of the study. Necessary modifications in the tool were made after incorporating the suggestions from the pre-test.

In addition, a field test was also done toward the end of the training session after various rounds of mock interviews. The field testing was conducted in Chandrapur municipality, ward no.4, of Rautahat district (non-sampled ward) on the fourth day of the training. The research tool was slightly modified in consultation with the USAID ARH team based on the feedback from the field test.

1.10 Data Collection

The trained young, local researchers were sent to their allocated districts in accordance with their field movement plan. Data collection/fieldwork was started simultaneously in all study areas. Each selected municipality had a team of two members consisting of one male and one female local enumerator. The province-level supervisors were responsible for ensuring the quality of data at the field level.

1.11 Field monitoring, management, and reporting mechanism

The field teams were closely monitored by the province-level supervisors and core team members of CREHSS, and the monitoring and evaluation (M&E) team of CARE Nepal and USAID. A strong mechanism was established for the monitoring and supervision of the overall data collection. The enumerators were required to report each day's data collection update to the province-level supervisors. In addition to that, any issues in the field that needed addressing were also first communicated to the supervisors. A WhatsApp group was utilized as a means to communicate and solve any field-level issues. Similarly, the supervisors were required to update the data collection status each day to the central team of CREHSS, and the CREHSS team were required to send the data collection update to the CARE and USAID team. In this way, the data collection was closely observed by each of the focal points of CREHSS, CARE, and USAID. Apart from this, the CREHSS, CARE, and USAID teams conducted several rounds of monitoring visits (real-time data monitoring) to different study M/RMs and provided constructive feedback to the data collection team, which helped ensure the data quality. Field researchers were in close contact with the USAID ARH program/M&E team throughout the study process. An update on data collection and field progress was submitted to CARE Nepal officials daily.

1.12 Data management and analysis

Quantitative data was collected using tablets/mobiles in the ODK platform. Several quality check mechanisms, such as range checks, logical checks, and skip instruction checks, were developed to help detect errors during the data collection. All collected data was kept secure in the office's password-protected computers.

The data collected each day in the field was sent to the server, which was downloaded each day by the data management officer at the CREHSS office. The data was checked thoroughly to identify any inconsistencies, and cross-verification was done with the field researchers for data validation.

Quantitative data were analyzed using descriptive statistics, and bivariate analysis of key indicators was done across various socio-demographic variables. SPSS Software (version 26) was used to analyze the quantitative survey. The preliminary results of the analysis were shared with the project team for review and feedback before finalization.

In the case of qualitative data management, as soon as the transcription of the first few (1-2) KIIs and FGDs were completed, the researchers were requested to immediately send the transcripts as well as the recordings via email. Those transcripts were read thoroughly and cross-verified by listening to the audio of the interviews to identify any feedback that needed to be conveyed to the researchers for further improvement. Following this process, wherever required, researchers were given feedback for further probing of questions and how to administer certain questions. Initial feedback was found to be effective, as shown in later transcripts.

All the data obtained from the qualitative survey, KIIs and FGDs were fully transcribed. To maintain the data quality, a cross-check was conducted after listening to the recordings. The qualitative data were thematically analyzed. First, the transcripts were read several times, and the codes were generated from the transcriptions. Similar codes were merged, and quotes were kept on different themes under different indicators (tables). Qualitative data was used to support the results from the quantitative survey.

1.13 Ethical considerations

Ethical approval of the study was received from NHRC (***Protocol Registration No: 559/2022 P***). Training on ethical considerations was provided by the ethical review team of NHRC to all the researchers during the training session. The study teams strictly followed existing social and research ethics throughout the study period.

The study participants and informants were interviewed after taking written consent. The consent of parents and assent of minor children were obtained before the interview. The consent process ensured that the respondents were well-informed about the organization and interviewer, the purpose of the study, their voluntary participation, the confidentiality of information, the anonymity of the informants, time duration, and the risk and benefits of their participation in the study.

Respondents were informed that they could skip any questions if they felt uncomfortable or could leave the interview anytime during the interview. However, they were told that the information provided to them would be valuable for designing and implementing the program later. All the interviews were conducted in confidential areas where the respondents felt comfortable for the interview. Each respondent was provided with a unique code to ensure the confidentiality of the respondents, and no personal identifier was used.

The enumerators and data supervisors were oriented on approaches and factors that must be followed during human subject research and ***do no harm considerations***. The research implementation team ensured the data security, and the raw data with individual identifiers of the respondents were not shared with anyone outside the study team. All the data are stored in password-protected laptops and only accessible to the study team. After transcription, all the recordings of qualitative interviews and FGDs were deleted.

1.14 Data quality assurance

Data quality assurance was ensured before, during, and after the data collection in the following ways:

Prior to data collection
A couple of meetings were conducted with the team of CARE Nepal and other ARH implementing partners, USAID and CREHSS, for tool development. Standard tools were developed based on the key research questions and indicators of the study, which were pretested prior to data collection to minimize the possibility of error and inadequacy of data. Field researchers (enumerators/supervisors) were trained on the study's content, process, and techniques that ensured and enhanced the data quality. Mock interviews were conducted several times during the training. Necessary revisions were made to tools prior to the survey based on the feedback from the pre-test, mock interviews, and field tests.

During data collection
Core team members of CREHSS, the program team of CARE Nepal, and focal persons from USAID visited the survey sites to observe and monitor the fieldwork/data collection and to understand, support and provide observations and feedback for immediate improvement to mitigate any challenges in the field. Several quality check mechanisms were implemented. The data collected each day was uploaded to the central server to protect it from any data loss and ensure data security. The supervisors were informed about the status of data collection/submission and completeness. Regular virtual meetings were organized by the core study team with the province-level supervisors to explore any challenges in data collection and were sorted out immediately.

After the data collection
Data quality was assured even after data collection. After the researchers uploaded the completed questionnaires, the data management officer at the CREHSS office was assigned to check the questionnaire. All the data was stored on password-protected computers where all the personal identifiers were deleted, and it was accessible only to the study team members. In addition, no personal identifiers were disclosed anywhere in the study.

1.15 Limitations of the study

Below are the limitations of this baseline study:

- This study selected one adolescent per family. Therefore, we may have missed other adolescents in a family who had other issues such as contraception, pregnancy, etc.
- Since the baseline is focused on the potential beneficiaries of the CARE Nepal ARH project, areas that intentionally concentrate on adolescent boys and girls and their parents/guardians, the finding of this study is not generalizable to the general population of other areas and the nation.
- Due to the cross-sectional nature of the study, the factors analyzed were measured at a single point in time. Thus, the analysis can only provide evidence of an association between those items and cannot show a cause-effect relationship.

1.16 Challenges and mitigation

The below table represents the challenges associated with the study and the mitigation measures that were followed to address those challenges:

Challenges	Mitigation measure
Even though there was four days intensive training, a few enumerators were confused about some methodological procedures, such as cluster formation, household selection, and respondent selection.	Those who had any confusion were immediately reached out to by the supervisors and explained well about the overall process. Moreover, the social media group, WhatsApp, was formed before the field visit. Video messages were sent to the social media group in the subjects of confusion.
Most adolescent boys and girls were in school, so our enumerators had difficulties finding them at their homes during the daytime.	To mitigate this challenge, enumerators utilized morning and evening time to collect data from the school-going adolescents.

2 Housing characteristics and household population

- The average age of the HH population was 25.8 years.
- Almost half (48%) of the HH population had completed primary-level education (1-8).
- Slightly above half (51%) of the HH members were currently married.
- Nearly half of the HHs (47%) had agriculture as the main source of their family income.

2.1 Household Socio-demographic characteristics of Household population

Household composition data of each adolescent's household was collected in the study from an adult member/primary caregiver. Key characteristics such as age, sex, educational status, marital status, province and place of residence and disability status of each member of the HH were collected. 'Households' are defined as families who live together and share the same kitchen. The total number of the HH population in surveyed HHs was 30488 (average family size=5.4), where 15387 were male, and 15101 were female.

Province-wise disaggregation showed that 70 percent of the HH population belonged to Madhesh, 21 percent belonged to Lumbini while only 9 percent of the HH population belonged to Karnali Province.

In terms of place of residence, two-thirds of the HH population (66%) lived in urban municipality.

The composite index for wealth quintile was calculated using equal weight for the number and kinds of various HH assets and consumer goods owned by the HH, such as a radio, television, landline phone, internet facility, computer, bicycle, motorcycle, tractor/trailer truck and car/bus and housing characteristics such as ownership of registered land, food sufficiency, ownership house where of currently living, roof type, and presence of electricity/solar and toilet facilities. A higher proportion of the HHs belonged to the highest wealth quintile (25%) compared to the lowest and middle wealth quintile (20% each), second wealth quintile (18%), and fourth wealth quintile (17%). A higher proportion of the male-headed HHs belonged to the highest wealth quintile (30%) compared to the female-headed HHs (23%).

The average age of the HH population was 25.8 years. The average age was slightly higher among males (26.5 years) than females (25.1 years). Similarly, the median age of the HH population was 20 years which indicates that half of the population was below 20 and half were above 20 years.

The information regarding the education status of each of the HH members aged four years and above (n=29642) was assessed in the study. Almost half (48%) of the HH population had completed basic level education (1-8), a quarter of the HH members were uneducated (25%), while almost one-fifth of them (19%) had completed secondary level education.

The marital status of the HH members aged ten years and above was assessed in the survey. Slightly over half (51%) of the HH members were currently married.

Nearly half of the HHs had agriculture as the primary source of family income (47%), followed by daily wage labor (21%) and foreign employment (15%).

Table 4 Sociodemographic characteristics of HH population

	Male	Female	Total HH
Province	N=15387	N=15101	N=30488
Karnali	8.4	9.1	8.8
Lumbini	21.1	21.6	21.3
Madesh	70.5	69.3	69.9
Municipality/Rural Municipality	N=15387	N=15101	N=30488
Rural Municipality	34.1	34.4	34.3
Urban Municipality	65.9	65.6	65.7
Wealth quintile	N=2268	N=3402	Total HH=5670
Lowest	14.5	23.4	19.9
Second	16.7	19.0	18.1
Middle	21.1	18.7	19.7
Fourth	18.3	16.2	17.0
Highest	29.5	22.7	25.4
Age	N=15387	N=15101	N=30488
Mean age (years)	26.5	25.1	25.8
Median age (years)	20.0	19.0	20.0
Education (aged 4 years and above)	N=14936	N=14706	N=29642
Uneducated	20.1	29.5	24.8
Informal education	6.4	9.5	7.9
Basic level education (1-8)	51.2	43.7	47.5
Secondary level education	20.5	16.5	18.5
Bachelor	1.4	0.8	1.1
Masters and above	0.4	0.1	0.2
Marital status (10 years and above)	N=13337	N=13230	N=26567
Unmarried	48.0	45.0	46.5
Currently married	49.9	51.4	50.6
Divorced/separated	0.1	0.2	0.2
Widowed	1.9	3.3	2.6
Other	0.1	0.0	0.1
The primary source of family income	N=2268	N=3402	N=5670
Agriculture			
Government service	50.1	44.9	47.0
Private service	3.2	3.1	3.2
Business	3.5	5.0	4.4
Daily wage labor	7.1	7.3	7.3
Foreign employment	22.4	20.7	21.4
Others	12.9	15.7	14.6
	0.7	3.1	2.2

2.2 Socio-Demographic Characteristics of Adolescents

Province-wise disaggregation showed that two-thirds of the total adolescents surveyed (67%) belonged to Madhesh province, almost a quarter of them belonged to Lumbini province (24%) and 10 percent of them belonged to Karnali province.

In regard to their place of residence, out of the total adolescents, two-thirds (67%) resided in urban municipality.

One-fourth (26%) of adolescents belonged to Madhesi other castes, followed by Madhesi Dalit (20%), and Hill Chhetri (13%). Most of the adolescents were Hindu (92%). More than four-fifths of the surveyed adolescents (82%) belonged to a nuclear family type.

Table 5 Socio-demographic characteristics of adolescents surveyed

	Male	Female	Total
Province			
Karnali	**3.8**	**5.7**	**9.5**
Lumbini	**9.5**	**14.3**	**23.8**
Madesh	**26.7**	**40.0**	**66.7**
Municipality/Rural Municipality			
Rural Municipality	**13.3**	**20.0**	**33.3**
Urban Municipality	**26.7**	**40.0**	**66.7**
Age group			
10-14	56.0	53.2	54.4
15-19	44.0	46.8	45.6
Caste/Ethnicity			
Hill Brahmin	1.4	3.5	2.7
Hill Chhetri	12.9	13.2	13.1
Madhesi Brahmin/Chhetri	7.6	4.7	5.9
Madhesi other	27.7	24.9	26.0
Hill Dalits	7.0	5.8	6.3
Madhesi Dalit	19.8	19.2	19.5
Newar	0.1	0.2	0.2
Hill/Mountain Janajati	7.6	7.0	7.2
Terai Janajati	7.3	10.4	9.2
Muslim	7.0	7.4	7.2
Others	1.5	3.7	2.8
Religion			
Hindu	92.5	92.4	92.4
Buddhist	0.1	0.1	0.1
Christian	0.4	0.2	0.3
Muslim	6.8	7.3	7.1
Others	0.1	0.1	0.1
Family type			
Nuclear	81.0	83.3	82.4
Joint	16.9	15.0	15.8
Extended	2.1	1.7	1.9
Total	100.0	100.0	100.0
Number	2268	3402	5670

3 Disability status

- Eight percent of the adolescents had some difficulty, whereas 2 percent of adolescents had a lot of difficulty (measured based on the Washington Group of questions on disability) in at least one of the six disability types (difficulty seeing, difficulty hearing, difficulty walking or climbing steps, difficulty remembering or concentrating, difficulty with self-care, difficulty communicating).

3.1 Disability status of the HH population

The study also investigated the disability status of the household population. Only 2 percent of HH members had some disability. Around 1 percent reported having a vision and/or hearing impairment and/or physical disability.

Table 6 Disability status of the HH population

Type of disability*	Male	Female	Total
No disability	97.5	97.6	97.5
Vision Impairment	1.3	1.2	1.2
Deaf or hard of hearing	0.9	0.7	0.8
Retarded mental health conditions	0.2	0.2	0.2
Intellectual disability	0.2	0.2	0.2
Acquired brain injury	0.0	0.1	0.1
Autism spectrum disorder	0.1	0.1	0.1
Physical disability	0.6	0.6	0.6
Difficulty in speaking (multiple responses possible)	0.2	0.3	0.3
Total	100.0	100.0	100.0
Number	15387	15101	30488

* Multiple responses

3.2 Disability status of Adolescent

A set of questions (Washington Group of questions) related to disability were asked to the adolescents to explore if they have any kind of disability.

(Washington Group of questions)
1. Do you have difficulty seeing, even if wearing glasses?
2. Do you have difficulty hearing, even if using a hearing aid(s)?
3. Do you have difficulty walking or climbing steps?
4. Do you have difficulty remembering or concentrating?
5. Do you have difficulty with self-care, such as washing all over or dressing?
6. Using your usual (customary) language, do you have difficulty communicating, for example, understanding or being understood?

The composite index of percentage distribution of difficulty in at least one out of the six disability types was calculated. Eight percent of the adolescents had some difficulty, whereas 2 percent had a lot of difficulty in at least one of the six disability types.

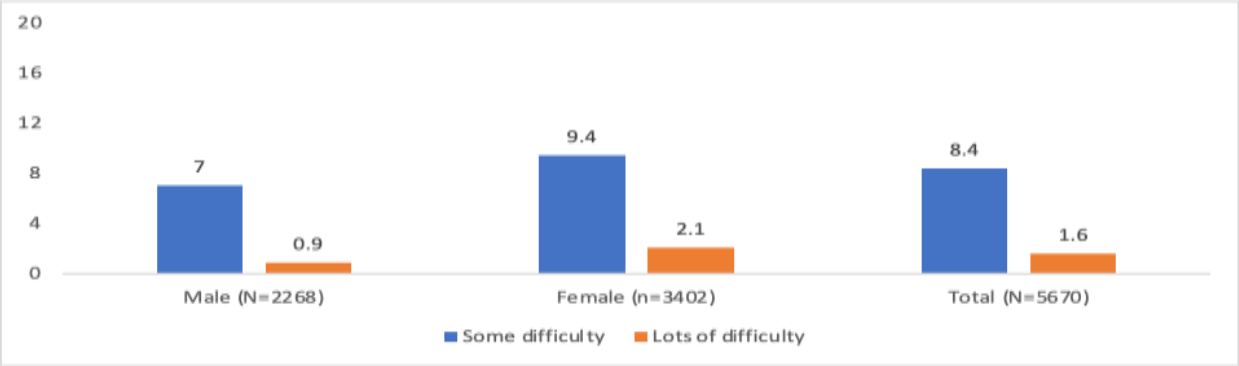

Figure 1 Percentage distribution of difficulty (some and a lot) in at least one of six disability indicators

4 Education status

- Most adolescents (92%) had ever attended school/formal education.
- Overall, 81% of the total 5670 adolescents were currently going to school. Among the adolescents who had never attended school/formal education (n=436), 26% had ever attended informal education.
- More than three-fifths (62%) reported that they never attended school/informal education due to a financial crisis in their family, while more than one-third (37%) revealed that they were not interested in going to school/informal education classes.
- Parents/caregivers also mentioned that the major reason for their sons (62%) and daughters (60%) not currently going to school was due to a financial crisis in their family.
- Fourteen percent of adolescents (male=13%, female=15%) who have ever attended school were not currently going (drop out) to school.
- More than two-fifths of adolescents (44%) revealed that they discontinued going to school due to the family's financial crisis and a lack of interest in going to school (43%).
- Findings from the quantitative survey, and supported by qualitative interviews, shows that enrollment among girls is higher than boys but girls are not regular and only attend exams. Among the married vs unmarried, most of the married adolescent girls do not attend classes as they are shy to attend classes after their marriage and are also obliged to do the household chores.

4.1 School enrollment status

Most adolescents (92%) had ever attended school/formal education. The proportion of adolescents ever attending school/formal education was highest in Karnali Province (99%) and lowest in Madhesh Province (90%). Similarly, a slightly higher proportion of the adolescents residing in urban municipality (93%) than those living in rural municipality (91%) had ever attended school/formal education. The disaggregation based on wealth quintile showed that ever attendance of school/formal education was lowest among adolescents belonging to the lowest/poorest wealth quintile and highest among those belonging to the highest/richest wealth quintile (96%). Sex-wise disaggregation revealed that a slightly higher proportion of male adolescents had ever attended school/formal education (94%) than that female (92%). Caste/ethnicity-wise analysis showed that a higher proportion of adolescents from the Madhesi Dalit (19%) caste and Muslim caste (17%) had never attended school/formal education.

The qualitative information from the KIIs and FGDs states there has been an increase in school enrollment in recent years and shows the attendance among girls is high. However, the situation between married and unmarried adolescent boys and girls differs. Contradicting the findings from the quantitative survey, in the qualitative interviews, the enrollments among girls are more than boys, but they are not regular and only attend exams. One of the exciting findings also shows that students in Madhesh province enroll in both public and private schools at the same time. They attend classes in private schools but take their exams at public schools. Among the married vs. unmarried, most of the married adolescent girls do not attend classes as they are shy to participate in classes after their marriage and are also obliged to do the household chores. In some cases, in Madhesh, girls do not go to Madarasa due to shyness as soon as they experience signs of puberty (development of their body parts).

> *Married adolescents do not enroll in schools. There are minimal chances that they will join schools. Some enrolled students get married at 16-17 age and eventually discontinue school after marriage.* -**KII, Health teacher, Kamala Municipality**
>
> *The school enrollment in our community has increased compared to last year. The enrollment among girls is better than boys. However, school attendance is low; they are not regular but attend only during exam time*. - **KII, Health teacher, Ramgopalpur Municipality**
>
> *In our community, most of the girls do not go to Madarasa after the age of 12. It is because they are shy after the development of their body parts. Furthermore, they focus more on household chores. Also, their parents are poor, so they cannot continue their schooling*. - **KII, Religious Leader, Kamala Municipality**
>
> *The schools are open to everybody. In our school, we have separate classrooms for disabled children. Moreover, we also have teachers who are blind, and they teach there. This year, we have students who will take SEE exams as well*. - **KII, health teacher, Ramgopalur Municipality**
>
> *Since our parents are uneducated, they do not understand the importance of educating us. In addition, they do not care about our studies. We are never encouraged by our parents.* **-P2, FGD with married female adolescents, Kamala Municipality**

The school enrollment among disabled people has been encouraged by various support provided by different organizations like DAC Nepal and enabling environment by the students. The FGD with disabled adolescents from Banke district shared that the ramp constructed at the school has eased their commute to the school. Furthermore, the toilet facilities at the school are also constructed disable-friendly. It has increased school enrollment among disabled students.

Table 7 Ever attended school/formal education by socio-demographic characteristics.

	Ever attended school/formal education.	Total number of adolescents
Province		
Karnali	99.1	540
Lumbini	97.3	1350
Madhesh	89.6	3780
Municipality/Rural Municipality		
Rural Municipality	91.1	1890
Urban Municipality	92.9	3780
Wealth Quintile		
Lowest	82.9	1126
Second	93.6	1025
Middle	93.6	1115
Fourth	95.0	964
Highest	95.9	1440
Age group		
10-14	93.6	3082
15-19	90.7	2588
Sex		
Male	93.5	2268
Female	91.5	3402
Caste/Ethnicity		
Hill Brahmin	96.7	151
Hill Chhetri	98.6	740
Madhesi Brahmin/Chhetri	96.4	334
Madhesi Other	95.5	1476
Hill Dalit	95.5	358
Madhesi Dalit	81.1	1103
Newar	100.0	10
Hill/Mountain Janajati	98.8	410
Terai Janajati	91.9	519
Muslim	83.5	411
Others	98.1	158
Total	92.3	5670

Reasons for never attending school and informal education

Among the adolescents who had never attended school/formal education (n=436), slightly more than a quarter (26%) had ever attended informal education, the proportion being slightly higher among males (34%) than females (21%).

The study investigated the reasons among adolescents who had never attended formal/informal education (N=325). More than three-fifths (62%) reported that they never attended school/informal education due to a monetary crisis in the family. In comparison, more than one-third (37%) were not interested in attending school/informal education classes.

The qualitative information from KIIs and FGDs states several reasons for not attending the schools. Poverty remains the main reason for it. Behind poverty, other reasons were lack of awareness of family

members regarding the importance of education, household chores, alcoholic household members, and unsupportive parents. Regarding the discontinuation of studies, girls discontinued due to marriage and household chores, whereas boys discontinued due to peer-influence. The peers who left school lured school-going peers showed the dreams of purchasing telephones and enjoying their freedom. Some students also shared the painful scenario witnessed, such as lack of employment despite degrees; hence, they do not see any future after studies. Therefore, they choose to do some jobs and are not interested in attending school. To support the above themes on school enrollments, attached are the excerpts from the interview transcripts:

> *We often do not like how our teacher teaches us in our class. They never make an effort to know if we have understood or not. They are more concerned about finishing the syllabus. This is the reason we sometimes do not like to attend our classes. P4-* **FGD with unmarried female adolescents, Mahagadimai Municipality**

> *Maybe the major reasons for not attending school are due to poverty. As the families are poor, they have to go to other areas (India or cities) for work. People know they have to educate their children, but they cannot do it due to poverty.* **-KII, Head of Education Department, Janaki RM, Banke District**

> *The economic condition of the family members is the primary reason for school drop-out, but peer influence is also evident among the students in villages. Family members drinking alcohol is also the reason for early dropout of the students among the Dalits, and children also start to imitate the habit of their family members. The peer influence, mainly following others who go to India for employment opportunities, has also stirred many cases of school dropouts.* **- KII, Health Teacher, Lungri RM**

Meanwhile, the FGDs with the grandparents had different views and situations for the school-going situation. The transcripts state:

> *In our time, we did not have opportunities to study. Even if we wanted to study, there were no schools available. Our parents also told us to go to India and earn money rather than study. -***P3, FGD with grandparents, Bagchaur Municipality**

The FGD with unmarried adolescents from Janaki RM states that the main reasons for not attending school were either they wanted to use mobile phones or lacked the desire to participate in school. Further adding to the context of education, adolescents do not value education despite their parents encouraging their children to attend. The FGD with married adolescent states that they do not attend schools after their marriage because they are often teased (married females attending schools seem abnormal) by their friends at school after getting married.

> *Some students do not attend the school because they are scared of the teachers. They are afraid because they are asked questions; if they do not know, the teacher punishes them. This is one of the reasons not to attend school. -***P6, FGD with unmarried adolescents, Bheriganga Municipality**

Table 8 Reason for never attending school/informal education

Reason for never attending school/informal education*	Male	Female	Total
Due to marriage	3.1	3.1	3.1
Due to pregnancy/childbirth	0	0.4	0.3
Financial crisis in family	65.3	60.4	61.8
School is far from home	3.1	8.4	6.8
Have to take care of children/siblings at home	2.0	4.8	4.0
Engaged with household chores	11.2	29.5	24.0
School does not have separate toilet for boys and girls	2.0	0.4	0.9
School environment was not disable friendly	0	1.8	1.2
Unsafe to travel to school	1.0	0	0.3
Not interested to go to school	36.7	37.0	36.9
Parents asked not to go	2.0	13.2	9.8
Others	8.2	7.5	7.7
Total Number	98	227	325

** Multiple responses*

4.2 Current school-going status of adolescents ever attending school

Overall, 81% of the 5670 adolescents were currently attending school. Among those adolescents who had ever enrolled in school/informal education, a large majority of the adolescents (86%) were now going to school at the time of the survey.

The qualitative information shows that many adolescent boys in the village do not attend school. The findings show that they imitate their peers and drop out of their school. Furthermore, after working in India, they are attracted to buying different materials, such as mobile phones. To support the above themes on school enrollments, attached are the excerpts from the interview transcripts:

> In our community, we can witness boys drop out their school more than girls. Most of the boys drop out of their school and go for foreign employment (either in India or other Arab countries). They are more interested in buying smartphones than pursuing their education. -**KII, Health Teacher, Dhanusa**

> Despite obtaining degrees, I have seen many of my seniors not getting jobs. Therefore, we can see high dropouts of students. They leave their school after grades 8 to 10. -**P1, FGD with parents, Bagchaur, Salyan**

> *Generally, adolescent females do not attend school because they are asked to assist in the household chores. They only attend the exams.* **P1, FGD with married adolescents, Kamala Municipality.**

On the counterparts, the study explored the age and grade of adolescents at which they discontinued going to school among those who were not currently going to school (14%, n=760). The age of discontinuation of school ranged from 5 years to 18 years, the proportion being higher in between the age group 12-16 years (58%). Similarly, almost one-sixth (15%) of the adolescents reported that they dropped out of school after completing grade 10.

The qualitative information also reveals that most school drop-out occurs at the age of around 15 to 16 (after grade 6). The trend of school dropout among boys is higher, whereas, in cases of married adolescents, girls show more dropouts.

> *The main reason for the school dropouts in our community is the perception of the parents. They think that the ultimate aim of life is earning money. Hence, parents do not encourage their children to do their studies and especially send their sons for foreign employment after the age of 15-16.* -**KII, Health Teacher, Dhanusa**

Also, the reason behind the dropout of school was further explored in the study among those who were not currently going to school (14%, n=760). More than two-fifths of the adolescents (44%; male=55%, female=38%) each revealed that they discontinued going to school due to the financial crisis in the family and due to a lack of interest in going to school (43%; male=51%, female=38%).

As shown in the quantitative, the qualitative information also echoes poverty as the main reason for school dropouts. In addition, the household chores for females are the main reason for school dropouts.

Table 9 Current school-going status of adolescents ever attending school

	Male	Female	Total
Currently, school going status			
Yes	86.7	85.2	85.8
No	13.3	14.8	14.2
Total	100.0	100.0	100.0
Number	2170	3175	5345
Reason for Drop out*			
Due to marriage	1.7	15.1	10.0
Due to pregnancy/childbirth	0.0	1.1	0.7
Financial crisis in family	55.0	37.8	44.3
School is far from home	6.9	9.6	8.6
Have to take care of children/siblings at home	1.0	6.6	4.5
Engaged with household chores	17.0	29.3	24.6
School does not have separate toilet for boys and girls	0.0	0.4	0.3
School did not provide menstrual pads	0.0	0.4	0.3
School environment was not disable friendly	0.0	0.4	0.3
Unsafe school environment (bullying, harassment)	1.0	1.1	1.1
Unsafe to travel to school	1.0	1.7	1.4
Not interested to go to school	51.2	37.8	42.9
Parents asked not to go	1.0	12.3	8.0
Others	8.0	6.6	7.1
Number	289	471	760

** Multiple responses*

Percent of schoolgirl dropouts by socio-demographic characteristics

A substantial proportion of the adolescent girls (15%) who had ever enrolled in school (N=3175) reported dropping out. Province-wise analysis showed that adolescent girls belonging to Madhesh Province had a significantly higher ($p<0.001$) school dropout rate (17%) than Lumbini (13%) and Karnali Province (4%).

Similarly, school dropout among adolescent girls was significantly higher ($p<0.05$) among those residing in rural municipality (17%) than those living in urban municipality (14%). Likewise, school dropout was significantly higher ($p<0.001$) among adolescents aged 15-19 years (26%) compared to those aged (10-14 years).

Similarly, adolescent girls belonging to the lowest wealth quintile were the ones who had the significantly highest ($p<0.001$) school dropout rate accounting for 19 percent. In contrast, those belonging to the highest/richest wealth quintile had the lowest dropout rate (13%). Caste/ethnicity-wise analysis showed that Madhesi Dalit adolescent girls had the highest ($p<0.001$) while girls belonging to Hill Brahmin ethnicity had the least (3%) school dropout rate.

The qualitative findings regarding the school dropouts of girls show that girls from the Madhesh province discontinued their schools after grade 10, as they were deemed appropriate for marriage. Also, after marriage, girls were not allowed to attend school and were made to do all the household chores.

Table 10 Percent of schoolgirl dropouts by socio-demographic characteristics

	Dropping out of school (Female)	Total number of female adolescents
Province* (Chi-square=40.3, p=0.000)**		
Karnali	4.0	322
Lumbini	13.2	804
Madhesh	17.2	2049
Municipality/Rural Municipality* (Chi-square=4.7, p=0.029)		
Rural Municipality	16.8	1041
Urban Municipality	13.9	2134
Wealth Quintile ** (Chi-square=14.7, p=0.005)		
Lowest	19.4	682
Second	13.4	614
Middle	14.6	602
Fourth	13.5	526
Highest	13.0	751
Age group* (Chi-square=282.6, p=0.000)**		
10-14	5.0	1711
15-19	26.3	1464
Caste/Ethnicity* (Chi-square=154.2, p=0.000)**		
Hill Brahmin	3.4	119
Hill Chhetri	5.8	446
Madhesi Brahmin/Chhetri	21.5	158
Madhesi Other	14.8	813
Hill Dalit	10.3	194
Madhesi Dalit	28.4	529
Newar	0.0	7
Hill/Mountain Janajati	5.5	237
Terai Janajati	11.3	327

	Dropping out of school (Female)	Total number of female adolescents
Muslim	21.1	223
Others	16.4	122
Total	14.8	3135

**** Significant at chi-square test p<0.001, **=p<0.01 and *=p<0.05*

4.3 Desire to enroll in school again

Out of the 760 adolescents who had dropped out of school, more than one-fourth (28%) wanted to rejoin formal education. Among them, 36 percent were female, and 16 percent were male.

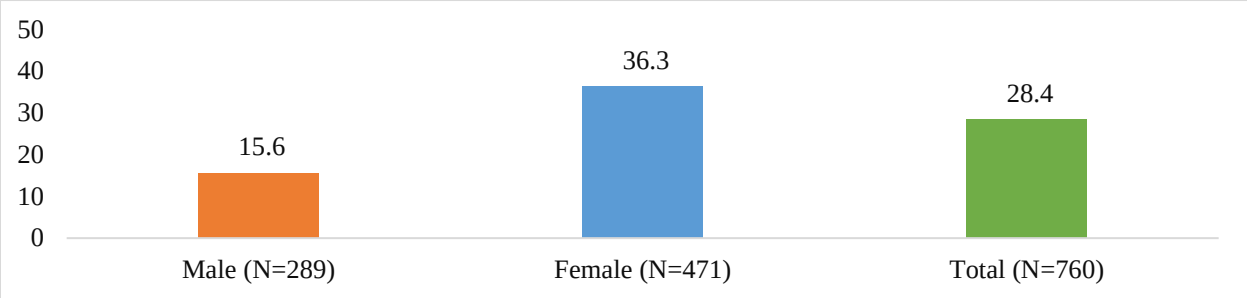

Figure 2 Desire to re-join formal education

Among those respondents who reported they don't want to re-join formal education (n=544), almost three-fifths (56%) stated that 'they were not interested in going to school,' one-third of them (33%) said 'they don't want to rejoin school due to financial crisis in the family' followed by 'engagement in household chores (24%)'.

The qualitative findings show that there are limited follow-up programs to address the discontinued students. The teachers casually ask their reason for dropping out from school. Some of the schools have also made efforts to rejoin the students. The interview with concerned authorities stated that,

> *We do not have any program addressing the issue of dropouts. When we start the enrollment program in the school, we teach them how they can continue their schooling till grade 10*. **-KII, Head of Education Department, Janaki RM, Banke District**
>
> *We have made an effort to rejoin the students in school. For example, we held a meeting with parents, teachers, and students. We informed the importance of education in their future and shared what they could do with their studies.* **-KII, Health Teacher, Dhanusa**
>
> *We must teach everybody about the advantages of attending school. Maybe, we have to perform some street dramas to demonstrate the importance of education. This might raise awareness among the local people.* **P1, FGD with unmarried adolescents, Janaki Gaupalika, Banke**
>
> *Since the school is very far, we need a bicycle to reach our school. The bicycle facilities are available from grade 9, and if we get that facility from grade 5, it will be beneficial.* **-P1, FGD with unmarried adolescents, Mahagadimai**

Furthermore, FGD with the LGBTQI also shared that they had to discontinue their education due to their identity and sexual orientation.

"I was compelled to drop out of the school and stay at home when my identity was disclosed."

Meanwhile, the FGD with the married adolescents from Bheri Ganga Municipality stated that they have the desire to enroll in school again if their parents-in-law and husband allow and support their education. But there are other issues, such as time management, competitive studies, and punishment in the school, which discourage them from attending the school. Therefore, they want to participate in vocational education like tailoring and sewing as they think it is more suitable than attending classes.

Table 11 Desire to re-enroll in school

	Male	Female	Total
Want to re-join formal education			
Yes	15.6	36.3	28.4
No	84.4	63.7	71.6
Total	100.0	100.0	100.0
Number	289	471	760
Reason for not wanting to re-join formal education *			
Due to marriage	2.5	22.0	13.2
Due to pregnancy/childbirth	0.0	9.7	5.3
Financial crisis in family	48.8	20.7	33.3
School is far from home	3.7	8.7	6.4
Have to take care of children/siblings at home	1.2	5.3	3.5
Engaged with household chores	18.9	29.0	24.4
Unsafe school environment (bullying, harassment)	1.2	.3	0.7
Unsafe to travel to school	0.0	1.0	0.6
Not interested to go to school	54.1	56.7	55.5
Parents asked not to go	.8	4.7	2.9
Others	6.1	3.0	4.4
Number	244	300	544

** Multiple responses*

4.4 Need any support to continue formal education

The study further explored if adolescents who want to rejoin formal education need any support to continue their education. More than four-fifths (88%) said they needed support, and among them also, more than two-thirds (68%) mentioned that they needed financial support to continue formal education.

Table 12 Desire to re-enroll in schoo

	Male	Female	Total
In need of support to continue formal education			
Yes	88.9	87.1	87.5
No	11.1	12.9	12.5
Total	100.0	100.0	100.0
Number	45	171	216
Type of support needed			
Financial support	87.5	62.4	67.7
Family support	10.0	34.2	29.1

Others	2.5	3.4	3.2
Total	100.0	100.0	100.0
Number	40	149	189

4.5 Difficult part of the school

The study tried to explore the difficult part of school perceived by the respondents among those who were currently going to school during the survey (n=4585). More than four-fifths (82%) stated 'they had no difficulty going to school.' However, above one-tenth (12%) mentioned 'they find it difficult traveling to school' followed by 'school homework (9%)'.

In the qualitative findings, the interviews stated that personal reasons, the desire to purchase materials, and the inability of the authorities to deliver the required materials were the difficult part of school attendance.

> *The situation of the school and students are not good. We are not able to provide the books and other materials such as bags. In higher grades, we provide English, Nepali, and Social Study books, but others, they have to buy them. (Sarcastically) Students are very aware of the cost of books, around NRs 400. Students always have complained that they cannot afford their books; however, they have sufficient money to buy a mobile phone worth NPR 20000. Furthermore, the students are more focused on purchasing the guess book (books with answers from the previous year) before the exams.* ***KII, Health teacher, Mahottari***

Table 13 Difficult part of going to school (among those who are currently going to school)

Difficult part of school *	Male	Female	Total
School homework	12.8	5.5	8.5
Travelling to school	12.8	10.5	11.5
Teachers' behavior	1.2	3.9	2.8
Unavailability of separate toilet for boys and girls	0.5	2.3	1.6
Unavailability of menstrual pad	0.1	1.4	0.9
Unavailability of menstrual pad disposal facility	0.2	2.0	1.3
Bullying/harassment	0.3	0.3	0.3
No problem	78.8	84.5	82.1
Others	1.6	1.0	1.2
Number	1881	2704	4585

** Multiple responses*

4.6 Desire to join any vocational training

Out of 1085 adolescents (boys and girls) who were not attending school during the survey, almost three-fourths (72%) wanted to join any vocational training. Among them, more than three-fifths (63%) preferred training in tailoring/embroidery, followed by arts and crafts (27%) and beautician training (18%).

The qualitative information regarding the desire to join vocational training was explored among the adolescents, and they stated that they had a desire to join it. The interview transcripts excerpts:

> *Whatever is available, I will join it. If I can join tailoring and sewing, then it would be good. Maybe make a stool/chair as well.* **-P3, FGD, Married Adolescents Female, Bheriganga Municipality**

Table 14 Desire to join any vocational trainings (among children not attending school)

	Male	Female	Total
Want to join any vocational trainings			
Yes	70.8	73.4	72.4
No	29.2	26.6	27.6
Total	100.0	100.0	100.0
Number	387	698	1085
Preferred vocational training *			
Tailoring/Embroidery	20.4	85.9	63.1
Electrician	43.4	1.2	15.9
Driving	47.1		16.4
Livestock farming	4.0	1.8	2.5
Carpentry	15.7	0.2	5.6
Plumbing	17.5	0.6	6.5
Beautician/beauty parlor	1.5	26.6	17.8
Art and craft	23.4	28.9	27.0
Mobile repairing	32.5	1.8	12.5
Others	7.3	1.6	3.6
Number	274	512	787

** Multiple responses*

5 Sexual activity, Marriage, and Pregnancy

- Almost all (97%) of the adolescents were unmarried.
- The mean and median age at first marriage was 16.2 years and 16 years, respectively (mean age: 16.8 years for males, 16.2 years for females; median age: 17.5 years for males, 16 years for females).
- Among the married and sexually active adolescents, almost half of the female adolescents (45%) had ever been pregnant.
- Among the adolescents who had ever been pregnant (n=88), the median age at first pregnancy was 17.0 years.
- Just over one-tenth (12.5%) of adolescents had given birth with at least 33 months of birth spacing.
- Still, almost a quarter (24%) of the recent child were delivered at home.
- There were several reasons stated as the reason for early marriage; socio-economic condition was the major reason for early marriage. Another interesting reason for early marriage stated by parents and grandparents was the fear of elopement and prestige.

5.1 Sexual Activity

The study explored the experience of sexual intercourse of the surveyed adolescents. Overall, 5 percent of adolescents reported that they ever had sex. Experience of sexual intercourse among early adolescents (10-14 years) was very minimal (0.1%) compared to older adolescents aged 15-19 years (11%). In the case of unmarried adolescents, only 2 (1.6) percent of the respondents shared they had ever had sex; 4 percent among males and 0.2 percent among females. Of the 15-19 unmarried boys – eight percent have had sexual intercourse and 0.4 percent of unmarried girls have had sexual intercourse.

Table 15 Percentage of adolescents with experience of sexual intercourse

		Male			Female			Total		
Age group		Unmarried	Ever married	Total	Unmarried	Ever married	Total	Unmarried	Ever married	Total
10-14	Yes	0.1	50.0	0.2	0.1	0.0	0.1	0.1	25.0	0.1
	No	99.8	50.0	99.6	99.9	100.0	99.9	99.9	75.0	99.8
	No response	0.2	0.0	0.2	0.0	0.0	0.0	0.1	0.0	0.1
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	N	1267	4	1271	1807	4	1811	3074	8	3082
15-19	Yes	8.0	100.0	9.6	0.4	99.4	11.3	3.5	99.5	10.7
	No	90.3	0.0	88.7	99.4	0.6	88.6	95.7	0.5	88.6
	No response	1.7	0.0	1.7	0.1	0.0	0.1	0.8	0.0	0.7
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	N	979	18	997	1416	175	1591	2395	193	2588
Total	Yes	3.5	90.9	4.4	0.2	97.2	5.3	1.6	96.5	4.9
	No	95.6	9.1	94.8	99.7	2.8	94.6	98.0	3.5	94.7
	No response	0.8	0.0	0.8	0.1	0.0	0.1	.4	0.0	0.4
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Total Number	2246	22	2268	3223	179	3402	5469	201	5670

5.2 Marital status

The study explored the marital status of the surveyed adolescents. Most adolescents were unmarried (97%), and only 3 percent were currently married. Sex-wise distribution showed that a higher proportion of female adolescents (5%) were married in comparison to the males (1%). Furthermore, about 11 percent of female adolescents aged 15-19 got married (indicator table).

Table 16 Marital status

	Male	Female	Total
Current marital status			
Unmarried	99.0	94.7	96.5
Currently married	1.0	5.2	3.5
Divorced/Separated	0.0	0.0	0.0
Widowed	0.0	0.0	0.0
Number	2286	3402	5670
Age at first marriage			
12	9.1	2.2	3.0
13	0.0	3.4	3.0
14	0.0	4.5	4.0
15	18.2	21.2	20.9
16	9.1	24.6	22.9
17	13.6	25.1	23.9
18	27.3	15.1	16.4
19	22.7	3.9	6.0
Mean Age	*16.8 years*	*16.2 years*	*16.2 years*
Median Age	*17.5 years*	*16.0 years*	*16.0 years*
Total	100.0	100.0	100.0
Number	22	179	201

The median age at first marriage was 16 years which implies half of the adolescents were married before the age of 16 years, and the remaining half were married after completing 16 years of age. It is of note that adolescents residing in rural areas had a comparatively higher median age at first marriage, 17 years, than those residing in urban areas (16 years). In regard to the wealth quintile, adolescents belonging to the highest/richest wealth quintile seemed to have higher median age at first marriage, 17 years, than those belonging to the lowest/poorest wealth quintile, 16 years. Sex-wise disaggregation showed that male adolescents had a comparatively higher median age at marriage, which is 17.5 years, than that of female adolescents, which is 16 years. The mean age at first marriage was 16.2 years; 16.8 years for male, 16.2 years for female.

The findings from the qualitative information also show the existence of early marriage despite knowing the legal age of 20 years. There were several reasons stated as the reason for early marriage; socioeconomic conditions were the major reason for early marriage. Another interesting reason for early marriage stated by parents and grandparents was the fear of the elopement of their children and their family prestige. Parents stated that if they find an appropriate groom, they are happier to marry off their daughters as early as they find to avoid elopement. They also shared the issue of social media, which has increased the cases of elopement. In some cases, the parents shared that they start finding a suitable groom after their daughter finishes grade 10. The marriage process also differs according to geographic variation. In the Madhesh province, the marriage process is different. Though the marriage is done earlier, the girls go to their husbands' houses relatively late (after 4-5 years).

> *Madhesh people arrange marriage and marry off their daughters early, but they send their daughters after 4-5 years. For example, they find a suitable groom around 17-18 years of age and fix the marriage and send their daughter when they are around 23-24 years old*. **-KII, Social Development Head, Janaki RM, Banke District, Madhesh Province.**

> *In some cases, it is due to the economic conditions of the family as well. If they can marry early, the family of the male will have two members (son and daughter-in-law) to earn money. It is difficult to maintain daily expenses with income from one member.* **-P4, FGD with Grandparents, Jimruk RM**

> *I married off my son at the age of 17. He was spoiled, and he was not listening to us. I was worried and decided to marry him so that he would be more responsible.* **- FGD with Grandparents, Bagchaur Municipality**

> *I got married when I was 15 years old. It was decided by my parents. I was very scared to object to the decision.* **-P1, FGD with married female adolescent, Suvarna RM**

> There are many instances of child marriage. Child marriage is evident in the adolescent phase of life. During adolescence, there are changes in the body in terms of physical, mental, and hormonal, and they romantically discuss love. This could result in child marriage. -**KII, Health Post In-Charge, Bheriganga Municipality, Surkhet**

Furthermore, the qualitative findings also added the reasons for the customs and traditions. Parents want to avoid elopement and save their prestige despite knowing the legal age of marriage. The information regarding the marriage was also categorized according to the ethnicity and area of their residence. The

interview excerpts state that elopement was more evident among the people from the hilly region than in the Terai region.

> *Elope marriage is more common among people from the hilly region than in the Terai region. Young boys and girls may elope knowingly or unknowingly and attempt to marry themselves. In some cases, they are influenced by their friends.* **- KII, Health Post In-charge, Janaki RM, Banke District, Madhesh Province.**

There is evidence of early marriage in the community, and it is due to the prejudice of society. The misconception that females should be married before the onset of menstruation still exists in some communities.

> *Girls get married early due to misconceptions still existing in society. For example, people still think that girls should be married before the onset of menstruation. There are still arranged marriages happening at an early age; it could be due to a lack of awareness***. - KII, Health Teacher, Lungri RM**

The discussion with parents states the pressure exerted by the community people to marry off their daughters early was evident in the focus group discussion. The statements on the pressure for early marriage:

> *The families are pressured. Even though we do not want to marry off our daughter, community people keep saying the proper age of the marriage. They keep questioning why we are not marrying our daughter and further question if there are any affairs she is having***. -P7, FGD Parents, Chandranagar, Sarlahi**

> *In the community, they think negatively if we do not marry off our daughter early. To save our reputation, also we have to marry our daughter early*. -**P2, FGD Parents, Chandranagar, Sarlahi**

> *The legal age of marriage is 20 years; since there are poor people in our community who cannot take care of their daughters and cannot send them to school, they prefer to marry them. They think of daughters as burdens. If they are capable of cooking food and doing the household chores, they try to find a groom and marry them.* **-KII, FCHV, Bara**

> *The issues related to marriage might be linked to social psychology and lack of education as well. Whenever adolescents are ready for sexual activities, parents are afraid that they might be engaged in premarital sex and their reputation will be hampered. Therefore, the parents tend to find suitable partners early and marry them off. They are afraid of the concept of boyfriend and girlfriend. There is a huge stake in reputation attached to the girl and their family.* **-KII, Government Official, Mahagadimai**

The findings from the FGD with the married female adolescents from the Bheriganga Municipality and Janaki Rural Municipality show that they were aware of the legal age (20 years old) of marriage, but they married early. They blame themselves for marrying early, and few regret their decision to marry early. Meanwhile, some were married forcefully as they were deemed appropriate to get married due to the development of their physical structure and economic conditions, despite their age.

Table 17 Mean and Median Age at first marriage by socio-demographic characteristics

	Median age at marriage	Mean age at marriage	Total number of married adolescents
Province			
Karnali	16.0	16.1	23
Lumbini	17.0	16.8	32
Madhesh	16.0	16.2	146
Municipality/Rural Municipality			
Rural Municipality	17.0	16.9	47
Urban Municipality	16.0	16.0	154
Wealth Quintile			
Lowest	16.0	16.2	45
Second	16.0	15.9	35
Middle	16.0	16.2	38
Fourth	16.0	16.4	37
Highest	17.0	16.5	46
Age group			
10-14	12.5	14.0	8
15-19	16.0	16.3	193
Sex			
Male	17.5	16.8	22
Female	16.0	16.2	179
Caste/Ethnicity			
Hill Brahmin	15.0	15.6	5
Hill Chhetri	17.0	16.7	26
Madhesi Brahmin/Chhetri	16.0	16.4	16
Madhesi Other	17.0	16.4	45
Hill Dalit	16.0	16.4	15
Madhesi Dalit	16.0	16.2	54
Hill/Mountain Janajati	17.0	16.7	9
Terai Janajati	17.0	16.9	8
Muslim	15.0	14.7	14
Others	16.0	16.1	9
Total	16.0	16.2	201

5.3 Pregnancy status

Ever been pregnant

Among the married and sexually active adolescents, almost half of the female adolescents (45%) reported that they had ever been pregnant. Similarly, the married male adolescents were also asked if their wives had ever been pregnant. Almost half of them (45%) mentioned that their wife had been pregnant at least once.

Province-wise disaggregation showed that the proportion of adolescents who had ever been pregnant was highest in Madhesh Province (52%) and lowest in Lumbini Province (29%). Analysis based on place of residence showed that a higher proportion of the adolescents who had ever been pregnant resided in urban municipality (47% each for female adolescents and wives of male adolescents) compared to those who resided in rural municipality (39%; female adolescents and 40%; wife of male adolescents).

The qualitative information also reveals early pregnancy among married adolescents. Following marriage, most married female adolescents are expected to have babies immediately and should be limited to household chores. There were also some instances of less gap between two children.

> *We have evidence of the different consequences of early marriage. In cases of early marriage, there are high chances of pregnancy, and as a result, they are unhealthy. In some cases, they also lack nutrition and birth spacing. Therefore, we should bring programs to decrease the incidences of early marriage*. **-KII, Health Post In-charge, Janaki RM, Banke District**

Table 18 Ever been pregnant by socio-demographic characteristics

	Wife of male adolescent	Total number of males	Female	Total number of females
Province				
Karnali	50.0	4	31.6	19
Lumbini	100.0	1	29.0	31
Madhesh	40.0	15	51.6	124
Municipality/Rural Municipality				
Rural Municipality	40.0	5	39.0	41
Urban Municipality	46.7	15	47.4	133
Wealth Quintile				
Lowest	33.3	3	41.0	39
Second	100.0	3	48.4	31
Middle	0.0	3	51.4	35
Fourth	33.3	6	36.7	30
Highest	60.0	5	48.7	39
Age group				
10-14	50.0	2	0.0	0
15-19	44.4	18	45.4	174
Caste/Ethnicity				
Hill Brahmin	0.0	0	40.0	5
Hill Chhetri	50.0	4	31.8	22
Madhesi Brahmin/Chhetri	0.0	1	80.0	15
Madhesi Other	25.0	4	42.5	40
Hill Dalit	100.0	1	21.4	14
Madhesi Dalit	42.9	7	44.4	45
Hill/Mountain Janajati	0.0	0	33.3	9
Terai Janajati	100.0	1	85.7	7
Muslim	100.0	1	55.6	9
Others	0.0	1	50.0	8
Total	45.0	20	45.4	174

Median age at first pregnancy

Among the adolescents who had ever been pregnant (n=88), the median age at first pregnancy was 17.0 years which indicates that half of the adolescents had been pregnant for the first time below the age of 17 years, and half had been pregnant at age above 17 years. Province-wise disaggregation showed that adolescents belonging to Madhesh and Lumbini Province had slightly a higher median age at first pregnancy, which was 17 years each, compared to Karnali Province, 16 years. No variation was observed in regard to the place of residence (municipality/rural municipality) and the median age at first pregnancy.

In regard to caste/ethnicity, adolescents who belonged to the Muslim community had the lowest median age at first pregnancy, 15.5 years, while Hill Dalit had the highest median age at first pregnancy, which was 18 years.

In the FGD with grandparents, they shared interesting information about the age of pregnancy and deliveries. Even though the children get married early, they suggest giving birth after the age of 20 years.

> *Now, we are the oldest in the community. In our experience, I suggest them give birth to children after the age of 20 years even if they marry early***.-P5, FGD with Grandparents, Bagchaur Municipality.**

> *If they give birth after 20, I feel they did the right things and planned well for the family.* **-P4, FGD with Grandparents, Bagchaur Municipality**

Table 19 Median age at first pregnancy

	Median	N
Province		
Karnali	16.5	8
Lumbini	17.0	10
Madhesh	17.0	70
Municipality/Rural Municipality		
Rural Municipality	17.0	18
Urban Municipality	17.0	70
Caste/Ethnicity		
Hill Brahmin	16.5	2
Hill Chhetri	17.0	9
Madhesi Brahmin/Chhetri	17.0	12
Madhesi Other	17.0	18
Hill Dalit	18.0	4
Madhesi Dalit	17.0	23
Hill/Mountain Janajati	17.0	3
Terai Janajati	17.0	7
Muslim	15.5	6
Others	16.5	4
Total	17.0	88

Ever given birth to the child

More than three-fourths (77%; 67% respondent's wife, 79% female adolescents) of the adolescent who had ever been pregnant had given birth to a child.

Birth spacing

Only eight adolescents aged 15-19 out of 12 female adolescents with two or more children provided the full date of birth (year and months) of two children. A few adolescents (n=4) mentioned they did not know the date of birth of their child(ren) (year and month). Out of the eight mothers who provided the full

delivery date of their two children, only one mother (12.5%) had given birth with at least 33 months of birth spacing.

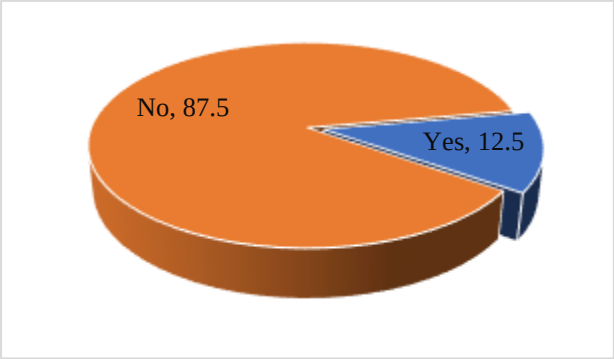

Figure 3 Percentage of the women aged 15-19 with a birth spacing of 33 months and more (N=8)

5.4 Place of delivery for recent child

The place of delivery for a recent child of adolescents who had ever given birth to a child was explored in the study. More than three-fourths (76.5%, n=52) of recent births were delivered in a health facility. Almost two-thirds (63%, n=43) of the deliveries for the recent child took place in governmental health facilities, with the highest number of deliveries at governmental hospitals/clinics (54%, n=37), followed by private health facilities (13%, n=9). It is of note that almost a quarter (24%, n=16) of recent children of adolescents were delivered at home.

Province-wise disaggregation showed that 100 percent (n=8) of adolescents from Lumbini Province delivered their last child at the health facility, followed by Madhesh (75%, n=41) and Karnali (only 60%,n=3). On the other hand, 40 percent of the adolescents from Karnali Province (n=2 out of 5) and 26 percent (n=14 out of 55) belonging to Madhesh Province had delivered their recent child at home.

The qualitative information on the utilization of health services reveals young girls and boys mainly seek services at private health facilities. There were different reasons, such as the availability of health care workers and privacy available at the private facilities.

> *People, especially adolescents, often visit private hospitals because they feel private hospitals keep their information secure and maintain their privacy. Furthermore, private hospitals also provide better health resources.* -**KII-Gov Official-Mahagadimai**

In the FGD with the unmarried adolescents from Janaki RM, adolescents visit the private health facilities because they are provided healthcare immediately, and they do maintain the privacy and confidentiality of the patients.

Table 20 Place of delivery of a recent child by socio-demographic characteristics

	Home	Government Hospital/Clinic	PHC center	Health Post	Private Hospital/Nursing home	Total number of adolescents
Province						
Karnali	40.0	20.0	0.0	40.0	0.0	5
Lumbini	0.0	62.5	0.0	37.5	0.0	8
Madhesh	25.5	56.4	1.8	0.0	16.4	55
Municipality/Rural Municipality						
Rural Municipality	21.4	64.3	0.0	14.3	0.0	14
Urban Municipality	24.1	51.9	1.9	5.6	16.7	54
Wealth Quintile						
Lowest	17.6	58.8	5.9	11.8	5.9	17
Second	13.3	60.0	0.0	20.0	6.7	15
Middle	40.0	46.7	0.0	0.0	13.3	15
Fourth	25.0	50.0	0.0	0.0	25.0	8
Highest	23.1	53.8	0.0	0.0	23.1	13
Age group						
10-14	100.0	0.0	0.0	0.0	0.0	1
15-19	22.4	55.2	1.5	7.5	13.4	67
Sex						
Male	50.0	33.3		16.7		6
Female	21.0	56.5	1.6	6.5	14.5	62
Caste/Ethnicity						
Hill Brahmin	50.0	0.0	0.0	50.0	0.0	2
Hill Chhetri	16.7	50.0	0.0	33.3	0.0	6
Madhesi Brahmin/Chhetri	12.5	50.0	0.0	0.0	37.5	8
Madhesi Other	14.3	64.3	0.0	0.0	21.4	14
Hill Dalit	0.0	50.0	0.0	50.0	0.0	2
Madhesi Dalit	31.6	57.9	5.3	0.0	5.3	19
Hill/Mountain Janajati	0.0	66.7	0.0	33.3	0.0	3
Terai Janajati	50.0	25.0	0.0	0.0	25.0	4
Muslim	50.0	50.0	0.0	0.0	0.0	6
Others	0.0	75.0	0.0	0.0	25.0	4
Total	16	37	1	5	9	68
	23.5	54.4	1.5	7.4	13.2	100%

5.5 Post-partum FP after the recent birth

Out of the 68 adolescents who had ever given birth to a child, 10 of them did not make any ANC visit. It is of note that among the adolescent female who received ANC for their most recent birth (N=58), only 12% (n=7) were counseled regarding post-partum family planning. Among those who received family planning methods (n=4), three adolescents adopted injectables/ Depo (DMPA), while one of them adopted pills. Among the 16 adolescents (24%) who had their last delivery at home, 8 of them were attended by either the FCHV or health service provider during their delivery; however, none of them received any counseling regarding family planning methods immediately after the delivery.

Table 21 Post-partum Family Planning

	Female
Received post-partum FP counseling during ANC of most recent birth (among those who have ANC check-up)	
Yes	12.1
No	87.9
Number	58
Received any family planning method/device immediately after the last delivery prior to the discharge from the health facility	
Yes	8.2
No	91.8
Number	49
Adopted method/device immediately after your last delivery prior to the discharge from the health facility	
Pills	25.0
Depo (DMPA)	75.0
Number	49
Received family planning method/counseling immediately after last delivery (	
No	61.5
Not applicable	38.5
Number	13

6 Knowledge and utilization of reproductive health and family planning services

- Only 27% of adolescents mentioned the appropriate birth spacing between two children is 33 or more months.
- More than two-fifths (43%) of the adolescents were aware of the menstrual cycle of women.
- One-third (33%) of the adolescents having knowledge about the fertile period correctly reported that the most fertile time is '*halfway between two menstrual periods'.*
- Less than two-thirds of the current school-going adolescents (62%) stated that their schools provide menstrual pads to girls.
- A large majority of the adolescents (87%) claimed the availability of separate toilets for males and females at their schools. However, only 17 percent of the male and 19 percent of the female adolescents stated that their school had a resting room where menstruating girls could rest if needed.

6.1 Knowledge of legal age at marriage

Almost half (total=49%; 37% among 10-14 and 63% among 15-19 years) of the adolescents were aware of the legal age of marriage for the girl as 20 years. However, only over one-third (total=36%; 29% among 10-14 and 44% among 15-19) of the adolescents correctly reported the legal age of marriage for boys as 20 years. A lesser proportion of female adolescents were able to correctly identify the legal age of marriage for boys (32%) in comparison to girls' legal age of marriage (54%).

Table 22 Knowledge of legal age at marriage

	Male	Female	Total
Legal age for marriage for boys			
10-19 years	3.4	2.9	3.1
20 years	40.7	32.1	35.6
21 and above	20.0	31.8	27.1
Do not know	36.0	33.2	34.3
Total	100.0	100.0	100.0
Legal age for marriage for girls			
10-19 years	8.2	7.7	7.9
20 years	41.0	54.4	49.0
21 and above	8.9	7.6	8.1
Do not know	41.8	30.3	34.9
Total	100.0	100.0	100.0
Number	2268	3402	5670

6.2 Knowledge of appropriate age for a first pregnancy and birth spacing

Over two-fifths, (44%) of the adolescents reported the appropriate age for first pregnancy is above 20 years. It is notable that more than half of male (57%) and female (52%) adolescents had no idea about the appropriate age for a first pregnancy. Moreover, 2% of adolescents (3% male, 2% female) reported an appropriate age for the first pregnancy is below 20 years.

More than a quarter of the adolescents mentioned the appropriate birth spacing between two children is '33 or more months (27%)', and more than one-tenth mentioned the appropriate birth spacing between two children is 'less than 33 months'; however, it is of note that almost three-fifths (59%) said 'they do not know about the appropriate birth spacing.' A quarter of the male adolescents (25%) and above a quarter of the female adolescents (29%) mentioned that the appropriate birth spacing is 33 months or more.

Table 23 Knowledge of appropriate age for a first pregnancy and birth spacing

	Male	Female	Total
Appropriate age for first pregnancy			
Below 20 years	2.8	2.1	2.4
Above 20 years	40.2	45.6	43.5
Do not know	57.0	52.3	54.2
Total	100.0	100.0	100.0
Knowledge of birth spacing			
Less than 33 months	13.7	14.7	14.3
33 or more months	24.5	28.8	27.1
Do not know	61.8	56.5	58.6
Total	100.0	100.0	100.0
Number	2268	3402	5670

6.3 Knowledge of the menstrual cycle

More than two-fifths (total=43%; aged 10-14=25% and aged 15-19=63%) of adolescents had knowledge about the menstrual cycle of women. Among them, only 28 percent of male adolescents reported knowing about the menstrual cycle, while more than half of the female adolescents (52%) knew about it. In terms of age groups, a higher percentage of adolescents aged 15-19 years (male=49%, female=72%) were aware about the menstrual cycle compared to adolescents aged 10-14 years (male=12%, female=34%).

More than half of the adolescents who had knowledge about the menstrual cycle stated that the normal range of days for the menstrual cycle is 30 days (51%), followed by 28 days (28%) and 25 days (13%). More than half of the males (55%) and half of the female adolescents (50%) reported the normal duration of the menstrual cycle as 30 days. One-fifth of the male (21%) and less than a third of the female adolescents (30%) correctly identified the duration of the menstrual cycle as 28 days.

Table 24 Knowledge of the menstrual cycle

		Male						Female					
		10-14		15-19				10-14		15-19			
		%	N	%	N	%	N	%	N	%	N	%	N
Knowledge on menstrual cycle of women	Yes	12.0	153	49.3	492	28.4	645	34.2	619	72.0	1146	51.9	1765
	No	88.0	1118	50.7	505	71.6	1623	65.8	1192	28.0	445	48.1	1637
	Total	100.0	1271	100.0	997	100.0	2268	100.0	1811	100.0	1591	100.0	3402
Knowledge on normal range of days for the menstrual cycle	Below 25 days	1.3	2	1.6	8	1.6	10	1.3	8	1.0	11	1.1	19
	25	12.4	19	13.0	64	12.9	83	17.9	111	11.8	135	13.9	246
	26	.7	1	4.5	22	3.6	23	1.6	10	1.7	20	1.7	30
	27			.8	4	.6	4	.6	4	.5	6	.6	10
	28	20.9	32	21.5	106	21.4	138	18.9	117	35.7	409	29.8	526
	29	2.0	3	2.6	13	2.5	16	2.1	13	1.4	16	1.6	29
	30	60.8	93	53.3	262	55.0	355	54.9	340	46.6	534	49.5	874
	More than 30 days	2.0	3	2.6	13	2.5	16	2.6	16	1.3	15	1.8	31
	Total	100.0	153	100.0	492	100.0	645	100.0	619	100.0	1146	100.0	1765

6.4 Knowledge of the fertile period

Sixteen percent of the adolescents mentioned that they had knowledge regarding the fertile period during the menstrual cycle. However, among them, only one-third had correct knowledge regarding the fertile period during the menstrual cycle, i.e., halfway between two menstrual periods (33%).

Table 25 Knowledge of the fertile period

Knowledge of the fertile period	Male	Female	Total
Yes	10.4	19.2	15.7
No	7.6	8.4	8.1
Do not know	82.0	72.4	76.2
Total	100.0	100.0	100.0
Number	2268	3402	5670
Knew about fertile days			

Just before her menstrual period begins	6.4	9.5	8.7
During her menstrual period	11.9	15.1	14.3
Right after her menstrual period has ended	32.6	28.7	29.8
Halfway between two menstrual periods	38.1	30.6	32.6
No specific time	1.7	9.2	7.2
Do not know	9.3	6.9	7.5
Total	100.0	100.0	100.0
Number	236	654	890

6.5 Menstrual hygiene facilities at School

The study explored the availability of menstrual hygiene facilities at school. Less than two-thirds of the current school-going adolescents (62%) stated that their school provides menstrual pads to girls; a higher proportion of the female (71%) compared to male adolescents (49%) reported this.

A large majority of the adolescents (87%) claimed the availability of the separate toilet for male and female at their school. Only 17 percent of the male and 19 percent of the female adolescents stated that their school had a resting room where menstruating girls could rest if needed.

Table 26 School providing menstrual pads to girls have separate toilets and resting room.

	Male	Female	Total
School providing menstrual pads to girls			
Yes	49.2	71.0	62.1
No	11.1	11.1	11.1
Do not know	39.7	17.9	26.8
Total	100.0	100.0	100.0
School having separate toilet for girl and boy			
Yes	83.6	89.0	86.8
No	8.7	8.1	8.4
Do not know	7.8	2.9	4.9
Total	100.0	100.0	100.0
School having resting room			
Yes	17.4	19.6	18.7
No	41.3	60.5	52.6
Do not know	41.3	19.9	28.7
Total	100.0	100.0	100.0
Number	1881	2704	4585

6.6 Knowledge of sanitary methods which can be used during menstruation

A higher proportion of the adolescents stated that menstrual pads could be used during menstruation (63%; 48% male, 73% female), followed by cotton clothes (40%; 23% male, 52% female). It is notable that nearly one-third (31%) of the adolescents (50% male whereas 18% female) stated that they do not know about the sanitary methods that could be used during menstruation.

In regard to the knowledge about sanitary methods, the FGD with unmarried adolescents of Janaki RM and Kamala Municipality shared that they do use menstrual pads provided at the school, whereas some use pads by buying themselves. Meanwhile, they also shared their experience from their house, the other

female members of their household use cotton clothes. As per them, the knowledge regarding the use of menstrual pads was learned from health teachers, FCHV, and elders from the house.

Table 27 Knowledge of sanitary methods can be used during menstruation

Knowledge of sanitary methods *	Male	Female	Total
Cotton clothes	22.6	52.3	40.4
Menstrual Pad	47.9	73.1	63.1
Menstrual cup	0.8	0.5	0.7
Tampon	0.8	0.1	0.4
Others	0.0	0.6	0.4
Do not know	49.6	18.4	30.9
Number	2268	3402	5670

**Multiple responses*

7 Family planning

- Out of the total adolescents, one-fifth (20%) had heard about family planning methods.
- Almost one-sixth of them (16%) were aware of 3 or more family planning methods. Nearly one-tenth of them (9%) were aware of the use of 3 or more methods of family planning.
- Among those who had ever heard of FP methods, the highest percentage of adolescents knew the use of male condoms (67%), followed by LAM (62%) and withdrawal (60%). They were least aware of the use of IUCD/copper-T (38%), followed by the implant (42%).
- More than three-fifths (62%) of adolescents had ever used family planning methods.
- The major reasons reported by the married adolescents for not using family planning methods were the *husband staying away from them* (42%) and refusal to use them (25%).
- The Contraceptive Prevalence Rate (CPR) among adolescent girls aged 15-19 years for all methods was 15 percent, and the CPR for modern methods was 13.3 percent.
- Thirty-five percent of all adolescent girls aged 15-19 had an unmet need for family planning (14% for limiting and 21% for spacing).
- The total demand for family planning among adolescent girls was 51 percent; however, only over a quarter (26%) of the adolescent girls' demand for contraception was satisfied through modern methods.

7.1 Knowledge of FP Methods

Out of the total surveyed adolescents, one-fifth (total=20%; aged 10-14=5% and aged 15-19=38%) had heard about family planning methods.

Table 28 Knowledge of FP Methods

Ever heard about family planning methods	Male	Female	Total
Yes	20.1	20.3	20.2
No	79.9	79.7	79.8
Total	100.0	100.0	100.0
Number	2268	3402	5670

Almost one-sixth of the adolescents (total=16%; aged 10-14=4% and 15-19=30%) who had ever heard of family planning was aware of 3 or more methods of family planning. Almost one-tenth of them (total=9%; aged 10-14=2% and 15-19=17%) were aware of the use of 3 or more methods of family planning.

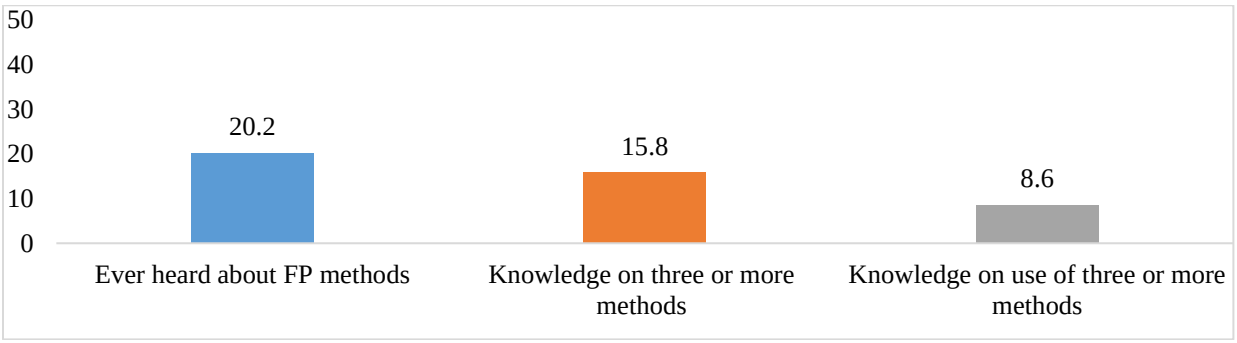

Figure 4 Percentage distribution of knowledge of FP (N=5670)

Province-wise analysis showed that ever heard about family planning, awareness of three or more methods of family planning, and awareness of the use of 3 or more methods of family planning was highest in Karnali province (ever heard:43%, known three or more methods: 38%, known about the use of 3 or more methods: 25%) and lowest in Madhesh province (ever heard:16%, known three or more methods: 10%, known about the use of 3 or more methods: 5%). Analysis of urban vs. rural residence showed that a higher proportion of the adolescents living in the urban municipality had ever heard about family planning, were aware of 3 or more methods of family planning, and were aware of the use of 3 or more methods of family planning areas (ever heard:26%, known three or more methods: 20%, known about the use of 3 or more methods: 10%) than those living in rural municipality (ever heard:9%, known three or more methods: 8%, known about the use of 3 or more methods: 5%). Disaggregation based on the wealth quintile depicted that adolescent belonging to the poorest/lowest wealth quintile had the lowest (ever heard:10%, known three or more methods: 7%, known about the use of 3 or more methods: 3%) and those belonging to the richest/highest wealth quintile had the highest level of awareness on FP device, and it's used (ever heard:28%, known three or more methods: 22%, known about the use of 3 or more methods: 13%).

The contraception-seeking behavior among unmarried male and female adolescents was also further explored among the health workers and FCHV. The perception of unmarried adolescents seeking FP methods was not considered a good practice.

The knowledge of FP methods among the female adolescents was very limited, as shared during the FGD with married adolescents from Janaki RM.

Furthermore, the FGD was conducted with the LGBTQI, and they shared a lack of knowledge and practice of FP methods:

> *"We do not know about Family planning. We know we cannot bear a child."*-***FGD with LGBTQI, Participant.***
>
> *"We have our partners, and we are engaged in sexual relationships too but never heard about the safe sex or use of contraception."* -***FGD with LGBTQI, Participant C & H***

Table 29 Awareness of FP device and Knowledge of use of FP device by socio-demographic characteristics

	Ever heard about family planning methods	Knowledge of 3 or more methods	Knowledge of use of 3 or more methods	Total N
Province				
Karnali	43.0	37.8	24.8	540
Lumbini	23.9	22.5	11.2	1350
Madhesh	15.6	10.2	5.4	3780
Municipality/Rural Municipality				
Rural Municipality	9.0	8.1	5.1	1890
Urban Municipality	25.8	19.6	10.4	3780
Wealth Quintile				
Lowest	10.0	7.0	3.3	1126
Second	16.0	11.4	5.2	1025
Middle	21.7	17.2	9.4	1115
Fourth	23.2	19.1	10.6	964
Highest	27.8	22.4	13.3	1440
Age group				
10-14	5.4	3.5	1.5	3082
15-19	37.8	30.4	17.1	2588
Sex				
Male	20.1	15.3	8.9	2268
Female	20.3	16.1	8.4	3402
Caste/Ethnicity				
Hill Brahmin	39.1	36.4	15.2	151
Hill Chhetri	33.5	30.7	18.9	740
Madhesi Brahmin/Chhetri	30.2	20.4	12.0	334
Madhesi Other	18.4	12.3	6.3	1476
Hill Dalit	30.4	26.5	16.5	358
Madhesi Dalit	9.5	5.5	3.1	1103
Newar	60.0	60.0	60.0	10
Hill/Mountain Janajati	31.2	28.3	14.6	410
Terai Janajati	16.0	11.0	3.9	519
Muslim	4.1	2.9	1.0	411
Others	10.1	10.1	5.7	158
Total	20.2	15.8	8.6	5670

7.2 Knowledge of Reproductive Health (RH), including Family Planning (FP)

The knowledge of seven different topics of RH and FP viz: i) accurate knowledge of menstruation, ii) accurate knowledge of the correlation between pregnancy and fertile days in the menstrual cycle, iii) accurate understanding of the usage of contraceptive methods-any three methods, iv) knowledge of healthy timing and spacing (33 months), v) knowledge of age at 1st pregnancy, vi) knowledge of the fertile period, vii) knowledge of contraceptive methods and its use was assessed in the survey. A composite index was developed from the abovementioned seven different RH-related questions. Out of the total surveyed adolescents, almost three-fourths (74%) had knowledge of at least one topic of RH and FP, more than a

quarter of them (29%) were aware of at least three topics of RH and FP, while fewer than one-tenth (9%) were aware of at least five topics of RH and FP. Furthermore, less than one percent (0.9%) of adolescents were aware of all seven topics of RH and FP.

Bivariate analysis was performed across key socio-demographic characteristics and knowledge of RH and FP. Province-wise disaggregation showed that the proportion of adolescents who knew at least three topics of RH and FP was comparatively higher in Karnali province (56%), followed by Lumbini (37%) and Madhesh province (23%). In regard to the place of residence, adolescents residing in urban municipality (34%) had higher knowledge of at least three topics of FP and RH than those residing in rural municipality (20%). In terms of wealth quintile, knowledge of at least one topic of RH and FP was highest among adolescents who belonged to the highest wealth quintile and lowest among those who belonged to the poorest wealth quintile. Early adolescents aged 10-14 years had considerably lower knowledge of at least three topics of RH and FP (11%) than late adolescents aged 15-19 years (51%). Sex-wise disaggregation showed that a considerably higher proportion of the female adolescents (83%) had knowledge of at least one topic of RH and FP than that of male adolescents (61%). Caste-wise disaggregation showed that 51 percent of the adolescents who belonged to Hill Brahmin had knowledge of at least three topics of RH and FP, while this knowledge was comparatively lower among Madhesi Dalit (only 17%) and Muslim adolescents (8%).

In the qualitative findings from the FGDs with the disabled students, they seem to know about the FP and RH, but they were shy to share about the medium from where they knew about it. Few of them shared most of the information they received was from the curriculum.

We do not care about these things in detail. We learn these things through experience and also believe these things are not relevant to us. I believe these things are for the older population. - ***P1, FGD with disabled adolescents, Banke district***

*Most of the adolescents visiting us for the discussion are married girls. The unmarried girls seldom visit us. In case they have any issues of excessive bleeding or stomach pain, they do visit us. If we can help, we do help them; otherwise, we send them to the health post. -****KII, FCHV, Mahagadimai Municipality***

Table 30 Knowledge of RH and FP by socio-demographic characteristics

	At least one	At least three	At least five	Total number of Adolescent
Province				
Karnali	90.7	55.9	25.6	540
Lumbini	82.4	36.9	10.0	1350
Madhesh	69.0	22.8	6.6	3780
Municipality/Rural Municipality				
Rural Municipality	67.9	19.5	5.7	1890
Urban Municipality	77.4	34.2	10.9	3780
Wealth quintile				
Lowest	66.0	19.3	4.4	1126
Second	72.9	25.1	6.2	1025
Middle	76.2	30.8	9.7	1115
Fourth	77.1	33.6	11.0	964
Highest	78.3	36.1	13.2	1440
Age group				

	At least one	At least three	At least five	Total number of Adolescent
10-14	59.1	11.3	1.7	3082
15-19	92.2	50.7	18.0	2588
Sex				
Male	60.5	24.5	8.4	2268
Female	83.4	32.5	9.6	3402
Caste/ethnicity				
Hill Brahmin	87.4	51.0	17.2	151
Hill Chhetri	89.2	49.1	17.6	740
Madhesi Brahmin/Chhetri	74.9	41.0	16.5	334
Madhesi Other	68.0	26.5	7.9	1476
Hill Dalit	87.2	45.8	17.6	358
Madhesi Dalit	65.6	16.7	3.1	1103
Newar	90.0	70.0	60.0	10
Hill/Mountain Janajati	87.1	42.0	11.0	410
Terai Janajati	75.5	17.0	4.2	519
Muslim	58.6	7.8	1.7	411
Others	81.6	29.1	8.2	158
Total	74.3	29.3	9.1	5670

7.3 Knowledge of the use of FP Methods

Among those who had ever heard of FP methods, the highest proportion of the adolescents had knowledge of the use of male condoms (67%), followed by LAM (62%) and with-drawl (60%). They were least aware of the use of IUCD/copper-T (38%), followed by the implant (42%). Sex-wise disaggregation showed that knowledge regarding the use of family planning methods varied among male and female adolescents. The highest proportion of the females were aware of the use of withdrawal method (68%) and least aware of the use of IUCD/Copper-T (36%) while the highest proportion of the males were aware of the use of male condoms (78%) and least were aware of the use of calendar method (35%).

Qualitative information on the knowledge and use of FP methods was sought in the KIIs. The respondents shared that the misconception and religious beliefs played a vital role in the usage of FP methods. The interview transcripts state:

> *Most of the unmarried adolescents are not interested in family planning issues. Married adolescents are very keen to know about the use and consequences of use of these FP-related issues. In a few cases, when they have RH-related issues, then they tend to blame the applied equipment (FP method). For example, when they adopt Depo (injectables), and they have excessive bleeding, then they blame it and do not continue to use it.* -**KII, FCHV, Ramgopalpur Municipality**

> *In Madrasa, they do not teach health education. In our religion, we do not believe in using FP methods as we believe that children are gifts from Allah. The use of contraceptives is usually done among married couples once they have more than two children, but it is not a good idea to use contraceptives among unmarried adolescents.* -**KII, Religious leaders, Chandranagar RM**

Table 31 Knowledge of the use of FP Methods among those who have heard of FP methods

	Male	Female	Total
Male condom	78.3	58.2	67.1
Female condom	49.1	38.5	43.9
Pills	52.5	55.3	54.3
DMPA (Depo)	54.5	55.2	55.0
IUCD/Coper-T	42.6	35.8	38.3
Implants	39.8	43.1	42.1
Emergency Contraception	49.1	50.6	49.8
Female Sterilization	52.2	49.8	50.7
Male sterilization	50.0	44.8	47.0
Lactational amenorrhea method	77.1	52.9	61.5
Calendar method	34.9	66.7	55.6
Withdrawal method	49.7	68.4	59.6
Number	455	689	1144

7.4 Knowledge of sources of family planning methods

Knowledge of the source of the family planning devices was assessed among adolescents who had ever heard about the family planning methods (n=1144). More than four-fifths (83%) of the adolescents (82% male, 84% female) were aware of the places/person where they can go to access any family planning methods or SRH services. Among them (n=952), the most common place for accessing FP methods and services for any SRH problems was reported to be a health post (74%), followed by a governmental hospital (54%). Only one percent reported NGOs such as Family Planning Association of Nepal (FPAN) & Marie stopes as the place to visit to access FP methods and SRH services.

Table 32 Knowledge of sources of family planning methods

	Male	Female	Total
Knowledge of source of FP methods and access to service for any RH problem	81.5	84.3	83.2
Number	455	689	1144
Known sources (places and persons) *			
Government hospital	53.1	54.9	54.2
Primary health care center	24.3	11.5	16.5
Health post	77.9	71.3	73.8
PHC/ORC	10.0	4.5	6.6
Mobile camp	3.0	0.2	1.3
FCHV	3.0	11.2	8.0
Volunteers/Field Mobilizers/ Facilitators	3.8	0.5	1.8
Satellite clinic	2.4	0.9	1.5
FPAN	0.3	0.0	0.1
Marie stopes	0.8	0.7	0.7
Private hospital/nursing home	7.5	4.8	5.9
Private clinic	27.5	14.1	19.3
Pharmacy	23.2	11.4	16.0
Pharmacy/Clinic with Sangini outlet	0.0	0.2	0.1
Shop	0.8	0.5	0.6
Friend/relative	0.3	0.2	0.2
Others	0.0	0.2	0.1
Number	371	581	952

** Multiple responses*

7.5 Use of family planning methods

Ever used of FP methods

Information regarding ever use of family planning was obtained from those who were aware of family planning methods and who had ever had sexual intercourse (N=169). The study found that 62 percent of adolescents had ever used family planning methods. Similarly, ever use of family planning was remarkably higher among the male (72%) than that of female adolescents (53%).

Province-wise disaggregation showed that the ever use of family planning among adolescents was highest in Lumbini Province (73%) and lowest in Madhesh Province (53%). It is of note that a considerably higher proportion of the adolescents residing in rural municipality (78%) than that in the urban municipality (59%) had ever used family planning methods. Regarding the wealth quintile, ever use of family planning was comparatively lower in the lowest (44%) and the second lowest wealth quintile (53%), while the utilization was much better in the middle and the highest wealth quintile (67% each) followed by the fourth wealth quintile (65%). Caste/ethnicity-wise analysis showed that ever use of family planning was found to be lowest among Hill Brahmin (17%) while it was highest among Hill Chhetri (78%).

The qualitative information on the use of planning was discussed with different stakeholders. Most of the respondents shared that the use of FP methods was good, but some of them, such as religious leaders, do not encourage the use of FP methods. Meanwhile, the use of FP methods among unmarried adolescents was deemed inappropriate. The unmarried adolescents who used FP methods were labeled as spoiled kids. In most of the cases, adolescent boys often visited health facilities and requested the FP methods, i.e., condoms.

Table 33 Ever used of FP by socio-demographic characteristics.

	Ever used FP methods	Total number of adolescents
Province		
Karnali	64.0	25
Lumbini	73.2	56
Madhesh	53.4	88
Municipality/Rural Municipality		
Rural Municipality	77.8	27
Urban Municipality	58.5	142
Wealth Quintile		
Lowest	43.5	23
Second	52.6	19
Middle	66.7	27
Fourth	65.2	46
Highest	66.7	54
Age group		
10-14	0.0	1
15-19	61.9	168
Sex		
Male	71.8	78
Female	52.7	91
Marital Status		
Unmarried	68.0	75

Currently married	56.4	94
Caste/Ethnicity		
Hill Brahmin	16.7	6
Hill Chhetri	78.0	41
Madhesi Brahmin/Chhetri	33.3	12
Madhesi Other	65.6	32
Hill Dalit	68.8	16
Madhesi Dalit	50.0	28
Hill/Mountain Janajati	72.2	18
Terai Janajati	60.0	10
Muslim	33.3	3
Others	33.3	3
Total	**61.5**	**169**

Types of FP methods used

Among those who had ever had sex and were aware of the FP, the majority of the male adolescents (93%) and about half of the female respondents (52%) reported using male condoms. The second most used family planning device was pills (35% as reported by females and 14% as reported by male adolescents).

Table 34 Types of FP methods used among them who ever had sex and were aware about the FP

Used family planning methods *	Male	Female	Total
Male Condom	92.9	52.1	74.0
Pill	14.3	35.4	24.0
IUCD/Copper-T	5.4	31.3	17.3
Injectable	10.7	2.1	6.7
Implants	1.8	2.1	1.9
Emergency contraception	8.9	2.1	5.8
Male sterilization	0.0	2.1	1.0
Withdrawal	5.4	8.3	6.7
Others	1.8	0	1.0
Number	56	48	104

** Multiple responses*

Reasons for not using any FP methods

Married adolescents who never used any family planning methods were asked about their reason for never using the family planning methods. The major reasons reported by the married female adolescents for not using family planning methods were 'husband staying away from them' (45%) and 'their own opposition/refusal to use any FP method' (22%). Similarly, the married male adolescents stated that the main reasons for not using family planning methods were 'their own opposition/refusal to use any FP method (60%), followed by lack of access to FP methods (20%).

Sex-wise disaggregation showed that the common reasons for not using any FP method among female were 'the husband being away' (45%), followed by 'their own opposition' (22%), 'infrequent sex' (10%), and 'being currently pregnant' (10%). On the other hand, married male adolescents were not using any family planning device due to 'their own opposition' (60%), followed by 'currently pregnant wife' (40%) and due to 'lack of access or the health facility being too far' (20%).

Table 35 Reason for not used/Not Using any FP method to prevent pregnancy (among married)

Reason for not using any FP method *	Male	Female	Total
Infrequent sex	0.0	10.0	9.2
Husband away	0.0	45.0	41.5
Currently Pregnant respondents/wife	40.0	10.0	12.3
Not menstruated since last birth	0.0	1.7	1.5
Breastfeeding	0.0	5.0	4.6
Up to God/fatalistic	0.0	6.7	6.2
Opposition/refusal to use any FP method	60.0	21.7	24.6
Knows no source	0.0	1.7	1.5
Side effects/health concerns	0.0	1.7	1.5
Lack of access/too far	20.0	0.0	1.5
Others	0.0	6.7	6.2
Do not know	0.0	3.3	3.1
Number	5	60	65

** Multiple responses*

Contraceptive prevalence rate

The survey revealed that the contraceptive prevalence rate (CPR) among married adolescent girls aged 15-19 years CPR for all methods was 15, and the CPR for modern methods was 13.3. Province-wise analysis showed that the CPR for the modern method was significantly higher ($p<0.001$) in Karnali province (36.8%), while it was the lowest in Madhesh province (8.1%). Similarly, modern CPR was higher among adolescent girls residing in urban municipality (14.4%) than those residing in rural municipality (9.8%). Analysis of the wealth index revealed that adolescent girls from the highest wealth quintile had the highest modern CPR (20.5%) while it was the least among those in the lowest wealth quintile (5.1%). However, place of residence and wealth index seemed not significantly associated with the use of modern contraception among adolescents.

The qualitative findings show that the use of FP methods was higher in males than in females. There were misconceptions about the use of FP methods among females. The females did not prefer to use FP methods because they had the misconception that it would decrease their fertility and increase the bleeding during menstruation. The misconception was higher in rural areas than in cities.

> *In comparison to the cities, people from rural areas use fewer contraceptives; it is because they hold a misconception that there are negative consequences of contraceptives. If they have any complications, they blame it on the contraceptives (bleeding and irregular menstruation are blamed on contraceptives).*-**KII, Government Official, Mahagadimai Municipality**

Table 36 Modern contraceptive prevalence rate among women aged 15-19 years

	Currently Married		
	CPR All methods-	CPR_Modern method	N
Province			
Karnali	42. 1	36.8	19
Lumbini	25.8	19.4	31
Madhesh	8.1	8.1	123
Municipality/Rural Municipality			

Rural Municipality	9.8	9.8	41
Urban Municipality	16.7	14.4	132
Wealth Quintile			
Lowest	5.1	5.1	39
Second	10.0	10.0	30
Middle	14.3	11.4	35
Fourth	26.7	20.0	30
Highest	20.5	20.5	39
Caste/Ethnicity			
Hill Brahmin	20.0	0.0	5
Hill Chhetri	40.9	36.4	22
Madhesi Brahmin/Chhetri	0.0	0.0	15
Madhesi Other	17.5	17.5	40
Hill Dalit	21.4	21.4	14
Madhesi Dalit	2.3	2.3	44
Hill/Mountain Janajati	22.2	11.1	9
Terai Janajati	14.3	14.3	7
Muslim	11.1	11.1	9
Others	12.5	12.5	8
Total	15.0	13.3	173

Note: only six Unmarried female adolescents aged 15 to 19 who were sexually active. and all they didn't use the contraception currently

Type of FP methods currently used

The most currently used family planning methods are male condoms (54%), pills (19%), IUCD/copper-T (16%), and withdrawal (11%). Sex-wise disaggregation showed that almost two times higher proportion of male adolescents reported currently using condoms compared to female adolescents (54%). More than a fifth of the female adolescents (23%) reported currently using IUCD/Copper-T and pills. Almost one-tenth of the male (9%) and slightly higher percent of female adolescents (12%) reported currently practicing the withdrawal methods.

Table 37 Type of FP methods currently used

Currently using method of family planning	Male	Female	Total
Male Condom	81.8	42.3	54.1
Pill	9.1	23.1	18.9
IUCD/Copper-T	0	23.1	16.2
Withdrawal	9.1	11.5	10.8
Total	100.0	100.0	100.0
Number	11	26	37

7.6 Unmet Need for family planning

Overall, 35 percent of the adolescent girls aged 15-19 had an unmet need for family planning (14% for limiting and 21% for spacing).

Province-wise analysis showed that Karnali province had the highest unmet need for family planning (45.5%; need for spacing only), followed by Madhesh province (37%; 17% for limiting, 20% for spacing)

and Lumbini province (21%; 4% for limiting, 17% for spacing). It is of note that adolescents residing in urban municipality had a higher unmet need for family planning (39.1%; 14% for limiting, 26% for spacing) than those residing in rural municipality (22%; 13% for limiting, 8% for spacing). Analysis based on the wealth quintile showed that adolescent girls who belonged to the middle wealth quintile had the highest unmet need for family planning (43%; 16.7% for limiting, 26.7% for spacing). Caste/ethnicity-wise analysis showed that Madhesi Brahmin/Chhetri (67%; 13% for limiting, 53% for spacing) had a higher unmet need for family planning compared to other castes.

The qualitative findings show that married female adolescents usually do not use the FP methods despite not wanting to have children. As per them, the major reasons for not using the FP methods were their shy nature and hesitancy. The transcripts state:

> P3: *Some people suggest that they should not use contraceptives as it may lead to infertility and create problems in later life.* -**FGD with married adolescents, Bheriganga Municipality**

Some also agreed that their decisions are made by their parents-in-law, and some were completely unaware about the use of contraceptives.

Table 38 Percent of adolescents (15-19) reporting an unmet need for family planning

	Unmet need for family planning			Total number of adolescent girls
	No unmet need	Unmet need for Limiting	Unmet need for spacing	N
Province				
Karnali	54.5	0.0	45.5	11
Lumbini	78.3	4.3	17.4	23
Madhesh	63.7	16.8	19.5	113
Municipality/Rural Municipality				
Rural Municipality	78.4	13.5	8.1	37
Urban Municipality	60.9	13.6	25.5	110
Wealth Quintile				
Lowest	70.3	13.5	16.2	37
Second	63.0	7.4	29.6	27
Middle	56.7	16.7	26.7	30
Fourth	77.3	13.6	9.1	22
Highest	61.3	16.1	22.6	31
Caste/Ethnicity				
Hill Brahmin	50.0	0.0	50.0	4
Hill Chhetri	61.5	7.7	30.8	13
Madhesi Brahmin/Chhetri	33.3	13.3	53.3	15
Madhesi Other	75.8	21.2	3.0	33
Hill Dalit	90.9	9.1	0.0	11
Madhesi Dalit	65.1	14.0	20.9	43
Hill/Mountain Janajati	57.1	0.0	42.9	7
Terai Janajati	50.0	16.7	33.3	6
Muslim	75.0	12.5	12.5	8
Others	71.4	14.3	14.3	7
Total	65.3	13.6	21.1	147

7.7 Demand satisfied by a modern method of contraception

Only 13 percent of the adolescent girls aged 15-19 had met the need for family planning, i.e., they are currently using contraception, while 35 percent of the adolescent girls had an unmet need for family planning. Thus, the total demand for family planning among adolescent girls (sum of met and unmet needs) was 48 percent, indicating only above a quarter (28%) of the adolescent girls' demand for contraception was satisfied with modern methods.

Province-wise disaggregation showed that a higher proportion of the adolescent girls belonging to Lumbini province (47%) had been satisfied with their demand of contraception than that of adolescents belonging to Karnali Province (45%) and Madhesh Province (18%). It is of note that adolescent girls who resided in rural municipality had comparatively higher demand satisfaction for family planning (31%) than that of the adolescent girls residing in the urban municipality (27%). Analysis based on the wealth quintile showed that adolescent girls belonging to the fourth wealth quintile had the highest demand satisfaction (47%) while those belonging to the lowest wealth quintile had the least demand satisfaction (15%).

Table 39 Percentage of the demand for contraception that is satisfied, according to background

	Unmet need for family planning			Met need for family planning (currently using)		Total demand for FP (sum of unmet need and met need)	Percentage of demand satisfied
	Unmet need for Limiting	Unmet need for spacing	Total	For spacing	Total		
Province							
Karnali	0	45.5	45.5	36.8	36.8	82.3	44.7
Lumbini	4.3	17.4	21.7	19.4	19.4	41.1	47.2
Madhesh	16.8	19.5	36.3	8.1	8.1	44.4	18.2
Municipality/Rural Municipality							
Rural Municipality	13.5	8.1	21.6	9.8	9.8	31.4	31.2
Urban Municipality	13.6	25.5	39.1	14.4	14.4	53.5	26.9
Wealth							
Lowest	13.5	16.2	29.7	5.1	5.1	34.8	14.7
Second	7.4	29.6	37	10	10	47	21.3
Middle	16.7	26.7	43.4	11.4	11.4	54.8	20.8
Fourth	13.6	9.1	22.7	20	20	42.7	46.8
Highest	16.1	22.6	38.7	20.5	20.5	59.2	34.6
Total	13.6	21.1	34.7	13.3	13.3	48	27.7

7.8 Decision for the Use of family planning methods

A higher proportion of the adolescents who were currently using family planning methods stated that decisions regarding the use of contraceptive methods were made jointly (43%), followed by mainly husband/partner (38%) and mainly respondents themselves (19%). It is of note that more than half of the male adolescents (55%) mentioned that they solely make the decision to use family planning devices,

while only 4 percent of the female adolescents stated they are the sole decision-makers for FP methods use.

Province-wise disaggregation showed that the proportion of adolescents currently using family planning methods who stated that the decision to use contraception was made jointly was highest among those belonging to Karnali province (88%) and least among those belonging to Madhesh province (33%). Similarly, a higher proportion of the adolescents residing in urban municipality (50%) mentioned that they decide jointly with their partner regarding contraceptive methods compared to those living in rural municipality (14%). Similarly, the proportion reporting the decision to use family planning methods is made jointly (husband and wife/partner together) was three times higher among female adolescents (54%) than those males (18%).

The qualitative findings show that the decision to use FP methods was mostly made jointly (husband and wife together), but in a few instances, parents are observed deciding for the family of their children.

> *In our times, the decision to have children was mostly made by our parents. They used to tell us that they wanted to see grandchildren soon. (Everyone laughs)*-**P1, FGD with grandparents, Bagchaur Municipality**

Table 40 Decision to use contraception by socio-demographic characteristics (among current users aged 15-19 adolescents)

	Mainly respondent	Mainly husband/ partner	Joint decision	Total number of current users
Province				
Karnali	0.0	12.5	87.5	8
Lumbini	28.6	42.9	28.6	14
Madhesh	20.0	46.7	33.3	15
Municipality/Rural Municipality				
Rural Municipality	28.6	57.1	14.3	7
Urban Municipality	16.7	33.3	50.0	30
Wealth Quintile				
Lowest	50.0	50.0	0.0	2
Second	0.0	0.0	100.0	3
Middle	25.0	25.0	50.0	8
Fourth	7.7	61.5	30.8	13
Highest	27.3	27.3	45.5	11
Sex				
Male	54.5	27.3	18.2	11
Female	3.8	42.3	53.8	26
Caste/Ethnicity				
Hill Brahmin	0.0	100.0		1
Hill Chhetri	16.7	33.3	50.0	12
Madhesi Other	27.3	36.4	36.4	11
Hill Dalit	25.0	0.0	75.0	4
Madhesi Dalit	0.0	100.0	0.0	2
Hill/Mountain Janajati	25.0	25.0	50.0	4
Terai Janajati	0.0		0.0	1
Muslim	0.0	100.0	0.0	1
Others	0.0	100.0	0.0	1
Total	18.9	37.8	43.2	37

7.9 Person/Place for obtaining family planning methods

Four-fifths of the adolescents (78%) reported that they mostly receive family planning methods from the health post, followed by governmental hospitals (30%), PHCCs (22%), Private clinics, Pharmacy and PHC/ORC (11% each)

7.10 Preferred place/person for receiving FP service

Most of the adolescents who were currently using family planning methods preferred health posts (60%) over other health facilities for receiving family planning services. The most preferred place for receiving family planning services among female current users was the health post (62%), followed by the governmental hospital (15%). In the case of male current users, the most preferred health facility to obtain FP services was health posts (54%), followed by PHCCs (18%).

Qualitative information on preferred places and persons to receive FP services was also sought, and most of the respondents shared that they prefer private health facilities over public health facilities.

> *Of course, people do seek health care from the health post, but if they are not cured, then they visit a private clinic. Most of the people seek health care service in the health post, but they prefer private clinics as the public hospital does not have good service in terms of doctor and other resources. They also come for traditional healing to us.- **KII, Religious leaders, Chandranagar RM***

*During menstruation, we often suffer from stomachaches, and when we visit the health post, it has only male doctors. They don't have female doctors, so we don't share our problems with them. It would be good if female doctors were available. **P1, FGD with unmarried adolescents, Mahagadima**i*

Table 41 Preferred place/person for receiving FP service (among current users)

Preferred place/person for receiving FP service	Male	Female	Total
Government hospital	0.0	15.4	10.8
Primary health care center	18.2	0.0	5.4
Health post	54.5	61.5	59.5
PHC/ORC	9.1	0.0	2.7
Mobile camp	0.0	3.8	2.7
Private hospital/nursing home	0.0	3.8	2.7
Private clinic	9.1	3.8	5.4
Pharmacy	9.1	7.7	8.1
Others	0.0	3.8	2.7
Total	100.0	100.0	100.0
Number	11	26	37

8. Adolescent friendly services

- More than two-thirds of the adolescents (69%) stated they don't know, what Adolescent Friendly Services (AFS) mean.
- Only 14 percent of the adolescents were aware of the place where Adolescents Friendly Services (AFS) are available.
- Only 7 percent of the adolescents (10% male, only 5% female) who were aware of the AFS had ever sought the service.

8.1 Knowledge about Adolescent-friendly services (AFS)

Adolescents were asked about the types of services provided by the health facilities which they think are suitable/appropriate/comfortable for boys and girls like them to access. The adolescents responded spontaneously for this question. It is of note that more than two-thirds of the adolescents (69%) stated they do not know what Adolescent Friendly Services (AFS) mean. A higher proportion of female adolescents were unaware of the AFS (73%) compared to male adolescents (61%). Only less than one-sixth of the adolescents (15%) said they understand AFS as '*feasible opening hours of the services (before and after the school opening hour or at the evening/morning)'* followed by '*services are physically accessible in terms of distance (within 30 minutes)*' and '*welcoming and comfortable environment (HF provider greeting well to them, and not being judgmental about them irrespective of what services they need)*'.

Table 42 Knowledge about Adolescent-friendly services (AFS)

Knowledge of Adolescent-friendly services (AFS)*	Male	Female	Total
Feasible opening hours (before and after the school opening hour or in the evening/morning)	20.3	11.6	15.1
The disability-friendly physical structure of health institutions	6.0	6.4	6.3
Physically accessible in terms of distance (within 30 minutes)	16.5	11.7	13.6
Welcoming and comfortable environment (HF provider greeting well, not judgment about them)	11.9	7.1	9.0
Positive attitude and friendly behavior of the provider during the service delivery/counseling session	10.1	4.4	6.7
Maintenance of privacy (separate counseling and examination room)	9.7	3.8	6.1
Maintenance of confidentiality (HF provider keeping all the client's identification confidential and trustworthy)	9.7	3.5	6.0
Availability of family planning methods	3.2	2.8	3.0
Gender-friendly provider	3.7	1.5	2.3
Clear display of logo/information about the availability of AFS	1.3	1.7	1.5
Presence of IEC materials related to adolescent RH and sexual health (changes in puberty/developmental changes)	0.8	1.2	1.1
Others	0.3	0.8	0.6
Do not know	61.4	73.3	68.6
Number	2268	3402	5670

* Multiple responses

8.2 Aware of the places/persons where adolescent-friendly services are available

Out of the total respondents, only 14 percent of the adolescents were aware about the place where Adolescents Friendly Services (AFS) are available.

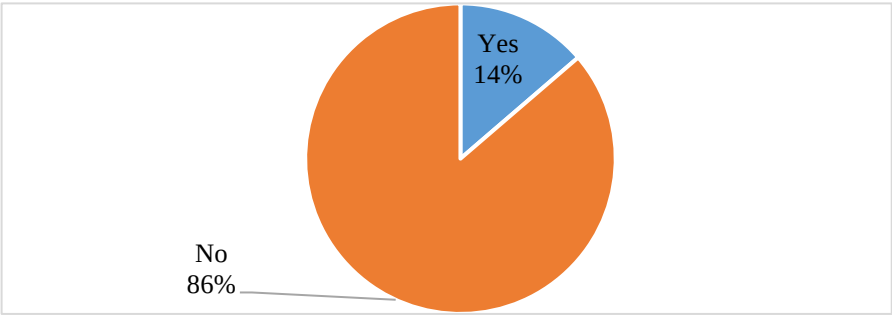

Figure 5 Knowledge about the Availability of adolescent friendly services (N=5670)

Among them, most of the respondents reported AFS are available in health post (65%), followed by governmental hospital/clinic (54%), PHCC (20%) and private clinic (7%).

Table 43 Aware about the places/person where adolescent friendly services are available

	Male	Female	Total
Knowledge about the places/person where adolescent friendly services are available	13.8	13.7	13.7
Total	100.0	100.0	100.0
Number	2268	3404	5670
Places/person where adolescent friendly services are available *			
Government hospital/clinic	43.8	60.3	53.7
Primary health care center	26.8	16.1	20.4
Health post	74.4	59.0	65.2
Urban Health Clinic	8.3	4.9	6.3
Community Health Center	6.7	5.2	5.8
PHC/ORC	9.3	3.9	6.0
Private hospital/nursing home	5.8	4.7	5.1
Private clinic	13.7	2.8	7.2
Pharmacy	13.1	1.7	6.3
Others	0.3	0.2	0.3
Number	313	466	779

** Multiple responses*

8.3 Ever sought adolescent-friendly services (AFS)

Only 7 percent of the adolescents (10% male, only 5% female) who were aware of the AFS had ever sought the service. Among them (n=54), the majority had sought contraceptive use/safer sex counseling (57%), followed by 'to receive contraceptive device' (44%), 'to receive emergency contraceptive' (39%), 'services for RH problems' (28%).

Majority of the female sought the AFS for 'contraceptive use/safer sex counseling' (64%), while other reasons for seeking services were 'to receive contraceptive methods' (59%), 'to receive emergency contraceptive' (46%) and 'for RH problems (menstrual health problem)' (46%). In the case of male, the

most common service sought was 'contraceptive use/safer sex counseling' (53%), followed by 'to receive contraceptive device' (34%) and 'to receive emergency contraceptive' (34%).

The qualitative findings on the AFS state that there is a need for AFS. The respondent stated that there is a need for programs addressing health, education, and child marriage. The interview transcripts excerpts:

> *If we conduct the program and address the issue of health, education, and child marriage, it would be beneficial for adolescents. If we focus on adolescent boys and girls, they will have a better future and better economic standards. If they marry at a young age, there are good chances of them not having proper education resulting in poor health conditions.* **-KII, Health Post In-charge, Janaki RM**

The findings from the qualitative show AFS seeking among adolescents was very limited, and it could be due to the culture and traditions. The unmarried FGD adolescents from Mahagadimai M stated that they do not use public facilities and use either pharmacy or private health facilities for the purchase of required medicines. The interview states:

> *Adolescents prefer to use private hospitals more than public hospitals because the public hospital does not have privacy and confidentiality. Private hospitals also have better facilities. Therefore, they prefer to use private hospitals. -* **KII, Government Official, Mahagadimai Municipality**

Table 44 Ever sought adolescent-friendly services (among those who were aware of the services)

	Male	Female	Total
Ever sought adolescent-friendly services			
Yes	10.2	4.7	6.9
No	89.8	95.3	93.1
Total	100.0	100.0	100.0
Number	313	466	779
Types of sought adolescent-friendly services *			
Contraceptive use/safer sex counseling	53.1	63.6	57.4
Received contraceptive device	34.4	59.1	44.4
Received emergency contraception	34.4	45.5	38.9
Received abortion service	0.0	4.5	1.9
RH problems (menstrual health problems)	15.6	45.5	27.8
VCT for HIV	9.4	0.0	5.6
Others	3.1	9.1	5.6
Number	32	22	54

** Multiple responses*

9 Exposure to Family Planning/RH Information

- Only around one-tenth (9%) of the adolescents and 12 percent of the parents/caregivers had heard/read about the family planning/RH messages in the last six months.
- Among the adolescents who had heard/read about the family planning/RH messages in the last six months, 61% recalled hearing or seeing messages on menstrual hygiene, 58% reported hearing or seeing about the use of FP methods, while 28% reported having heard or seen about birth spacing followed by ANC/PNC check-up (22%).
- The majority of the adolescents (69%) reported they had received information about FP/RH-related services from the textbook/curriculum book, followed by television (23%), peer educators/facilitators (22%), radio (21%), newspaper or magazine (13%), peers (11%).

9.1 Heard/read FP/RH message

The study explored information on adolescents' and parents' exposure to family planning/RH information in the last six months preceding the survey. Only around one-tenth (9%) of the adolescents and 12 percent of the parents/caregivers had heard/read about the family planning/RH messages in the last six months. Disaggregation based on urban vs rural residence showed adolescents residing in urban areas had almost three times higher exposure to family planning/RH information (11%) compared to those living in rural areas (4%). In regard to parents, those living in urban areas had slightly a higher exposure to family planning/RH information (10%) compared to those living in rural areas (13%). Sex-wise disaggregation showed that exposure to family planning/RH information in the last six months was almost similar among both adolescent girls and boys (8% vs 9%). In case of parents, exposure to family planning/RH information was almost double among male parent (15%) than female parent (9%). Similarly, disaggregation based on medium of communication showed that a higher proportion of adolescents (8%) as well as parents (29%) had heard/read of family planning/RH messages via. print media compared to other communication channels.

Table 45 Exposure to Family Planning/RH Information:

Ever heard/read of family planning/RH messages in the last six months	Adolescent	Parents	Total
Yes	8.8	11.8	9.4
No	91.2	88.2	90.6
Total Number	5670	1512	7182
Place of residence			
Rural	4.0	10.1	5.3
Urban	11.2	12.6	11.5
Sex			
Male	8.2	15.3	9.9
Female	9.2	8.6	9.1
Source of information of family planning/RH messages			
Radio	1.9	4.1	2.4
Television	2.0	5.7	2.8
Electronic Platform	2.0	4.5	2.6
Community Group Dialogue	0.4	1.4	0.7
Interpersonal Communication	2.3	8.7	3.4

Print	7.6	28.6	6.3
Other	0.00	0.30	0.1
Total Number	5670	1512	7182

9.2 Sources of information on FP/RH-related services

Knowledge regarding the sources of information of FP/RH-related services was assessed among the adolescents as well as parents/caregivers who had ever heard/read of family planning/RH messages in the last six months. The majority of the adolescents reported they had received information about FP/RH-related services from the textbook/curriculum book (69%), followed by television (23%), peer educator/facilitators (22%), radio (21%), social media (20%), newspaper or magazine (13%) and peers (11%).

In regard to parents/primary caregivers, almost half of them reported that they received FP/RH information from television (48%). In a similar way, more than one-third of each (35%) reported receiving information from radio and social media (Facebook, Instagram, Tik Tok, YouTube, etc.)

Table 46 Sources of information on FP/RH-related services: Adolescent

Sources from where you get the information on family planning*	Adolescent	Parents	Total
Radio	21.4	34.8	24.9
Television	22.8	48.3	29.5
Newspaper or magazine	13.4	14	13.6
Textbook/curriculum book	69.4	14	54.9
Social media (Facebook, Instagram, Tik Tok, YouTube, etc.)	20.2	34.8	24.0
ARH Booklet	1.4	1.1	1.3
Brochure or flipchart, Poster, hoarding board	2.4	3.4	2.7
Video game/Mobile apps	1.2	1.7	1.3
Street drama	1.6	3.4	2.1
Mother's group/teachers	3.4	8.4	4.7
Family members	6	6.7	6.2
Peers	11.2	20.8	13.7
Online platforms	1.8	1.7	1.8
FCHVs	7.4	24.2	11.8
Health service providers	1.6	9	3.5
Health-related seminars/campaigns	1.4	2.8	1.8
Other community-level events	1	0	0.7
Peer/educator/facilitators	22.4	2.8	17.3
Others	0.4	2.8	1.0
Total Number	500	178	678

** Multiple responses*

9.3 Recall hearing or seeing Family Planning/Reproductive Health (FP/RH)

Among the adolescents who had heard/read about the family planning/RH messages in the last six months (n=678), a large majority (92%) were able to recall hearing or seeing Family Planning/Reproductive Health

(FP/RH). Among them, slightly more than three-fifths (61%) recalled hearing or seeing messages on menstrual hygiene. In a similar way, more than half (58%) reported hearing or seeing about the use of FP methods, while more than a quarter (28%) reported having heard or seen about birth spacing, followed by ANC/PNC check-up (22%). Only about 8 percent of adolescents have not remembered any message.

Of the total respondents (n=7182), only 9 percent who had heard/read about the family planning/RH messages in the last six months were able to recall hearing or seeing a Family Planning/Reproductive Health (FP/RH) (Table not shown, refer indicator table).

Among the primary caregivers, almost four-fifths (78%) recalled hearing/seeing about the use of FP methods, followed by ANC/PNC check-up and menstrual hygiene (51% each).

Table 47 Percent of respondents who recall hearing or seeing a specific USG-supported Family Planning/Reproductive Health (FP/RH)

Recall hearing or seeing a specific FP/RH message *	Adolescent	Parents	Total
Use of FP methods	58.2	78.1	63.4
ANC/PNC check-up	21.8	50.6	29.4
Menstrual hygiene	60.6	50.6	58.0
Birth spacing	28	29.8	28.5
FP service delivery point	17.8	36.5	22.7
Adolescent-friendly service centers	5.8	6.2	5.9
Have not remembered any	9.2	3.4	7.7
Others	2.2	1.1	1.9
Total Number	500	178	678

** Multiple responses*

10 Involvement in Community Group

- Eleven percent of the adolescents were involved in sports club, 10 percent were involved in a children or youth club, 7 percent were involved in school management committee and 5 percent were involved in a saving group/microfinance organization.

10.1 Involvement in different activities as a leader or member

The study explored information regarding the involvement of adolescents in different activities, such as being a leader or holding some representative position before joining USAID ARH formed groups. Only above a tenth (11%) of them were involved in sports clubs; 10 percent were involved in children or youth clubs, followed by the school management committee (7%) and saving group/microfinance organization (5%). Similarly, a negligible proportion of the adolescents were involved in social or cultural organization clubs or associations (2%) and health mothers' groups (1%).

Table 48 Involvement in different activities as a leader or member

Involvement in different activities as a leader/member *	Male	Female	Total
Children or youth club	11.9	7.9	9.5
Social or cultural organization club or association	2.6	2.2	2.3
Savings group/Microfinance organization	7.0	3.1	4.6
Sports club	14.6	8.9	11.2
School management committee	4.5	9.2	7.3
Health mother's group	0.0	2.3	1.4
Number	2268	3402	5670

* Multiple responses

10.2 Knowledge and Participation in Health Mother's Group (HMG) Meeting

Out of the total adolescents surveyed, 13 percent (16% male and 12% female) had heard about Health Mother's Group (HMG) meeting.

Province-wise disaggregation showed that Madhesh Province had the lowest percentage (only 8%) of adolescents who had heard about the HMG meetings compared to Lumbini (23%) and Karnali Province (25%). The proportion of adolescents who had heard about the HMG's meeting was almost similar across both the urban (13%) and the rural municipalities (14%). Sex-wise distribution showed that a higher proportion of male adolescents (16%) had heard about HMG meetings than female adolescents (12%). Regarding the wealth quintile, the proportion of the adolescents who had heard about the HMG's meeting was lowest among those falling in the lowest quintile (only 8%), while the percentage seemed to have subsequently increased with the increase in the wealth quintile, highest in fourth quintile (16%).

In the qualitative findings, the married female adolescents shared that they are not aware of the HMG or any other groups. They stated:

> P1: *We are not aware of any groups in our society. Even if we are aware of and attend such groups, the community people have a negative perspective towards us. They often gossip and keep their opinion that we should stay at home and do household chores rather than roam around in the village. Hence, we do not attend such meetings.* **P1, FGD with married adolescents, Kamala Municipality**

> P4: *Yes, we do participate in the HMG meetings. Even some unmarried female adolescents also attend the meeting. We discussed sanitation, water, and FP & RH issues. We get permission from our family members to attend the meeting.* **P4, FGD with unmarried adolescents, Mahagadimai Municipality**

However, some of the adolescents were aware of the HMG, and some were also linked with other groups, such as finance and saving groups, but they were not regular. Therefore, they suggested that there should be an alternative group and they should have flexible timing to conduct the meetings. In addition, the FGD with unmarried adolescents from Bheriganga Municipality suggested that there should be a group to prevent and advocate against drug addiction.

Table 49 Heard about HMG by socio-demographic characteristics

	Heard about the HMG meeting	Total number of adolescents
Province		
Karnali	25.2	540
Lumbini	22.7	1350
Madhesh	8.4	3780
Municipality/Rural Municipality		
Rural Municipality	14.0	1890
Urban Municipality	13.1	3780
Wealth Quintile		
Lowest	8.4	1126
Second	12.9	1025
Middle	14.7	1115
Fourth	15.7	964
Highest	15.1	1440
Age group		
10-14	7.6	3082
15-19	20.3	2588
Sex		
Male	15.7	2268
Female	11.9	3402
Caste/Ethnicity		
Hill Brahmin	21.9	151
Hill Chhetri	25.4	740
Madhesi Brahmin/Chhetri	21.6	334
Madhesi Other	6.2	1476
Hill Dalit	15.4	358
Madhesi Dalit	8.1	1103
Newar	60.0	10
Hill/Mountain Janajati	22.7	410
Terai Janajati	12.1	519
Muslim	10.2	411
Others	16.5	158
Total	13.4	5670

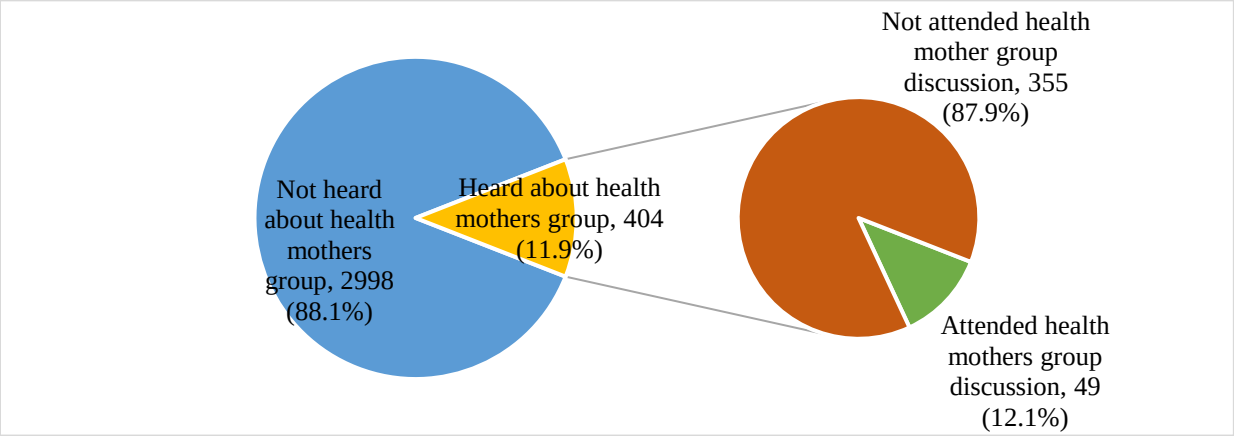

Figure 6 Health Mothers group discussion among female

Out of the female adolescents who had heard about HMG meetings (n=404), only 12 percent (n=49) reported that they had attended HMG meetings conducted by the FCHVs. Among them, almost two-thirds (65%) mentioned that they received information related to child feeding in the meeting. In a similar way, more than two-fifths (45%) discussed the nutrition topic in the HMG, followed by food/cooking (43%)

Table 50 Knowledge and Participation in Health Mother's Group Meeting

	Male	Female
Heard about Health Mothers Group Meeting		
Yes	15.7	11.9
No	84.3	88.1
Total	100.0	100.0
Number	2268	3402
Attended Health Mothers Group Meeting conducted by FCHVs		
Yes		12.1
No		87.9
Total		100.0
Number		404
Topics discussed in the Health Mothers Group Meeting *		
Received information on child feeding		65.3
Received information on food/cooking		42.9
Received information on gardening		4.1
Received information on poultry		20.4
Received information on water filtration		6.1
Received information on reproductive health		18.4
Received information on women's health care		36.7
Watch the demonstration on cooking		24.5
Discuss about nutrition		44.9
Discuss about handwashing		16.3
Discuss about toilet		8.2
Discuss about family planning		18.4
Discuss about diarrhea		4.1
Others		2.0
Number		49

Participation in Health Mother's Group

Only 9 percent of the married female adolescents aged 15-19 years had ever attended Health Mother's Group conducted by the FCHVs. Among them, 7 percent had attended at least one Health Mother's Group in the last six months. Province-wise analysis showed that a higher proportion of the adolescents (female) who belonged to Lumbini Province (13%), followed by Karnali Province (11%) and Madhesh Province (7%), had ever attended HMG conducted by the FCHVs. Ever attendance of HMG's meeting was highest among the adolescents falling in the lowest/poorest wealth quintile (13%) while lowest among those falling in the middle wealth quintile (6%). Slightly a higher percentage of adolescents residing in urban municipality (9%) than those residing in the rural municipality (7%) had ever attended HMG's meeting.

Regarding attendance at HMG's meeting, a higher proportion of the female adolescents who belonged to Lumbini Province (13%), followed by Karnali Province (6%) and Madhesh Province (5%) had ever attended HMG conducted by the FCHVs in the last six months conducted by the FCHVs. Similarly, ever attendance

of HMG meetings was almost the same among both the adolescents residing in urban and rural areas (7% each)

Qualitative information on the participation and knowledge of HMG was sought from KII. There was minimal participation of the adolescent girls. There were different reasons shared for less attendance of the adolescent girls; not being aware of the HMG, shyness to attend the meeting, and household chores.

In our HMG, there are 32 participants, and out of that, there are four female married adolescents. If we call them for a meeting, they do attend it. In the case of unmarried adolescents, they do not attend the meetings because they learn all these things at school. **-KII, FCHV, Bagchaur Municipality**

Adolescents do visit the mother group. Adolescents from the age of 17 and above visit us. There are quite a variety of age groups, and they are from the age of 17 and onwards. We do hold the meeting in the mid-month (around the 15th of every month). In our meetings, most of the married girls visit us. For the married adolescents, we visited their households in the community and shared the objectives of the meetings, and eventually, they were allowed to attend the meeting (by family members). However, adolescents do not share their feelings openly in the HMG because they are shy to speak out with the older age group mothers. **-KII, FCHV, Suwarna RM**

Yes, I agree with you that most adolescents have not heard about HMGs. It is because most of the time, there are regular people who attend our meetings. To make the adolescents aware of the HMGs, there should be a separate meeting addressing the adolescents. **-KII, FCHV, Ramgopalpur Municipality**

Table 51 Percent of married female adolescents 15-19 years who attended at least one Health Mother's Group (HMG) meeting in the last six months by socio-demographic characteristics

	Ever attended the HMG meeting conducted by FCHVs	Attended HMG meetings in the last six months conducted by FCHVs	Total number of married female adolescents
Province			
Karnali	10.5	5.3	19
Lumbini	12.9	12.9	31
Madhesh	7.3	5.7	123
Municipality/Rural Municipality			
Rural Municipality	7.3	7.3	41
Urban Municipality	9.1	6.8	132
Wealth Quintile			
Lowest	12.8	10.3	39
Second	10.0	6.7	30
Middle	5.7	2.9	35
Fourth	6.7	6.7	30
Highest	7.7	7.7	39
Caste/Ethnicity			
Hill Brahmin	20.0	20.0	5
Hill Chhetri	4.5	0.0	22
Madhesi Brahmin/ Chhetri	40.0	26.7	15
Madhesi Other	2.5	2.5	40
Hill Dalit	7.1	7.1	14
Madhesi Dalit	0.0	0.0	44

	Ever attended the HMG meeting conducted by FCHVs	Attended HMG meetings in the last six months conducted by FCHVs	Total number of married female adolescents
Hill/Mountain Janajati	22.2	22.2	9
Terai Janajati	14.3	14.3	7
Muslim	11.1	11.1	9
Others	12.5	12.5	8
Total	8.7	6.9	173

10.3 FCHVs recommending the referral sites for RH and FP needs/problems

Of the total, only 9 percent of the adolescents stated that FCHVs mention the referral sites for RH/FP needs/problems, while the majority (77%) reported they do not know whether the FCHVs mention the referral sites for any RH/FP problems or not.

Out of the adolescents who said that FCHVs mention referral sites (n=501), almost three-fourths (72%) stated that FCHVs refer to the health post, and slightly more than a fifth (21%) mentioned that FCHVs refer the clients needing RH/FP information to the government hospital.

Table 52 FCHV mention the referral sites for the reproductive health and family planning needs/ problems

	Male	Female	Total
FCHVs mentioning the referral sites for RH and FP needs/problems			
Yes	12.7	6.2	8.8
No	13.1	14.8	14.1
Do not know	74.2	79.0	77.1
Total	100.0	100.0	100.0
Number	2268	3402	5670
Referral sites mentioned by the FCHVs			
Government hospital	44.3	48.6	46.1
Primary health care center	20.8	22.2	21.4
Health post	75.1	68.4	72.3
Urban health clinic	5.9	5.2	5.6
Community health center	4.5	1.4	3.2
Institutionalized family planning clinics	1.4	1.4	1.4
Mobile camp	7.6	1.4	5.0
Private hospital/nursing home	2.8	2.8	2.8
Private clinic	3.8	4.7	4.2
Others	0.0	0.5	0.2
Do not know	0.7	1.9	1.2
Number	289	212	501

** Multiple responses*

10.4 Support and treatment received by disabled women attending the HMG meeting

Out of the three female adolescents with a disability who had participated in the HMG meeting, all of them mentioned that they were treated well by other HMG members who participated along with them. Similarly, all of them also mentioned that they felt comfortable attending the HMG meeting (table not shown).

11 Menstrual Hygiene Practices

- The mean and median age of the adolescents at their first menstruation were 12.7 years and 13 years, respectively.
- Almost two-thirds (65%) of the female adolescents reported using menstrual pads as an absorbent product during menstruation, followed by cotton clothes (23%).
- Only a quarter of the adolescent girls (26%) reported changing their absorbent every four hours during menstruation, followed by every three hours (24%). Over a fifth (22%) of adolescent girls revealed that they change the absorbent as needed.
- Most adolescent girls (85%) reported that they could wash or change in privacy while at home during their last menstruation.
- Most adolescent girls (90%) reported going to school during menstruation.
- Out of the 167 adolescents who reported not going to school (sometimes or never) during menstruation, a large majority (84%) did not go to school due to abdominal discomfort, followed by a lack of menstrual pad disposal facility at school (13%).

11.1 Experience of menstruation and age of menarche

Of the total 3402 female adolescents surveyed, more than two-thirds (69%) had onset of menstruation.

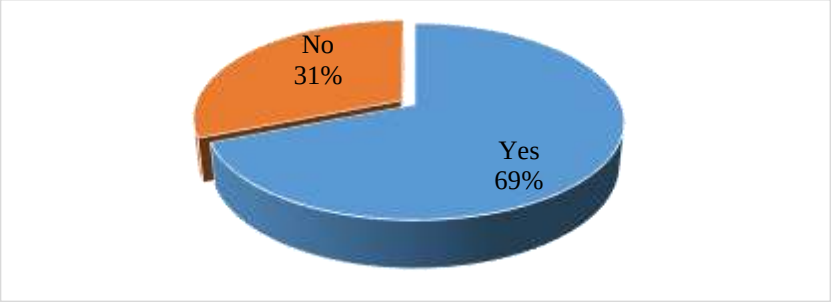

Figure 7 Females who have ever had menstruation (N=3402)

Among the adolescents who had ever had menstruation, the majority (72%) had their first menstruation at the age of 12 to 13 years. Above one-tenth of them (13%) had their menarche at 14 years. The mean and median age of the adolescents at their first menstruation were 12.7 years and 13 years, respectively. Province-wise disaggregation showed that adolescents belonging to Madhesh Province had comparatively lower mean and median age at first menstruation, 12.5 years and 12 years, respectively, compared to other Provinces.

Table 53 Mean and median age at first menstruation

	Mean age	Median age
Province		
Karnali	13.1	13.0
Lumbini	13.1	13.0
Madhesh	12.5	12.0
Municipality/Rural Municipality		
Rural Municipality	12.8	13.0
Urban Municipality	12.7	13.0

Wealth Quintile		
Lowest	12.7	13.0
Second	12.8	13.0
Middle	12.8	13.0
Fourth	12.7	13.0
Highest	12.7	13.0
Age group		
10-14	12.2	12.0
15-19	13.0	13.0
Caste/Ethnicity		
Hill Brahmin	12.9	13.0
Hill Chhetri	13.2	13.0
Madhesi Brahmin/Chhetri	13.0	13.0
Madhesi Other	12.7	13.0
Hill Dalit	12.8	13.0
Madhesi Dalit	12.4	12.0
Newar	13.4	13.0
Hill/Mountain Janajati	13.0	13.0
Terai Janajati	12.5	12.0
Muslim	12.4	12.0
Others	12.9	13.0
Total	12.7	13.0

11.2 Menstruation cycle

Among the female adolescents who had ever had menstruation (n=2343), a majority (72%) had a menstruation cycle of 26-32 days.

The study also explored how female adolescents perceived their menstrual cycle. More than three-fourths (76%) of adolescent girls perceived their menstruation cycle as 'normal.'

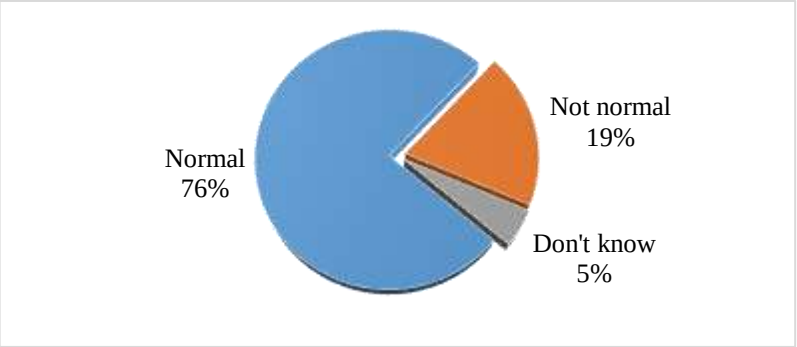

Figure 8 Percentage distribution of perception on own menstruation cycle (N=2343)

Out of the 454 adolescent girls who perceived that their menstruation cycle is not normal, almost three-fourths (74%) had not tried anything to fix their irregular menstrual cycle; however, above one-tenth (14%) had talked about it with their family, and 8 percent of them had consulted the doctor.

Table 54 Perception of the menstruation cycle

	Female
Duration of menstruation cycle	
26-32 days	71.7
Earlier than 26 days	14.6
Later than 32 days	11.0

Irregular	2.7
Total	100.0
Number	2343
Perception that own menstruation cycle is normal	
Yes	75.9
No	19.4
Do not know	4.7
Total	100.0
Number	2343
Tried anything to fix irregular menstrual cycle	
No	74.4
Yes, I have consulted with the doctor	7.5
Yes, I have talk about it with my family	13.7
Yes, I have talk about it with my friends	4.4
Total	100.0
Number	454

11.3 Tracking of menstrual cycle

The study also investigated the ways in which adolescent girls track their menstrual cycle. Almost three-fifths (59%) of them reported using the calendar method. However, one-third (33%) of the adolescent girls stated they never track their menstruation cycle.

Table 55 Tracking of the menstrual cycle

Ways of tracking menstrual cycle	Female
Calendar method	58.7
Cycle beads methods	0.5
Mobile apps	0.1
I do not track	33.4
Other	7.3
Total	100.0
Number	2343

11.4 Absorbent products used during the menstruation

Almost two-thirds (65%) of the female adolescents reported that they use menstrual pads as an absorbent product during menstruation, followed by cotton clothes (23%). On the other hand, above a tenth of them (12%) mentioned that they use both; cotton pads and menstrual pads.

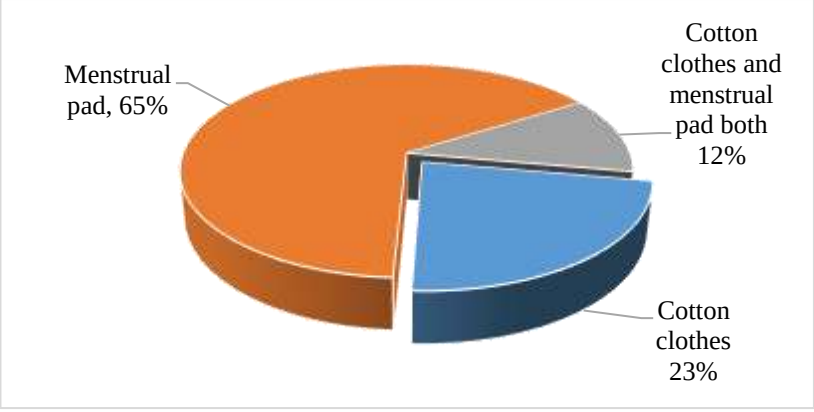

Figure 9 Absorbent product used during menstruation (N=2343)

Province-wise disaggregation showed that the use of menstrual pads was highest among the adolescents who belonged to Karnali Province (82%), followed by Lumbini (66%) and Madhesh Province (only 62%). A considerably higher proportion of the adolescents who belonged to Madhesh Province were found using cotton clothes (29%). On the other hand, a substantial proportion of the adolescents who belonged to Lumbini Province were found using cotton clothes and were not attending school during the time of the survey pads (22%). In regard to the place of residence, the use of cotton cloths as absorbent during menstruation was higher among adolescents from rural municipality (27%) than those from urban municipality (21%). In terms of wealth quintile, the use of menstrual pads was highest among those who were in the highest/richest quintile (71%), while the utilization of menstrual pads was found to be lowest among those in the lowest/poorest quintile (56%). This variation in the utilization of menstrual pads among different wealth quintile may be due to the cost of buying the menstrual pads or other associated factors which needs further exploration. In terms of caste/ethnicity, the use of pads among adolescents not attending school was found to be substantially lower among adolescents belonging to the Muslim community (52%) and Madhesi Dalit (44%) compared to other caste/ethnicities.

Table 56 Absorbent use during menstruation by socio-demographic characteristics

	Cotton cloth pads	Menstrual pad	Cotton cloth pads and menstrual pads both	Others	Total number of female adolescents
Province					
Karnali	4.9	82.0	12.7	0.4	244
Lumbini	12.0	66.0	22.0	0.0	523
Madhesh	29.4	62.4	8.1	0.2	1576
Municipality/Rural Municipality					
Rural Municipality	27.4	71.3	1.2	0.1	731
Urban Municipality	21.0	62.5	16.4	0.2	1612
Wealth Quintile					
Lowest	35.1	55.7	9.1	0.2	485
Second	22.3	66.3	11.4	0.0	413
Middle	22.9	65.4	11.0	0.6	463
Fourth	19.5	66.4	14.1	0.0	405
Highest	15.8	71.4	12.8	0.0	577
Age group					
10-14	24.9	65.1	10.0	0.0	782
15-19	22.0	65.3	12.5	0.3	1561
Caste/Ethnicity					
Hill Brahmin	5.1	63.3	31.6	0.00.0	79
Hill Chhetri	5.2	75.4	19.0	0.3	305
Madhesi Brahmin/Chhetri	21.3	77.0	1.6	0.0	122
Madhesi Other	20.0	69.0	11.0	0.0	616
Hill Dalit	9.1	72.7	18.2	0.0	143
Madhesi Dalit	43.9	44.4	11.2	0.5	437
Newar	20.0	80.0	0.0	0.0	5
Hill/Mountain Janajati	7.2	69.7	23.0	0.0	152
Terai Janajati	24.5	75.1	0.4	0.0	233
Muslim	42.2	51.8	5.4	0.6	166
Others	29.4	70.6	0.0	0.0	85
Total	**23.0**	**65.2**	**11.7**	**0.2**	**2343**

11.5 Reuse of the absorbent materials

Out of the 811 adolescent girls who use cotton cloth as an absorbent during menstruation, slightly more than four-fifths (81%, n=659) reported that they reuse the absorbent, i.e., the cotton pad used during menstruation. Among them, almost all (99%) mentioned they wash the absorbent (cotton pad) with soap and water. Similarly, a large majority (86%) of the adolescent girls reported they dried up the washed cotton cloth outside in the sunlight, whereas 13 percent of them said they dried up the cotton cloth inside the house.

Table 57 Reuse the absorbent materials

	Female
Reuse and washing status of the absorbent	
Reuse status of the absorbent used during menstruation (n=811)	81.3
Washing absorbent with soap and water during menstruation (n=659)	99.4
Ways of drying reusable cotton clothes during menstruation	
Outside the house, in sunlight	86.3
Inside House	12.6
Outside house without sunlight	1.1
Total	100
Number	659

11.6 Frequency of changing absorbent and underwear during menstruation

The information on the frequency of changing absorbents and underwear during menstruation was sought in the study. Only a quarter of the adolescent girls (26%) reported that they change their absorbent every four hours during menstruation, followed by every three hours (24%). More than a fifth (22%) of adolescent girls revealed that they change the absorbent as per their need. In a similar way, regarding the frequency of changing underwear during menstruation, half of the adolescent girls (50%) reported that they change their underwear once a day during menstruation, whereas two-fifths (40%) reported changing their underwear whenever it gets dirty during menstruation.

Table 58: Frequency of changing absorbent and underwear during menstruation

	Female
Number of times of changing absorbents during menstruation	
Every three hour	23.7
Every four hour	26.4
Every five hour	8.9
Every six hour	12.7
Once in a day	5.6
As per need	21.6
Others	1.1
Total	100
Number	2343
Number of times of changing underwear during menstruation	
Every time with pad	8.6
Once in a day	50.1
Whenever it gets dirty	39.7
Others	1.6
Total	100.0
Number	2343

11.7 Ability to wash and change in privacy at home during menstruation

A large majority of the adolescent girls (85%) reported that they were able to wash or change in privacy while at home during their last menstruation. Furthermore, a lower percentage of adolescent girls who used cotton clothes mentioned they were able to wash and change in privacy while at home during the last menstruation (75%) than other adolescents who used menstrual pads (89%) (indicator table).

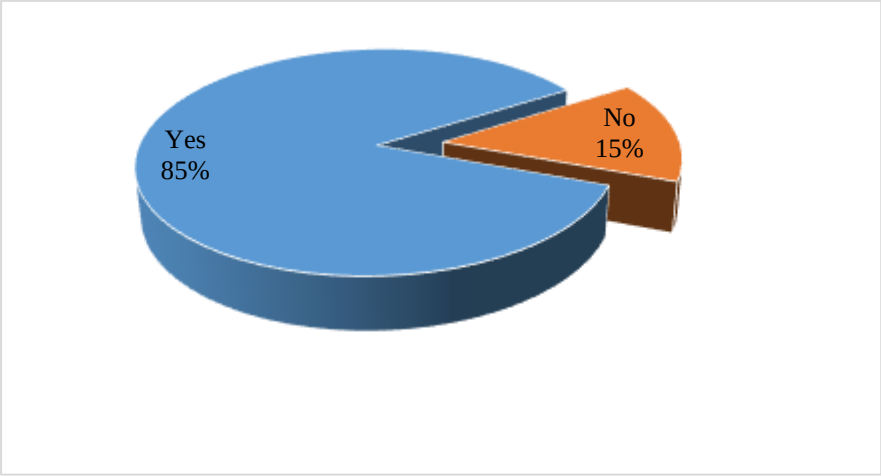

Figure 10 Able to wash and change in privacy while at home during last menstruation (N=2343)

The survey also explored the ways of disposing of the used pad (absorbent) at home among the adolescent girls who used menstrual pads as an absorbent (n=1801). More than one-third (37%) of them revealed that they bury the used menstrual pad underground, while almost a quarter (24%) stated they throw it in the routine waste.

Table 59 Wash and change in privacy

Ways of disposing of the used absorbent at home	Female
Burn it	17.5
Throw it in routine waste	24.3
Flush it	6.8
Bury it underground	36.9
Throw it in the environment	11.1
Others	3.5
Total	100.0
Number	1801

As mentioned above, more than four-fifths of adolescent girls (85%) reported that they were able to wash and change in privacy while at home during their last menstruation.

Province-wise analysis showed that the proportion of the girls who were able to wash and change in privacy while at home was significantly higher($p<0.001$) among those belonging to Lumbini province (97%) compared to other provinces (Karnali=92%, Madhesh= 81%). In terms of place of residence, adolescent girls from urban municipality reported greater access ($p<0.001$) to a private place to wash and change while at home (89%) compared to girls residing in rural municipality (78%). Regarding the wealth quintile, adolescent girls who belonged to the highest wealth quintile (91%) reported significantly higher ($p<0.001$) access to a private place to wash and change while at home, while those belonging to the lowest wealth quintile had the lowest access to wash and change in privacy during last menstruation. Age-wise analysis showed that the proportion of adolescent girls who were able to wash and change in privacy while at home during their last menstruation was almost similar among both the early adolescence group (10-14

years; 86%) and the late adolescence group (15-19 years; 85%). The disaggregation based on caste/ethnicity revealed that adolescents belonging to Hill/Mountain Janajati had the highest (98%) while those belonging to Madhesi Brahmin/Chhetri had the lowest (68%) access to a private place to wash and change during menstruation while at home.

Table 60 Percent of adolescent girls using appropriate menstrual hygiene materials with a private place to wash and change while at home

	Able to wash and change in privacy	Total number of adolescent girls
Province * (Chi-square=90.6, p=0.000)**		
Karnali	91.8	244
Lumbini	96.7	523
Madhesh	80.6	1576
Municipality/Rural Municipality * (Chi-square=50.5, p=0.000)**		
Rural Municipality	77.7	731
Urban Municipality	88.9	1612
Wealth Quintile* (Chi-square=62.5, p=0.000)**		
Lowest	74.8	485
Second	84.5	413
Middle	87.7	463
Fourth	88.6	405
Highest	90.8	577
Age group (Chi-square=1.02, p=0.312)		
10-14	86.4	782
15-19	84.9	1561
Caste/Ethnicity * (Chi-square=153.3, p=0.000)**		
Hill Brahmin	94.9	79
Hill Chhetri	94.1	305
Madhesi Brahmin/Chhetri	68.0	122
Madhesi Other	84.6	616
Hill Dalit	95.1	143
Madhesi Dalit	74.1	437
Newar	80.0	5
Hill/Mountain Janajati	98.0	152
Terai Janajati	90.6	233
Muslim	77.1	166
Others	97.6	85
Total	85.4	2343

**** Significant at chi-square test p<0.001, **=p<0.01 and *=p<0.05*

11.8 Experience of any kind of discrimination during menstruation

The study explored discrimination experienced by adolescent girls during menstruation. Almost two-fifths (39%) reported that they had experienced some kind of discrimination during menstruation. Among them,

almost all (97%) reported being restricted from going to the temple and worshipping god during menstruation, followed by being deprived of going into the kitchen (27%).

Table 61 Experience of any kind of discrimination during menstruation

	Female
Experienced any kind of discrimination during menstruation (n=2343)	39.2
Total	100.0
Kind of discrimination experienced during menstruation *	
Deprived of going to temple and worshipping	96.5
Deprived of going kitchen	26.5
Deprived of going out of home	9.3
Only limited to a certain place	7.4
Others	4.8
Number	918

11.9 Menstrual Issues and Practices of School going adolescent girl

Menstrual issues and practices of school-going adolescent girls (n=1722) were assessed in the survey. Most adolescent girls (90%) reported going to school during menstruation. Out of the 167 adolescents who reported not going to school (sometimes or never) during menstruation, a large majority (84%) did not go to school due to abdominal discomfort, followed by a lack of a menstrual pad disposal facility at school (13%). The girls who reported not attending school due to abdominal discomfort (n=140) were asked if they do something to reduce their pain, to which the majority (76%) mentioned taking rest to reduce stomach pain during menstruation. In regard to the utilization of the menstrual pad provided by the school, the majority of the adolescent girls (94%) (those who had ever had menstruation and who were currently going to school and of those whose school provided menstrual pads) reported utilizing the pads provided by the school. The adolescent girls were further asked about the menstrual hygiene facilities available at their school.

The majority (70%) of the respondents stated that there is an availability of separate bins at their school toilet for disposing of used absorbents during menstruation. Among those who reported not having a separate bin at school toilets for disposing of used absorbents (n=515), almost half of them (48%) reported bringing the used absorbent back home for disposal, while almost one-third (31%) reported throwing the used absorbent in the environment.

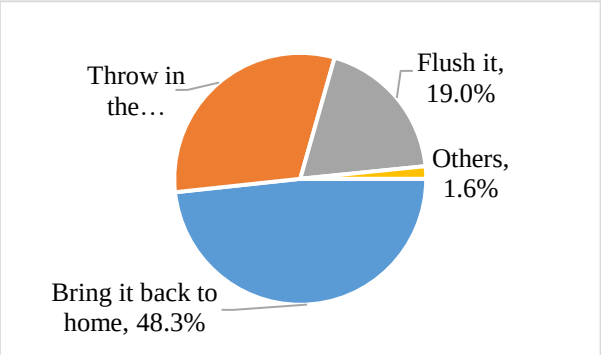

Figure 11 Ways of disposing of the used absorbent at school (N=515)

The qualitative findings show that menstrual pads are available at the school, but hygiene practice is not proper for the students.

*In our school, we have been providing menstrual pads for our students, but we do not have changing facilities at the school. I have raised the issues with the local government, but we are not able to resolve the situation**. - KII, Health Teacher, Dhanusa***

*We provide free menstrual pads in the school, but we do not have separate toilets for boys and girls. If girls are in period, they do not attend the classes as we do not have separate toilets to change the pads and maintain hygiene. We do not have facilities for the girls. -***KII, Health Teacher, Mahottari**

*Yes, we also teach about menstruation hygiene in Madrasa. In my opinion, we can teach married and unmarried adolescents about RH through school and other programs in the community. -**KII, Religious leaders, Dhanusa***

*We also believe in menstrual restrictions 'untouchable' in the Muslim community, but we do not have to stay away from others. We also believe that we should not do 'Namaz' (religious prayer) during menstruation. However, there have been changes than before; now, they use pads during menstruation, but before, they used cotton clothes. -**KII, Religious leaders, Dhanusa***

We get free menstrual pads at the school. For girls, we need a separate toilet to change menstrual pads, so if we are provided separate toilets with good water facilities, it will be easier for us- **P4, FGD with unmarried adolescents, Bheriganga Municipality**

Table 62 Menstrual issues and practices of school going adolescent girl

	Female
School going status during menstruation	
Yes	90.3
Sometimes	6.2
No	3.5
Total	100.0
Number	1722
Reason for not going to school during menstruation *	
Lack of separate private toilets for girls	18.0
Lack of access to absorbents at school	9.0
Lack of menstrual pad disposal facility at school	13.2
Abdominal discomfort	83.8
Cultural taboos	3.6
Others	2.4
Number	167
Activities done to reduce stomach pain during menstruation*	
Use of hot bag	4.3
Drink a lot of water	22.1
Take medicine	18.6
Take rest	75.7
I do not do anything	20.0
Others	0.7
Number	140
Use of the menstrual pad provided by the school	
Yes	94.1

	Female
No	5.9
Total	100.0
Number	1504
Availability of separate bin at school toilet for disposing of used absorbent	
Yes	70.1
No	29.9
Total	100.0
Number	1722
Ways of disposing of the used absorbent at school	
Bring it back home	48.3
Throw in the environment	31.1
Flush it	19.0
Others	1.6
Total	100.0
Number	515

12 Access to Digital technology

- Almost a quarter (23%) of the adolescents had their own mobile phone.
- Out of 4365 adolescents who did not have their own mobile phone, almost one-third (30%) stated using the phone of their mother/mother-in-law, followed by father/father-in-law (13%).
- More than two-fifths (41%) reported using the internet or data.
- Almost one-third (31%) of the adolescents reported that they use the internet/data for educational purposes, and among them (n=25), nearly half (46%) stated that accessing the internet/data for online classes/courses, followed by to gain knowledge in other subjects (math/science/social science) (19%).
- Slightly above a fifth (21%) of adolescents reported playing digital games.
- Almost two-thirds (64%) of the adolescents who played digital games wanted to get information (academic/non-academic) through games, and 58 percent (61% male, 48% female) expressed their desire to learn FP/RH topics through games.

12.1 Basic digital literacy

The study also explored access to digital technology among adolescents. It was found that almost a quarter (23%) of adolescents have their own mobile phones. Access to own mobile phone was more than two times higher among male (34%) than female adolescents (16%). A higher percentage of male adolescent aged 15-19 (64%) compared to aged 10-14 (10%) had their own mobile phone which was lower among female adolescent (4% among 10-14 years and 30% among 15-19 years). In regard to marital status, in both male and female adolescents the access of mobile phone was comparatively higher among married (male 86% and female 60%) than unmarried (male 33% and female 14%).

Among the adolescents who had their own mobile phone, a large majority (87%) had a smartphone. Out of 4365 adolescents who did not have their own mobile phone, half (50%) mentioned that they did not use anyone's phone, however; almost one-third (30%) stated that using the phone of their mother/mother-in-law, followed by father/father-in-law (13%).

Two-fifths of adolescents (40%) reported spending an average of less than an hour a day using a mobile phone, followed by 1-2 hours (39%). Almost all adolescents (97%) did not use any other methods apart from a smartphone. Regarding the activities adolescents normally do on a mobile phone, more than two-thirds (67%) reported watching entertainment videos, followed by making audio and video calls (48%) and TikTok videos (47%).

Table 63 Basic digital literacy

	Male	Female	Total
Having own mobile phone			
Yes	33.6	16.0	23.0
No	66.4	84.0	77.0
Total	100.0	100.0	100.0
Number	2268	3404	5670
Type of mobile phone			
Smartphone	90.9	81.8	87.1
Featured Phone	9.1	18.2	12.9
Total	100.0	100.0	100.0
Number	762	543	1305
A person whose mobile phone respondents use			
No one	44.0	53.0	49.9
Mother/mother-in-law	30.9	29.6	30.1
Father/father-in-law	19.1	9.0	12.5
Brother/brother-in-law	3.6	4.5	4.2
Sister/sister-in-law	1.2	1.9	1.7
Husband/wife	0.0	1.0	0.7
Others	1.2	.9	1.0
Total	100.0	100.0	100.0
Number	1506	2859	4365
Average hours in a day using mobile phone			
Less than an hour	32.6	45.7	39.7
1-2 hours	42.3	35.9	38.9
3-5 hours	17.1	8.5	12.4
More than 5 hours	5.1	2.8	3.9
Only for calls	2.9	7.1	5.2
Total	100.0	100.0	100.0
Number	1606	2859	4365
Using other devices apart from a smartphone *			
Tablet	0.8	0.2	0.5
Laptop	2.3	1.4	1.8
PC	1.8	0.7	1.2
None	95.6	97.7	96.8
Total	100.0	100.0	100.0
Number	1606	1886	3492
Activities done normally on a mobile phone *			
Audio and video calls	49.3	46.3	47.7
Watch entertainment videos	70.0	64.7	67.2
Make entertainment videos (TikTok)	49.8	45.2	47.3
Watch educational/informational content	16.2	10.6	13.2
Listen to songs	41.1	29.5	34.9
Play games	49.6	13.8	30.3

	Male	Female	Total
Social Media	34.4	20.3	26.7
Watch health related messages/information	2.7	1.1	1.8
Others	2.3	2.5	2.4
Number	1606	1886	3492

** Multiple responses*

12.2 Internet and Data usage

Of the total adolescents interviewed, over two-fifths (41%) reported using the Internet or data. Sex-wise distribution showed that a higher proportion of male adolescents (54%) were found to use the internet or data than female adolescents (33%). Among the adolescents who used the internet or data (n=2341), almost half (49%) reported accessing the internet/data through data packs, followed by monthly WIFI subscriptions (28%). Similarly, a large majority (81%) of the adolescents mentioned they watch video streams using the internet/data, followed by making audio/video calls (54%) and browsing social media (53%).

In a similar way, almost one-third (31%) of the adolescents reported that they use the internet/data for educational purposes, and among them (n=25), nearly half (46%) stated that accessing internet/data for online classes/courses followed by gaining knowledge in other subjects (math/science/social science) (19%). Likewise, out of 1124 adolescents who paid for the internet or data, more than three-fifths (61%) spend less than 500 NRs per month. In regard to the ways for paying the internet, a majority of the respondents mentioned that they paid for the internet/data through cash.

Table 64 Internet and Data usage

	Male	Female	Total
Use of the Internet or data			
Yes	53.7	33.0	41.3
No	46.3	67.0	58.7
Total	100.0	100.0	100.0
Number	2268	3402	5670
Ways of accessing Internet/data*			
Data packs	53.4	44.8	49.3
Monthly WIFI subscription	27.3	28.9	28.1
Pay for a shared connection	16.2	23.0	19.5
Use only at free spots (for example, a restaurant, friend, or relative's house)	18.1	7.9	13.2
Others	.8	.2	.5
Number	1219	1122	2341
Activities mostly do while using the internet/data *			
Browse social media	60.9	45.0	53.3
Watch video streams	79.1	82.7	80.8
Audio/Video Calls	50.3	57.8	53.9
Play online games	40.4	6.1	24.0
Others	3.8	2.6	3.2
Number	1219	1122	2341
Use of mobile phone/data/internet for educational purposes			
Yes	35.2	25.7	30.6
No	64.8	74.3	69.4
Total	100.0	100.0	100.0

Number	1219	1122	2341
Topics searched while accessing mobile phones for educational purposes			
RH and sexual health-related topics	25.4	18.8	22.7
For online classes	42.0	45.8	43.5
Search for homework	7.0	17.0	11.0
To gain knowledge in other subjects (math/science/social science)	21.4	16.0	19.2
Others	4.2	2.4	3.5
Total	100.0	100.0	100.0
Number	429	288	717
Money spends on the internet and data per month			
Less than 500	56.4	68.0	61.4
500-999	25.9	14.4	20.9
1000 and more	17.7	17.7	17.7
Total	100.0	100.0	100.0
Number	637	487	1124
Ways of paying for Internet*			
Fone pay	2.2	1.2	1.8
Esewa	5.3	1.0	3.5
Khalti	1.1	9.2	4.6
IME pay	.5	.2	.4
Mobile banking	2.5	1.8	2.2
Cash to Service Provider	95.1	87.5	91.8
Number	637	487	1124

** Multiple responses*

12.3 Games-fit

Slightly above a fifth (21%) of the adolescents reported that they play digital games, among which almost all (99%) played digital games on a mobile phone. Adolescent boys (39%) were more likely to play digital games than adolescent girls (8%). Ludo was the most common digital game (51%) played by adolescents, followed by Garena Free Fire (44%). More than half of the adolescents (54%) knew about mobile games/apps through their school friends. Regarding aspects of digital games that adolescents like the most, the majority (75%) said that digital games are a good time pass, whereas almost one-third (32%) liked the gameplay aspect (challenges and levels of the game) of the digital game. Almost half of them (47%) were found to spend 1-2 hours a day playing their preferred game.

Table 65 Games-fit questions

	Male	Female	Total
Playing digital games			
Yes	39.0	8.3	20.5
No	61.0	91.7	79.5
Total	100.0	100.0	100.0
Number	2268	3402	5670
Devices for playing digital games *			
On mobile phone	99.4	99.3	99.4
On Tablet	0.3	0.0	0.3
On a PC or Laptop	0.7	0.7	0.7
In cyber	0.1	0.0	0.1
Others	0.3	0.4	0.3

	Male	Female	Total
Number	884	281	1165
Mostly played digital games*			
Garena Free Fire	56.6	4.6	44.0
PUBG	24.5	6.0	20.1
Ludo	46.0	67.6	51.2
Candy Crush	23.1	30.6	24.9
Minecraft	1.6	1.1	1.5
Temple Run	12.7	11.0	12.3
Subway Surfer	4.9	2.1	4.2
Digital card game- marriage call break	2.4	0.4	1.9
Others	7.0	8.9	7.5
Number	884	281	1165
Known about mobile games/apps*			
Out-of-school friends circle	54.4	20.3	46.2
School friends	56.6	47.7	54.4
Family Members	21.0	46.6	27.2
From videos	17.1	6.8	14.6
Others	1.9	3.2	2.2
Number	884	281	1165
Things like most about the games*			
The Concept/The story	17.2	5.3	14.3
The gameplay (e.g., challenges and levels)	36.1	19.9	32.2
Graphics quality/ Characters and artwork	16.1	0.7	12.4
Reward system	15.0	12.8	14.5
A good time pass	73.9	80.1	75.4
Chatting with other players	19.7	3.9	15.9
Others	0.2	0.7	0.3
Number	884	281	1165
Time spent in a day playing own preferred game			
Less than an hour	36.2	74.0	45.3
1-2 hours/day	54.1	25.3	47.1
More than 2 hours/day	9.7	0.7	7.6
Total	100.0	100.0	100.0
Number	884	281	1165
Want to get information (academic/non-academic) through games			
Yes	65.8	57.7	63.9
No	34.2	42.3	36.1
Total	100.0	100.0	100.0
Number	884	281	1165
Want to learn FP/RH topic through games			
Yes	61.0	47.7	57.8
No	39.0	52.3	42.2
Total	100.0	100.0	100.0
Number	884	281	1165

** Multiple responses*

Wants to learn FP/RH topics through games

Almost two-thirds (64%) of the adolescents who played digital games wanted to get information (academic/non-academic) through games, and 58 percent (61% male, 48% female) expressed their desire to learn FP/RH topics through games.

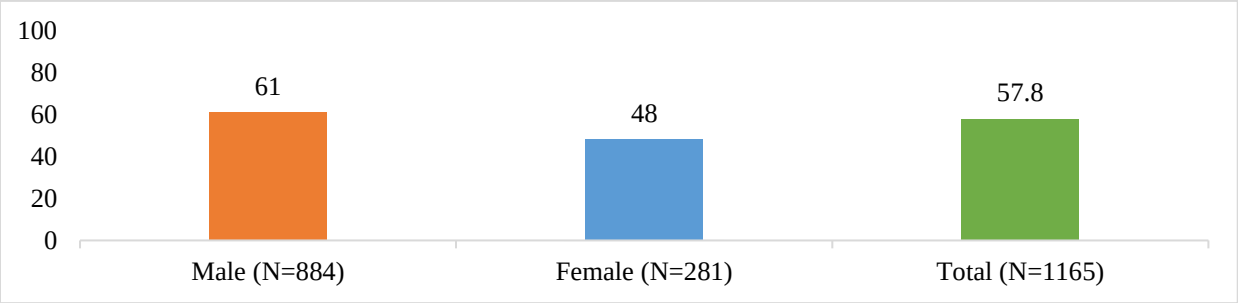

Figure 12 Percentage distribution of wanting to learn FP/RH topics through games

Desire to learn FP/RH topics through games by socio-demographic characteristics

As mentioned above, one out of five surveyed adolescents (21%) reported playing digital games. Of them, more than half (58%) reported that they wanted to learn FP/RH topics through games. Province-wise analysis showed that the proportion of adolescents who reported playing digital games was highest in Karnali province (24%) and lowest in Lumbini province (17%). However, adolescents wanting to learn FP/RH topics through the games were also highest in Lumbini province (45%) and lowest in Karnali province (34%). A higher proportion of adolescents from the richest/highest wealth quintile reported playing digital games (33%), while those in the poorest/lowest wealth quintile were the least to play digital games (only 10%).

Regarding age, a higher proportion of adolescents aged 15-19 years (23%) played digital games than that of early adolescents aged 10-14 years (18%). Also, a significantly higher proportion ($p<0.01$) of the adolescents aged 15-19 years (63%) wanted to learn FP/RH topics through games than that the early adolescents aged 10-14 years (53%). A significantly higher proportion of male adolescents (39%, $p<0.0001$) were found to play digital games compared to females (8%). The same trend was observed regarding the desire to learn FP/RH topics through games; adolescent males had a significantly greater ($p<0.001$) desire to learn FP/RH topics through games (61%) than females (48%). The proportion of adolescents wanting to learn FP/RH topics through the games was higher among those residing in urban municipality (59%) than that in rural municipality.

Table 66 Desire to learn FP/RH topic through games by socio-demographic characteristics

	Playing digital games	Total number of Adolescent	Want to learn FP/RH topics through games+	Total number of Adolescent
Province (Chi-square=3.9, p=0.141)				
Karnali	23.7	540	65.6	128
Lumbini	17.4	1350	55.3	235
Madhesh	21.2	3780	57.2	802

	Playing digital games	Total number of Adolescent	Want to learn FP/RH topics through games+	Total number of Adolescent
Municipality/Rural Municipality (Chi-square=.77, p=0.379)				
Rural Municipality	20.1	1890	55.9	379
Urban Municipality	20.8	3780	58.7	786
Wealth Quintile (Chi-square= 8.17, p=0.085)				
Lowest	9.6	1126	51.9	108
Second	16.8	1025	58.1	172
Middle	18.7	1115	53.6	209
Fourth	20.3	964	54.1	196
Highest	33.3	1440	62.3	480
Age group ** (Chi-square=12.0, p=0.001)				
10-14	18.3	3082	52.6	563
15-19	23.3	2588	62.6	602
Sex * (Chi-square=15.4, p=0.000)**				
Male	39.0	2268	61.0	884
Female	8.3	3402	47.7	281
Caste/Ethnicity* (Chi-square=22.6, p=0.012)				
Hill Brahmin	11.9	151	61.1	18
Hill Chhetri	15.7	740	47.4	116
Madhesi Brahmin/Chhetri	26.9	334	54.4	90
Madhesi Other	27.0	1476	59.9	399
Hill Dalit	17.9	358	62.5	64
Madhesi Dalit	16.9	1103	62.4	186
Newar	20.0	10	0.0	2
Hill/Mountain Janajati	16.1	410	47.0	66
Terai Janajati	18.9	519	59.2	98
Muslim	23.1	411	51.6	95
Others	19.6	158	80.6	31
Total	20.5	5670	57.8	1165

+Chi-square test was performed with want to learn FP/RH topic through games.

*** Significant at chi-square test p<0.001, **=p<0.01 and *=p<0.05

13 Social Norms for RH Behavior

A set of questions (refer to the below box) were asked to the parents/caregivers (community member) of the adolescent girls and boys in the survey about the lives and experiences of girls and boys in the community and how community members consider adolescents' behavior. The following statements were read. Thinking about the people of the community, parents were allowed to fully agree, agree, disagree, or fully disagree with each of the statements. Based on their extent of agreement and disagreement, the composite index for the positive social norms was calculated on a scale and then further categorized into three categories: 1) low level of-agreement with positive social norms/high level of agreement with negative social norms, 2) moderate level of agreement with positive social norms/moderate level of

agreement with negative social norms, and 3) high level of agreement with positive social norms/low level of agreement with negative social norms. Almost two-thirds of the community members (65%) had a moderate level of agreement with positive social norms/low level agreement with negative social norms, 16 percent of them had a high level of agreement with positive social norms/low level of agreement with negative social norms, and 19 percent of them had a low level of agreement with positive social norms/high level of agreement with negative social norms.

Social Norms affecting adolescents' reproductive health and well-being.

Negative impact:

- Married adolescent girls should give birth to a child right after marriage.
- Girls getting married under 20.
- Dowry taken at time of son's marriage
- Dowry given at time of daughter's marriage
- No matter how many daughters in family, there must be at least one son.
- Believe menstruation is impure thus girls should stay away from others during their periods.

Positive impact:

- Adolescent girls can discuss marriage options with parents.
- Girls can have a relationship or a love marriage.
- Girls (10-19) can go to the bazaar without any family member accompanying.
- An unmarried girl can visit a health facility to receive RH information.
- A girl can speak openly about menstruation.
- Girls can take an active role in their community to talk about their needs.
- Recently married adolescent girls can access RH counseling and FP services.

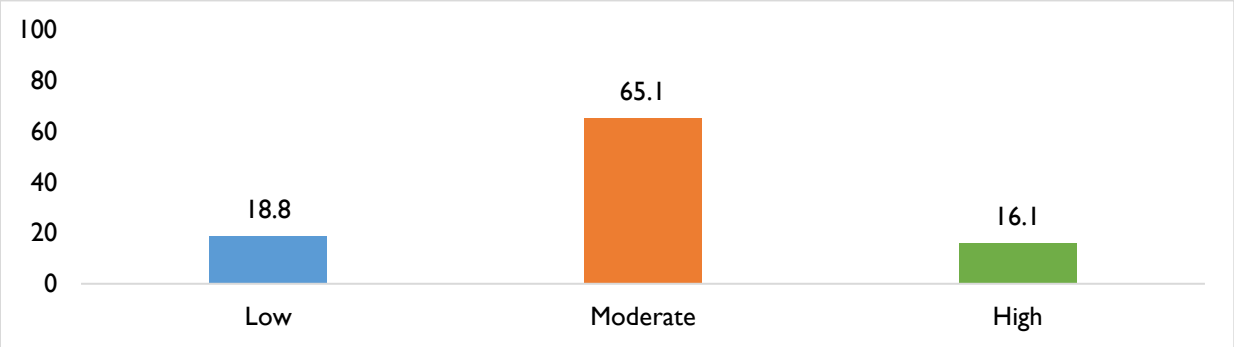

Figure 13 Percentage of community members describing positive changes in social norms for healthy RH behavior of adolescents (N=1512)

Province-wise analysis showed that a significantly higher proportion of the respondents ($p<0.001$) had a high level of agreement for positive social norms in the Lumbini province (33%), followed by Karnali (12%) and lowest in Madhesh province (11%). It is of note that a high level of agreement for positive social norm was significantly higher ($p<0.001$) among those residing in rural municipality (10%) than those living in urban municipality (14%). Therefore, province and place of residence had a significant association with high positive social norms for healthy RH behavior of adolescents. Similarly, a high level of agreement for

positive social norms also varied with the wealth quintile; the highest observed among those community people who are in the fourth wealth quintile (20%) and lowest among those in the lowest wealth quintile (12%).

In the qualitative information about the norms of having sons in the family, community people thought there is a need for sons in the family.

> *In our village, there is one family that has nine daughters and one son. During our time, the value of the sons was higher, but the situation has changed now. These days people view sons and daughters as equal. The importance of having a son is linked to saving the generation of the family.* **P5, FGD with grandparents, Bagchaur Municipality**

The findings of the qualitative discussion reveal some facts related to marriage after the age of 20 years. The respondents shared different views on the right age of marriage. Though most of the participants shared right age for marriage is 20 years, there are different factors which has resulted in early marriage, such as poverty, suitable groom, and support for the male's family, but there are some issues raised as the consequences of early marriage such as malnutrition, discontinuity of education, etc.

> *There is an issue of nutrition and the age of marriage. If people marry early, there are chances of suffering from malnutrition. It will affect the overall health of mothers and, ultimately, children. Hence, they should marry after the age of 20 years. Furthermore, the discontinuity of education is another major aspect that should be considered in the case of early marriage.* **P1, FGD with grandparents, Jhimruk RM, Pyuthan**

Regarding the use of FP methods and seeking behavior of the unmarried adolescents girls, most of the community members take it negatively.

Yes, they think it is bad. (Society also thinks it is bad.) If we visit the health post and ask for the FP and RH, people start to think negatively about us. ***P1,*** **FGD with unmarried adolescents, Janaki RM, Banke**

Table 67 Percentage of community members describing current positive social norms for healthy RH behavior of adolescents in the targeted municipality

	Social Norms- Positive			Total number of parents/ caregivers
	Low	Moderate	High	
Province * (Chi-square=101.8, p=0.000)**				
Karnali	11.1	76.4	12.5	144
Lumbini	16.9	50.6	32.5	360
Madhesh	20.5	68.7	10.8	1008
Municipality/Rural Municipality* (Chi-square=21.1, p=0.000)**				
Rural Municipality	22.6	57.1	20.2	504
Urban Municipality	16.9	69.0	14.1	1008
Wealth Quintile (Chi-square=24.8, p=0.002)				
Lowest	20.2	67.6	12.2	287
Second	26.9	59.8	13.3	264
Middle	13.7	67.4	18.9	291

	Social Norms- Positive			Total number of parents/ caregivers
	Low	Moderate	High	
Fourth	17.3	62.4	20.4	255
Highest	17.1	66.7	16.1	415
Caste/Ethnicity (Chi-square=135.4, p=0.000)				
Hill Brahmin	9.1	70.5	20.5	44
Hill Chhetri	11.8	64.6	23.6	195
Madhesi Brahmin/Chhetri	24.0	63.5	12.5	96
Madhesi Other	23.2	67.3	9.5	419
Hill Dalit	6.7	61.1	32.2	90
Madhesi Dalit	24.6	66.7	8.7	276
Newar	0.0	33.3	66.7	3
Hill/Mountain Janajati	8.0	50.9	41.1	112
Terai Janajati	14.4	69.7	15.9	132
Muslim	24.3	64.9	10.8	111
Others	23.5	67.6	8.8	34
Gender of primary caregivers (Chi-square=5.9, p=0.05)				
Male	18.8	62.7	18.5	713
Female	18.8	67.2	14.0	799
Total	18.8	65.1	16.1	1512

*** Significant at chi-square test p<0.001, **=p<0.01 and *=p<0.05

14 Gender equitable attitudes towards social norms (Gender-Equitable Men Scale)

Gender equitable attitudes of the parents/ caregivers towards various social norms were assessed in the survey through the Gender Equitable Men's Scale (GEMS). In the present study, the GEM scale was constructed from 12 statements covering gender norms, violence, sexuality, masculinity, and reproductive health, with response codes "fully agree," "partially agree," 'Neutral,' 'partially disagree' or "disagree. “The below statements were used to calculate the composite index and categorized it into three categories (least equity, moderate equity, and high equity).

A woman’s most important role is to take care of her home and cook for her family.
Women who carry condoms on them are “easy.”
Changing diapers, giving the kids a bath, and feeding the kids are the mothers‟ responsibilities.
It is a woman’s responsibility to avoid getting pregnant.
A man should have the final word about decisions in his home.
A woman should tolerate violence in order to keep her family together.
It is okay for a man to hit his wife is she won’t have sex with him.
A couple should decide together if they want to have children.
A man and a woman should decide together what type of contraceptive to use
Men can take care of children just as well as women can.
If a man sees another man beating a woman, he should stop it.
Women should be virgins until they get married.

Of the total parents (community people), 56.5 percent demonstrated moderate equity, 43.3 percent demonstrated high equity, and 0.1 percent demonstrated least equity regarding gender-equitable attitudes towards social norms (N=1512).

The social norms related to gender equitable attitudes were also analyzed in the qualitative information. Regarding the approval for adolescent girls to visit the bazaar without their family members, respondents stated the traditional thought behind it was to not approve the adolescents visiting the bazaar.

Regarding the approval for unmarried girls to visit the health facilities to receive information about RH, the respondents stated it is still taboo for girls to visit and understand RH information. The interview stated:

> *If we share the information of RH and FP with unmarried adolescent girls, they think we want to divert their adolescent girls to different issues. The cases may be violent.* - **KII, Health Post In-Charge, Janaki RM**

Regarding menstruation, most of the respondents stated that it is taboo and did not discuss it with a different gender. Furthermore, the respondents also stated there are still issues regarding menstruation among the educated as well.

> *The taboo in western Nepal is stricter than ours, but we have the tradition among our colleagues as well. Sometimes, if our male staff are late, they inform us that their wife had menstruation and he had to cook.* **-KII, Health Post In-Charge, Janaki RM**

Province-wise analysis showed that parents who belonged to Karnali province showed the highest high equity on GEM (77%), while those from Madhesh province showed the lowest high equity (34%). Community people who resided in the urban areas (48%) showed higher high equity on GEM compared to those residing in rural areas (35%). In terms of wealth quintile, those community people who belonged to the second and middle wealth quintile (48% each) showed higher high equity on GEM than those belonging to the lowest/poorest quintile (35%).

Table 68 Gender-Equitable Men Scale

		Least Equity (1-23)	Moderate Equity (24-47)	High Equity (48-72)	Total number of parents/ caregivers N
Province	Karnali		22.9	77.1	144
	Lumbini		43.6	56.4	360
	Madhesh	0.1	66.0	33.9	1008
Municipality/Rural Municipality	Rural	0.2	65.1	34.7	504
	Urban		52.3	47.7	1008
Wealth Quintile	Lowest	0.3	65.2	34.5	287
	Second		52.3	47.7	264
	Middle		52.2	47.8	291

	Fourth		55.3	44.7	255
	Highest		57.1	42.9	415
Caste/Ethnicity	Hill Brahmin		45.5	54.5	44
	Hill Chhetri		28.7	71.3	195
	Madhesi Brahmin/Chhetri		53.1	46.9	96
	Madhesi Other	0.2	66.8	32.9	419
	Hill Dalit		30.0	70.0	90
	Madhesi Dalit		72.1	27.9	276
	Newar			100.0	3
	Hill/Mountain Janajati		27.7	72.3	112
	Terai Janajati		54.5	45.5	132
	Muslim		84.7	15.3	111
	Others		73.5	26.5	34
Gender of primary caregivers	Male	0.1	63.1	36.7	713
	Female		50.7	49.3	799
Total		0.1	56.5	43.4	1512

15 Conclusion and program implications

Conclusion

The overall findings of the study give us a good picture of adolescents' and their families' knowledge, attitudes and practices FP/RH information and behavior as well as related social norms and other practices such as school attendance, marriage practices, digital access, etc. The study found that the majority of adolescents are in school, however dropping out of school is still prevalent among a substantial proportion of adolescent girls and boys, especially those aged 15-19 and even more so inin Madhesh province. Familyfinancial crises and adolescents' lack of interest in studies were the most common reasons for dropping out. There were very few married adolescents in our study, with the median age of marriage at 16 years. Early pregnancy was prevalent among married adolescents especially in Madhesh Province. Although ANC visits werehigh among pregnant adolescents, very few received family planning counselling during their last ANC visit, contributing to the low proportion of postpartum family planning adoption. Home deliveries are still prevalent even among adolescents with comparatively higher prevalence in Karnali Province, increasing the risk of maternal and neonatal morbidity and mortality. Overall, there was limited knowledge among adolescents (married and unmarried) about family planning and reproductive health including healthy timing and spacing.

The Contraceptive Prevalence Rate (CPR) among adolescent girls was considerably low. Similarly, married and sexually unmarried adolescents had substantially higher unmet needs for family planning services and lower demand satisfaction, indicating a gap in the utilization of family planning services among adolescents. The major reasons for not using family planning methods among the married adolescents were 'husband staying away' and 'own opposition/refusal to use any method'. Misconceptions around family planning methods was another reason for not using family planning methods.

Furthermore, the exposure to FP/RH Information was low among adolescents and their parents/caregivers and most of the adolescent received information of RP/RH from school/textbooks. A substantial proportion of the adolescent girls were unable to wash or change sanitary pads in privacy while at home during their last menstruation. Only a sizeable proportion of adolescents were aware about free pad distribution in school and the majority of the adolescents do not miss school during menstruation. However, the menstrual hygiene facilities in school (separate toilet, separate bin in toilet) was not optimum. A considerable proportion of adolescents do not have access to mobile phones, and only a sizeable proportion of them play mobile games, more likely among adolescent boys.
Parents/caregivers/community members expressed low level of agreement towards positive social norms for RH behavior, indicating the requirement of community-level awareness regarding various reproductive health issues to form a more acceptable and RH-friendly society.

Program Implications

The findings suggest several areas where the USAID ARH could focus and prioritize to improve reproductive health and family planning behavior among adolescents. These include:

- The majority of adolescents are in school and most of the adolescents have received FP/RH information from school either from teachers or textbooks. It is therefore imperative to have school-based interventions to inform the adolescents about FP and RH either through textbooks or through mobilization of schoolteachers.
- School dropouts are still prevalent in the program areas, especially among Madhesh province and among 15-19 years. UDAAN sessions envisioned in the program should be conducted in those pocket areas with high dropouts to reach the most vulnerable adolescents.
- Among the various social norms for RH behaviour, some of the social norms showing low level of agreement could be selected to create vignettes and follow up during the project course to measure the change in these social norms.
- In areas where the menstrual hygiene practice is low in school, advocacy and sensitization events could be organized to improve the understanding about menstrual hygiene practice among school and school management committee and extend support to improve menstrual hygiene facilities in school.
- Although married adolescents were limited in the study areas, the tendency for early pregnancy among the married adolescents was high. Additionally, the knowledge about healthy timing and spacing was considerably low. Information about healthy timing and spacing should be embedded in SAA sessions among married and young adolescent groups and parents' group.
- While the ANC visit among the pregnant adolescents was high, the counselling about family planning during ANC was considerably low. Capacity building efforts for the health workers at the public and private health facilities with regular onsite coaching and mentorship is essential to provide adequate and effective counselling to the pregnant adolescent for adoption of post-partum family planning to ensure healthy spacing of pregnancy.
- The unmet need for family planning is high among married and sexually active adolescents. Platforms like SAA session and school could be utilized to inform adolescents about the various misconceptions about family planning contraceptive to improve adoption of FP contraceptive methods.
- The exposure to FP/RH Information was remarkably lower among adolescents and their parents/caregivers. Hence, ARH interventions have a huge scope to improve the exposure to FP

and RH information through various Social and Behavioral Change Communication (SBCC) approaches.

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Annex: FGD Findings with LGBTQI+

Theme	Key questions
	Ice break: Can you introduce yourself by also sharing what you like to do in your free time? Yes, of course (all) **A:** My name is Roman Yadav. Regarding my identity, my citizenship says I'm a man. But I have a feeling of woman; I don't know where it comes from. I love to dance, sing, and make TikTok. I want to do something that makes me famous. In my village, people tease me, and they say I act like a girl. They don't want to be with me or be my friend. I go to the gym and eat nutritious food to prove to people that I'm a handsome man. I like to be handsome and good-looking. If anyone says I'm handsome, it makes me feel very happy. When I visit this office, and they say I look very handsome, it really makes me feel happy. Since my early childhood, I liked to spend time with girls. I like talking with them, gossiping with them. In school, I had friends, and all were girls. Currently, I don't have any partners; I only have girlfriends. I'm very confused and still questioning my identity and sexual orientation. This period of confusion is very stressful for me, and it makes me cry all night. I feel lonely. I do not know who I am. I feel completely normal about myself. I do not know where these feelings come from. Why do other people think that I'm not normal? Why do they tease me? You know, I make TikTok videos to see myself on videos and check who I am? Am I a man? Or something else? I laugh, pretend to be handsome, and do everything to prove to other people that I am a man in the videos I post on TikTok, but later I cry because I don't feel comfortable proving myself, which I am not. Recently I also posted a video with my sister in TikTok where I completely look normal. I do not see anything abnormal in me. Would you like to see my TIKTOK? See here……. **B:** Namaskar my name is Sehnaz. I love to watch TikTok in my free time. I feel helpless in my life. My parents don't support me. I want to do something good that could help me to earn money and support my parents like a son. I want to succeed in my life. I'm a girl, and I have a partner who is a girl. I'm in love with her. I'm lesbian. I have no attraction towards boys. I'm from a Muslim family, and it's even more difficult for me to share about myself with others. **C:** Namaste, I'm RK Raja Paswan. During my leisure time, I like to watch TIKTOK, watch songs on YouTube, and spend time with my wife. I was born as a girl, but I identify myself as a boy. I have no attraction toward man. I'm allergic to man. I am married to a girl. She is my wife. Our marriage is not registered, but we have escaped from our homes and are living together in this city. I do labor work for a living. Life is difficult, but having her (showing his wife) by my side makes me happy. **D:** Namaste. My name is Reshma Paswan. I cook and stay at home during my leisure time. I identify myself as a girl, and I'm his (showing to RK Raja) wife.

	RK Raja Paswan adds I want to do many things in my life. My family is not ready to make citizenship for me. If I had citizenship, I could go abroad and earn money for my family and my wife. But what to do? I make a living by daily wages and labor. We live together in this city; we have a rented room but separately from the family. My parents know that I'm in love with a girl, Reshma, but they ask how a girl can marry a girl. I tell them to see this world whether it happens or not. **E:** Namaste to all. Though my name is Satyanarayana Sah, all know me as Chotu. During my free time, I like to cook food, travel, and enjoy with friends. I am gay. **F:** Namaste My name is Bibek Kumar Thakur. I like to dance and travel to distant places. I am a transgender woman. I have a partner who is a man. He is out of the country now. **G:** Namaste, my name is Sony. I like dancing and like to earn money and support my family. I'm a transgender woman. **H:** Namaste my name is Ariyan Yadav. During my leisure time, I love to spend my time with my girlfriend. I have a girlfriend, and I love to be with her. But my girlfriend's family does not let her be with me, marry me. We are planning to flee together. My family knows about my choice and is ok with it. My girlfriend is 16 years old. I like to be a successful person in my life; I want to work hard. **I:** My name is Sudhir. During my leisure time, I like to play with my phone and watch TikTok. I'm a transgender woman. **J:** Namaskar, my name is Pradip Yadav. I'm a bisexual man. I love to work in favor of my community, even during my leisure time. We have lots of challenges to overcome. Since I started this organization, they have told me that I have become *Hijada.* So, I have no friends.
Community perception	● Have you disclosed your gender identity or sexual orientation to your friends, teachers, or family? What kinds of things might a person who is LGBTQI+ go through when coming out? ● Do you feel comfortable with your appearance? Would you like to do something differently? Why don't you? What would help you do so? ● Do you avoid expressing your gender (or your desired gender) through your physical appearance and clothing for fear of being assaulted, threatened, or harassed? ● What is the perception of the community towards LGBTQI+ adolescents and the community as a whole? ● Have you experienced different behavior from people due to your gender identity or sexual orientation? If yes, what do you think could be done to change people's perception and behavior toward the LGBTQI+ community?

	● In your experience, over the period of time, has the intolerance against LGBTQI+ people increased? Has it been the same or decreased in the community? Is it different for different types of people? Why? F: I was studying in grade eight at that time when first time my parents and teacher knew about my identity. I used to study in a district away from my home, and I had a rented room. There was a boy next to my room who was also studying in my school in grade ten. We started talking with each other, and gradually we fell in love. We decided to move in together, and we started living in one room. In the beginning, as we both were boys, everyone thought are just friends. Gradually, people knew that we were more than friends. One day, of my friends found out about our relationship, and they revealed it to the principal. The principal was so furious with me, and he beat me. He called my parents in the school and scolded me a lot. My parents got mad at me, knowing about my relationship. They said they were very embarrassed to hear about my relationship. They beat me so badly and the principal expelled me from school, saying I was doing a sin having a relationship with a boy. My parents told me that I had embarrassed them, and they would not want me to see them in the home and in the community as I had dishonored them. I was compelled to drop out of school and home when my identity was disclosed. I'm living in a district away from my family. My partner went to the Gulf country after that incident, we both are still in contact, and our relationship is still strong. He sends me money for my survival. Soon he is coming back, and we will marry. C: I have revealed my sexual orientation to my family- my father and mother. I shared with them that I was in love with a girl. My family was very upset and angry with me when I shared my feelings. They asked how can a girl fall in love with a girl and marry. This is unacceptable for them. My girlfriend lives near my maternal uncle's home; I met her when I used to visit my maternal uncle. Our interaction and friendship turned into love very quickly. Later, both our families knew about our relationship, and they separated us. Nobody supported our relationship; all were against us. We were so much in love. Therefore, we decided to elope and go to India. I had a friend, and she was the only person who supported us. She also said if I seek legal support, that could be a good way out. We got married, and I posted our video on Facebook, which went viral on social media. Because of the Facebook post, my girlfriend's family came to know our whereabouts and tried to take her back home from me. They counseled my girlfriend and took her away. Since my childhood, I have been fond of girly clothes like skirts, frocks, and wearing makeup. I used to hide and wear my elder sister's skirt. I used to like to sit with girls in school and play with them. But my teachers used to scold me for sitting with girls. My parents used to beat me for wearing skirts. I would like to be a boy. My parents used to bring skirts for me, but I did not like them. It comes from inside. I told my father that I wanted to live my life with my own terms and conditions. I am in love with a girl. He said they do not talk with me.

	My parents do not believe me. Even if my mother and father accept me but society will not accept me. Society will torture me and my family. **Sehnaz**: I and my partner left home but were caught all time and brought back home. I was given to the police station. Police also tortured me. My family and my mother try to understand me. They think I might take my life if they don't understand me. My girlfriend's family is very cruel; they don't understand us. My girlfriend's sister separated us. We have faced so many troubles. The first time we flew away, we couldn't go that far, and we were caught. My mother was tortured by my girlfriend's family; she was taken to the police and threatened. I feel I'm mismatched in this body; I shouldn't be a girl. But as I am living in a village, I have to dress like a girl, keep long hair, and wear *Salwar Kamij,* but I don't like it at all. **C:** Many people laugh at me, saying that I look like a boy. I have short hair. I wear a tight vest and press my breast with a shawl so that it looks flat and I can look more like a man. I want to take medicine that would reduce the size of my breast. If I make money, I will change my reproductive organs to be a complete man. **E:** I'm working in this organization as a coordinator, but I haven't been able to reveal my identity to my family. Our family doesn't accept if we share about ourselves, which doesn't match their expectations. We will have to leave our homes and family if we reveal our identity. My parents had fixed my marriage with a girl without my consent; I was stressed and sad about this. I felt so helpless and cried. There was none for my help in the family. I couldn't share my feeling with anyone that I have a romantic attraction with boys but not with girls. My father is a teacher, but still, I was not able to share with him. I talked with my supervisor, and I asked for his help to support me. He talked with my father to cancel my marriage. He didn't reveal anything about my identity. Somehow, my father agreed to delay my marriage. Still, my parents and relatives talk about my marriage. They think I will bring dowry if I get married to a girl. Every day go through mental stress. I feel only comfortable and happy within my community. I do not like my relatives and family members anymore. Family acceptance is a must. There are no laws. We face many verbal abuses and mental torture. When we walk through roads, people yell at us, telling us '*chhakka'*, and it makes me feel very disrespected. We want support from people like you, your organizations, and the government. Education is a must for us. Family acceptance is essential, and changing their perspective is important. Family and community awareness should be done to make people know about us, our emotions, and our needs. They should know we deserve respect. Counseling to the family is very important to change people's perspective towards us. A gradual change can be seen in the community now. Comparatively, people know a little bit more about LGBTQI+ but haven't seen a major change in their perspectives. Before, there used to be so much harassment verbally or in expression form. There are so many loopholes in the government structure. For example, there are only men or women categories in the registration sheet of government offices. For

	example, in school, there is either a girl's bench or a boy's bench, but if any LGBTQI reveals their identity at school, then discrimination will start. Bibek: I was restricted from school four years ago. I was born as a boy, but I have feelings for a girl. I used to talk with them and stay with them. I was tortured; that is why I don't talk or stay with boys. Then I talked with the Headteacher, but he said to stay with boys, not with girls, and the next day I was restricted from school. If we reveal to family and parents, come to know, then we are not accepted in the family anymore. Otherwise, we don't have an interest in staying outside of the family at such an early age of 12 or 13 years.
School going Issue	● Have you faced any problems because of your gender identity or sexual orientation to continue schooling, or did you have to leave school due to your identity? If yes, can you talk about some of them? ● During your time in school, have you ever been ridiculed, teased, insulted, or threatened (by peers or teachers) because of your identity? ● Did your school education address at any point LGBTQI+ issues? ● As a person of gender and (or) sexual minority/marginalized group, how do you feel you are supported by your family and teachers? **H:** At school, all laughed at me; once I entered the classroom with my short hair and pants, all laughed at me; teachers also teased me and scolded me. Since then, I don't like to go to school even though my parents insisted me to go to school. I tried to go to school, accumulating all my strength, but at school, everyone used to laugh at me; then, I started lying to my parents, and most of the time, I started spending school time outside the school and returned home when school time was over. I started lying to my parents and told them I was in school.

	B: I dropped out of the school and joined Madarsha. There was all girl students and all women teachers. I fell in love for the first time in Madarsha with my friend. We both were students there. It was my first romantic relationship. We were so much in love. Many girls had to share a room in Madarsha. Some of my friends knew about our relationship, and they reported it to the teacher. I was very badly beaten up and scolded. Our mothers were called; I was very scared. We were dropped out of Madarsha by my teacher. My mother said I was doing wrong, but she was supportive of me. My girlfriend's family arranged her marriage, and she was sent off. Even after her marriage, we were in touch, and our love was still there. She used to send me money and support me. We used to meet secretly and have a good time. But one day, her husband knew about our relationship, and he beat her and threatened me and my family. Since then, we no longer see each other. I still love her, though. C: My family used to send me to school, but I couldn't study because they used to teach in Nepali. I didn't understand Nepali. My partner, Reshma, is also a school dropout. She used to go to school, but she dropped out after we fell in love. Now she stays at home, cooks, and does household chores only. If there is any girl's school where they will accept us, then she is willing to rejoin school. I feel very insecure about sending her to a co-ed school. Education system: there should be principles of equality, freedom, a conducive environment, and acceptability in family, school, or college. Others in the school and community should accept and support us so that we do not drop out of school. Management at school is extremely poor. There is a school management committee for effective management, but not properly functioning. From early grade at school, there should be education on GLBTQI+ in the school curriculum. Teachers should be aware of it. If there is better education, then we will have a more supportive environment. The most important is education to have a job, for a better life for everything. Because most people in our community are not educated, they are involved in high-risk, unsafe, and low-paid work.
Access and utilization to FP/RH services	● If you need health care, where do you usually go to get it? Do the services in the health facility meet your needs? Are the providers sensitive to the needs of LGBTQI+ people? If they don't bring up FP/RH, probe. What about issues is MHM? ● Where do adolescents like you visit for FP/RH services, and why? Can you talk about some of the challenges that you face while seeking FP/RH services (in public and private facilities)? Is there any difference you find when you visit public and private health services? ● Do you feel that the health service providers in the facility have the expertise to address your specific needs? What could have been done to make the services more friendly in those facilities to meet your specific needs?

	● Has the gender of the health service provider been relevant for you to reveal your gender or sexual identity? Have you experienced different care from women or men service providers? **G:** Most of the time, I don't like to visit doctors or health services. It is very embarrassing. They never ask about my gender or if I need any specific support. They just see my appearance and guess my gender and treat me. I have never met a doctor who has talked about my needs. I visit them only when I'm severely sick. I had typhoid when I was in India; at that time, I saw a doctor, but he didn't ask my identity, and I also didn't share; I was uncomfortable thinking he would tease me. **F:** The doctors and health workers don't understand our needs and feelings at all. I had heard one thing there is a medicine that girls use to pause menstruation, and if that medicine is taken regularly, it will help grow breasts. As I wanted to transplant my breast, but I didn't have money, I thought this medicine would be a big help for me. I went to buy that and shared the health worker, but that health worker didn't give me medicine and said it was only for girls and he couldn't sell it to me. **G:** We feel comfortable with female health workers rather than male health workers though both of them don't understand our needs and emotions. The male health workers harass and abuse us if they know about our identity or orientation. Once, as I shared with you before, I attempted suicide because I couldn't tolerate the suffering and hates. I was rescued by my friends, and they took me to the health facility. The health worker treated me, and I was recovering. One day, staff from the health office attempted rape; he tried to drag me to the toilet. Somehow that day, I was saved. One of my friends shared with me that a doctor had raped her (a trans woman) when she was admitted to the hospital for surgery. I don't have friends, to be honest; there are few in this office, that's it. I have multiple partners (clients), and this is how (sex work) I make my living. I only have heard about condoms, but my partners say that our sex will not produce babies; therefore, we don't need to use them. If I try to use a condom, my partners start arguing with me, and sometimes we fight, also. I don't know anything about safe sex or protection. We don't use anything to protect. I use PrEP (pre-exposure prophylaxis) to prevent HIV. We get it from this office. They say we are at high risk of HIV due to multiple partners and involvement in sex work. **C and H:** We have our partners, and we are engaged in sexual relationships, too but never heard about safe sex or using any contraception. I don't know, even if it requires. We only heard about the condom, but that's not for us. Menstruation is the major thing that brings the whole emotional struggle to us. Every month when I start menstruating, it brings emotional turmoil within me. I want to take any medicine or do surgery so that I can stop it and I can be free. I do take the medicine that pauses menstruation.

Contraception use	● Do you have friends? Who are they? Do you have a boyfriend/girlfriend/other intimate partners? Do you know about contraception? What methods are available? Then what is your preferred method? ● What is your FP/RH need? What is the most preferred method of contraception? ● Who/what are the sources of information for you to know about the suitable methods of contraception to meet your needs? We don't know about Family planning. We know we can't bear a child. But we want to experience parenthood.
Social Norms and Stigma	Can you talk about some of the harmful social norms/stigma related to FP/RH for other adolescents like you? How do this stigma and these social norms affect you accessing FP/RH services? **Perceived Stigma** Have you experienced people saying that LGBTQI+ people are not normal? Did you ever pretend that you are straight to be accepted in family, school, and in society? Has any incident made you feel that your family was hurt and embarrassed because you are from the LGBTQI+ community? **Enacted Stigma** Have you been hit or beaten up for being a person from the LGBTQI+ community? Have you lost a place to live for being identified as LGBTQI+? Did any offensive or threatening incidents (including sexually assaulted) happen to you for being LGBTQI+? Did you ever lose your friends because you are LGBTQI+? Have you heard or seen anyone in your community supporting, protecting, or promoting the rights of LGBTQI+? All things considered, how satisfied would you say you are with your life these days? Would you say you're a happy person? If not, how much of the time do you think you are not happy? If someone was available that you trusted would you like to talk confidentially about some of your issues? Would you want to join a group with people like themselves or mixed? Are you on social media? Do you play games? What type? In the family, I was beaten up by my elder brother when I revealed I'm a trans girl. He even left the family and went to stay with his in-laws after I opened up about my identity. He hates me. One day, he beat me and hung me over the ceiling fan. He said I shouldn't be alive disgracing the family in society. We have no support from anybody. We have support from this office and a few organizations like yours. We have no nay support from the local level. During any emergency relief distributions from the local government, they say we don't fit in

	any category; therefore, we don't deserve any support. During covid, we had a miserable life. Many of our friends attempted suicide. Just because we are from an LGBTQI+ group and there were pouring hate and discrimination, many had to leave their rented home because they were not able to pay the rent. We don't have anyone who could listen to us, who can hear our story and struggle and console us. I'm from a Muslim family, and there are very strict rules for girls and women. I do pretend to be any other girl in front of my family and relatives. Our happiness is bound within the four walls of this office. We laugh, giggle, and open our hearts out only in this space and among people here. This community is our strength. When we step out of this space, our suffering starts. I cry and scream at God; why didn't he make me this way? Why does nobody understand us? Why is this world so complicated? Why so much hate? Our heart is full of sadness, loneliness, and tears; I doubt we will have a longer life. Please come to meet us soon; otherwise, you never know whether you will be able to see us or not. We would be happy to be part of a group in our own community. We would not be comfortable mixing with others. We want to learn about our rights, our health, how we can be safe, and learn what we can do so that our family, teachers, and society will accept us. It will be difficult to find adolescents from our community in villages as most of us have to leave our homes when we reveal our identity. You will find more adolescents at the district level through organizations like this organization.

Annex: Questionnaire

BASELINE STUDY FOR USAID ADOLESCENT REPRODUCTIVE HEALTH (ARH) PROGRAM

HH ID:

For HH head/parents/guardian of the adolescent

Section I. Identification table

SN	Questions	Response	Code
101	Name of Province	Karnali..... Lumbini..... Madhesh.....	1 2 3
102	Name of District	Salyan..... Surkhet..... Banke..... Rolpa..... Pyuthan..... Bara..... Dhanusha..... Mahottari..... Parsa..... Rautahat..... Sarlahi.....	1 2 3 4 5 6 7 8 9 10 11
103	Name of Municipality	.....	
104	Ward no.	.....	
106	Tole	Market Area (Bazar kshetra)..... Country side (Gramin kshetra).....	1 2
107	What is your Caste/Ethnicity?	Hill Brahman..... Hill Chhetri..... Madhesi Brahman/Chhetri..... Madhesi other backward class..... Hill Dalit ..... Madhesi Dalit ..... Newar ..... Hill/Mountain Janjati ..... Terai Janjati ..... Muslim..... Others (Specify).....	1 2 3 4 5 6 7 8 9 10 96

108	What is your religion?	Hindu..... Buddhist..... Christian..... Muslim..... Others (Specify).....	1 2 3 4 96
109	What is the main source of family income?	Agriculture…… Government service…….. Private service…… Business…….. Daily wage labor…… Migrant worker …… Others (specify)……..	1 2 3 4 5 6 96
109.1	What is the type of your family?	Nuclear …….. Joint …… Extended ……	1 2 3

110. Household Roster:

SN./Code	Name	Relationship with the household head	Age	Eligibility (aged 10-19) 1 Yes 2 No	If eligible, present at the household during the interview 1 Yes 2 No	Sex	Education (highest completed degree) (4 years and above)	Marital status (10 years and above)	Disability status	Mobile Number if the HH member has own mobile

***Options**

Relationship*: Self=1, Husband/Wife = 2, Grandfather/grandmother=3, Father=4, Mother=5, Brother=6, Sister=7, Daughter=8, Son=9, Daughter in law = 10, Grandson/Granddaughter = 11, others=96*

***Disability status**: 0= No disability, 1= vision Impairment, 2= deaf or hard of hearing, 3=retarded mental health conditions, 4=intellectual disability, 5=acquired brain injury, 6=autism spectrum disorder, 7=physical disability, 8= difficulty in speaking (multiple response possible)*
***Sex**: Male=1, Female=2*
***Marital status**: Unmarried=1, Currently married=2, Divorced/separated=3, Widowed=4, Other (specify) = 96*
***Education status:** Uneducated=1, Informal education=2, Basic level education(1-8) = 3, Secondary level=4, Bachelor=5, Masters and above=6*

111. Household possessions:

SN.	Amenities	Yes	No
1	Radio	1	2
2	Television	1	2
3	Landline phone	1	2
4	Internet	1	2
5	Computer	1	2
6	Cycle	1	2
7	Motorbike	1	2
8	Tractor/trailer	1	2
9	Car/bus	1	2

112. Source of HH Income:

S.N	Source of income	Average annual Income in NPR
1	Skilled wage labor	
2	Unskilled wage labor	
3	On farm enterprise Agriculture and livestock rearing	
4	Micro enterprise	
5	Off-farm enterprise	
6	Government service	
7	Non-government service/Private sector service	
8	Remittance	
9	Others (Please specify)	
	Total	

113. Land holding status of HHs:

S.N.	Questions and Filters	Coding Categories	Code	Skip
1	Do your family hold registered land?	Yes…… No……	1 2 ▼	 114
2	If yes, gender of HH member holding registered land	Female …… Male …… Both……	1 2 3	

		Others (specify)……	96	
3	If yes, registered land area in Kattha?	Bigaha/Kattha/Dhur …….. Ropani/Aana/Paisa ……		
4	How many month you have food (rice, wheat, maize, millet or barley) sufficiency form your own production?	0-3 months …….. 4-6 months …….. 7-9 months ……. 10-12 months……	1 2 3 4	

114. Resources and infrastructure

SN	Questions and Filters	Coding Categories		Code	Skip
0	Do you own the house you are living on now?	Yes …… No, living in rent …….. No, staying with a relative ….		1 2 3	
1	Roof of the household	Thatch roof house…… Stone roof house…… Tin roof house…… RCC roof house……		1 2 3 4	
2	Do you have electricity in your household?	Yes…….. No……		1 2	
3	Do you have solar system in your household?	Yes…… No……		1 2	
4	Do you have a toilet in your HHs?	Yes…… No……		1 2	
5	What is the major source of drinking water in your household?	Water tap …….. Natural spring water …… River …… Natural well …… Rain water collection …….. Hand pump …….. Others (specify) ……..		1 2 3 4 5 6 96	
6	What is the major cooking fuel in your household?	Kerosene…… Firewood……..….. Biogas…… Cow Dung…… Coal…… LPG Gas…… Electricity……..		1 2 3 4 5 6 7	
7	Do you have the following domestic animals in your house?	Yes	No		
7.1	Cow	1	2		
7.2	Buffalo	1	2		
7.3	Ox	1	2		
7.4	Pig	1	2		
7.5	Hen/Swan	1	2		
7.6	Goat/Sheep	1	2		
7.7	Fish pond	1	2		

Questionnaire for Adolescent (10-19 years)

Roster Code number of the selected adolescent: ☐☐

Section II: Socio-demographic information

SN	Question	Response	Code	Skip
201	What is your age?	……(in completed years)		
202	What is your sex?	Male…… Female…… Others (Specify)……	1 2 3	
203	What is the occupation of your mother/mother-in-law?	Homemaker…… Agriculture…… Government service…… Private service…… Business…… Teacher…… Migrant worker…… Daily wage labor…… Death of mother/mother-in-law… Others (specify)……	1 2 3 4 5 6 7 8 9 96	
204	What is the occupation of your father/father-in-law?	Homemaker…… Agriculture…… Government service…… Private service…… Business…… Teacher…… Migrant worker…… Daily wage labor…… Death of father/father-in-law … Others (specify)……	1 2 3 4 5 6 7 8 9 96	
204.1	What is the occupation of a guardian of there are no parents?	Homemaker…… Agriculture…… Government service…… Private service…… Business…… Teacher…… Migrant worker…… Others (specify)……	1 2 3 4 5 6 7 96	
205	How many living brothers/sisters do you have?	Number of brothers ☐☐ ☐☐		

	(if unmarried, ask from the birth house, and if married, ask about brother/brother-in-law, sister/sister-in-law)	Number of sisters		
206	**Questions to identify disability conditions**			
1.	Do you wear glass or contact lenses to see well?	Yes …… No ……	1 2	3
2.	Do you have difficulty seeing at all after wearing glasses or contact lenses, is it somewhat difficult, very difficult, or can't you see at all?	No difficulty at all …… Somewhat difficult …… Very difficult …… Can't see anything …… Don't know ……	1 2 3 4 98	4
3.	Do you have difficulty seeing at all, somewhat difficult, very difficult, or can't you see at all?	No difficulty at all …… Somewhat difficult …… Very difficult …… Can't see anything …… Don't know ……	1 2 3 4 98	
4.	Do you use a hearing aid?	Yes …… No ……	1 2	6
5.	Do you have difficulty hearing at all, some difficulty, a lot of difficulty, or not hearing at all after wearing a hearing aid?	No difficulty at all …… Somewhat difficult …… Very difficult …… Can't hear anything …… Don't know ……	1 2 3 4 98	7
6.	(In your opinion) Does the respondent find it difficult to hear at all, somewhat difficult, very difficult, or not at all? *(From the observation of interviewer)*	No difficulty at all …… Somewhat difficult …… Very difficult …… Can't hear anything …… Don't know ……	1 2 3 4 98	
7.	(In your opinion) Is it difficult for the respondent to understand or understand when communicating with others, is it difficult, very difficult, or can't communicate at all? *(From the observation of interviewer)*	No difficulty at all …… Somewhat difficult …… Very difficult …… Can't communicate at all …. Don't know ……	1 2 3 4 98	
8.	Do you find it difficult to remember or pay attention at	No difficulty at all …… Somewhat difficult ……	1 2	

	all, do you find it difficult, very difficult, or can't you pay attention at all?	Very difficult …….. Can't remember or pay attention at all …….. Don't know ……..	3 4 98	
9.	Do you have no difficulty walking or climbing stairs at all, is it somewhat difficult, very difficult, or can't you walk or climb stairs at all?	No difficulty at all …….. Somewhat difficult …….. Very difficult …….. Can't walk or climb stairs at all .. Don't know ……..	1 2 3 4 98	
10.	Do you find it difficult at all to shower or change your clothes, is it somewhat difficult, very difficult, or can you not shower or change your clothes at all?	No difficulty at all …….. Somewhat difficult …….. Very difficult …….. Can't shower or change clothes at all …….. Don't know ……..	1 2 3 4 98	

Section III: Education Status

S. N	Questions	Responses	Code	Skip
301	Have you ever attended school/formal education?	Yes..... No.....	1 2	304
302	Have you ever attended any informal education?	Yes No	1 2	304
303	Why have you never attended school (formal and informal)? *(Multiple response possible)*	Due to marriage..... Due to pregnancy/child birth..... Financial crisis in family..... School is far from home..... Have to take care of children/siblings at home..... ..... Engaged with household chores..... School does not have separate toilet for boys and girls..... School environment was not disable friendly..... Unsafe school environment (bullying, harassment)..... Unsafe to travel to school..... Not interested to go to school..... Parents asked not to go..... Other (specify).....	1 2 3 4 5 6 7 8 9 10 11 12 96	316

304	If yes, what type of school have you attended?	Private…… Public…… Community …….. Other formal school (Madarsa)……. Vocational training centers…… Informal education…… Others (specify) ……	1 2 3 4 5 6 96	
305	What is the highest grade you have completed?	……..		
306	Are you currently going to school?	Yes..... No.....	1 2	312
307	If no, what was your age when you discontinued going to school?	Age…….. (in years)		
308	If no, what was your grade when you discontinued going to school?	Grade……		
309	Why did you stop going to school? *(Multiple response possible)*	Due to marriage..... Due to pregnancy/child birth …… Financial crisis in family..... School is far from home..... Have to take care of children/siblings at home..... Engage in HH chores……. School did not have separate toilet for girls…… School did not provide sanitary pads.. School did not have facility to dispose sanitary pads…… School environment was not disable friendly..... Unsafe school environment..... Unsafe to travel to school..... Not interested to go to school..... Parents asked not to go..... Other (specify).....	1 2 3 4 5 6 7 8 9 10 11 12 13 14 96	
310	Do you want to re-join the formal education?	Yes..... No.....	1 2	314

311	If no, why don't you want to re-join the formal education? *(Multiple response possible)*	Due to marriage..... Due to pregnancy/child birth..... Financial crisis in family..... School is far from home..... Have to take care of children/siblings at home..... Engaged with household chores..... School does not have separate toilet for boys and girls..... School environment was not disable friendly..... Unsafe school environment (bullying, harassment)..... Unsafe to travel to school..... Not interested to go to school..... Parents asked not to go..... Other (specify).....	1 2 3 4 5 6 7 8 9 10 11 12 96	All 316
312	If yes, do you need any support to continue the formal education?	Yes..... No.....	1 2	316
313	If yes, please specify the type of support needed?	Financial support..... Family support..... Others (Specify).....	1 2 96	
314	How long does it take for you to go to school? ***Note: (only for those who are currently going to school)***	By foot/walking..... (in minutes) By vehicle..... (in minutes)		
315	What was the most difficult part of school for you? Note: *(only for those who are currently going to school)*	School homework..... Travelling to school..... Teacher's behavior..... Unavailability of separate toilet for boys and girls..... Unavailability of sanitary pad..... Unavailability of sanitary pad disposal facility..... Bullying/harassment..... No any problem ..... Others.....	1 2 3 4 5 6 7 96	Section IV
316	Do you want to join any vocational trainings?	Yes.....	1 2	Section IV

		No.....		
317	What is your preferred vocational training that you want to join? *(Multiple response possible)*	Tailoring/Embroidery..... Electrician..... Driving..... Livestock farming..... Carpentry..... Plumbing..... Beautician/beauty parlor..... Art and craft..... Mobile repairing..... Others (Specify).....	1 2 3 4 5 6 7 8 9 96	

Section IV: Marriage, Pregnancy and Delivery status

S. N	Questions	Responses	Code	Skip
401	What is your current marital status?	Unmarried…….. Currently married……. Divorced/Separated……. Widowed…….. Other (specify)……..	1 2 3 4 96	406
402	What was your age during your first marriage?	……. (in years)		
403	Have you/your spouse performed 'Gauna'?	Yes…….. No…….. Not applicable……	1 2 3	407
404	What was your age at the time of your 'Gauna'?	…….. (in years)		
405	What was the age of your husband/wife at the time of Gauna?	…….. (in years)		407
406	If unmarried, are you currently in a relationship like girlfriend/boyfriend, partner?	Yes…….. No…….. No response/don't want to answer……..	1 2 3	
Instruction to the Interviewer: *I would like to ask some questions about sexual activity in order to gain a better understanding of some important life issues. Let me assure you again that your answers are completely confidential and will not be told to anyone. If we should come to any question that you don't want to answer, just let me know and we will go to the next question.*				
407	Have you ever engaged in any sexual activity (sex)?	Yes…….. No…….. No response/don't want to answer……..	1 2 3	Section V
408	Who is this person with whom you had sexual activity (sex) for the first time?	Husband/wife…… Girlfriend/boyfriend…… Partner (not formally married).. Others (specify)……	1 2 3 96	
409	How old were you when you had sexual intercourse for the very first time?	……		
410	Have you/your wife/partner ever been pregnant?	Yes…….. No……..	1 2	Section V

411	If yes, what was your or your wife's/partner's age when you/your wife had your first pregnancy?	…….		
412	How many times have you/ your wife/partner been pregnant?	Number……		
413	Are you/your wife/partner currently pregnant?	Yes…… No……	1 2	
414	Have you/your wife ever given birth to a child?	Yes…… No……	1 2	417
415	How many children (live birth) have you/your wife given birth to?	……		
416	Where did you give birth to your last child?	**Home** Her home …….. Other home …… **Public Sector** Govt. Hospital/Clinic……. PHC center…….. …… Health Post…….. PHC Outreach clinic…… Other Public Facilities (Specify)…… **Non-Govt. (NGO)** FPAN…….. Other NGO Facilities (specify)…… **Private Medical Sector** Pvt. Hospital/ Nursing home…….. Private clinic…….. Other Private Medical Facilities…….. Other (Specify)……	 1 2 3 4 5 6 7 8 9 10 11 12 96	

Note: Ask for each pregnancy

417	**Order of Pregnancy**	**Pregnancy outcome**	**Have/had done ANC check-up?**	**Number of ANC check up**	**Was this an intended pregnancy?**	**Date of pregnancy outcome**	**Where did your (Pregnancy Outcome) occur?**

	Currently Pregnant	-	Yes...1 No...2		Yes, wanted at the time (planned pregnancy) ……1 At a later time (mistimed pregnancy) ……2 Not at all (unwanted)…….3	-	-
	Second last pregnancy	Miscarriage..1 Abortion...2 Still birth..3 Live birth..4	Yes...1 No...2		Yes, wanted at the time (planned pregnancy) ……1 At a later time (mistimed pregnancy) ……..2 Not at all (unwanted)…….3	Year…….. Month….. Can't remember..	Option of 416
	Third last pregnancy	Miscarriage/abortio1 Still birth Live birth	Yes..1 No...2		Yes, wanted at the time (planned pregnancy) ……1 At a later time (mistimed pregnancy) ……..2 Not at all (unwanted)…….3	Year…….. Month….. Can't remember..	Option of 416
	Fourth last pregnancy	Miscarriage/abortion Still birth Live birth	Yes..1 No...2		Yes, wanted at the time (planned pregnancy) ……1 At a later time (mistimed pregnancy) ……2	Year…….. Month….. Can't remember..	Option of 416

					Not at all (unwanted)..... 3		
	Fifth last pregnanc y	Miscarriage/abor tion Still birth Live birth	Yes..1 No...2		Yes, wanted at the time (planned pregnancy) ……1 At a later time (mistimed pregnancy) .....2 Not at all (unwanted)..... 3	Year…….. Month….. Can't remembe r..	Option of 416

418	Would you like to have (a/another) child?	Yes..... No.....	1 2	420
419	When are you planning to have next child?	Currently pregnant..... Within 1 year..... Soon (within 2 years)..... Want child after two years..... Not decided yet.....	1 2 3 4 5	
	Post-partum FP *(For those who have given birth to at least one child)*			
420	Did you receive post-partum FP counselling during ANC of most recent birth?	Yes..... No..... Never been to ANC visit…. Not applicable …….	1 2 3 4	
421	Did you receive /adopt any family planning method/device immediately after your last delivery	Yes..... No..... Last delivery at home…	1 2 3	Section V

	prior to the discharge from the health facility?			
422	If yes, which method/device did you adopt?	IUCD/Copper-T..... Implant..... LAM..... Other (specify).....	1 2 3 96	
423	**If home delivery,** Did you receive family planning method/counselling immediately after your last delivery? (If HW, FCHV is present during home delivery)	Yes……. No……..	1 2	

Section V. Knowledge and utilization of reproductive health and family planning services

SN	Question	Response	Code	Skip
501	What is the legal age for marriage for both boys and girls?	……..for boys ……..for girls Don't know ……	 98	
502	What do you think is the appropriate age for first pregnancy?	…….. Years Don't know ……	 98	
503	After birth of a child, how long should you have to wait to get pregnant again?	…….. Months Don't know ……	98	
504	Do you know about the menstrual cycle of a women?	Yes..... No.....	1 2	506
505	What is the normal range of days for the menstrual cycle?	…… days		
506	From one menstrual period to the next, are there certain days when a woman is more likely to become Pregnant?	Yes…… No…… Don't know……..	1 2 3	508

507	Is this time just before her period begins, during her period, right after her period has ended, or halfway between two periods?	Just before her menstrual period begins. During her menstrual period…… Right after her menstrual period has ended …… Halfway between two menstrual periods... No specific time…….. Don't know……	1 2 3 4 5 98	
508	Does your school provide sanitary pad to girls during their menstruation?	Yes..... No..... Don't know ……	1 2 98	
509	Does your school have separate toilet for girl and boy?	Yes..... No..... Don't know	1 2 98	
510	Does your school have a resting room where menstruating girls can rest if needed?	Yes..... No..... Don't know	1 2 98	
511	Do you have a RH focal teacher at the school with whom you can share about your reproductive health?	Yes..... No..... Don't know …….	1 2 98	513
512	If yes, what is the gender of the teacher?	Male…… Female…….. Others (Specify).....	1 2 96	
513	After the birth of a child, can a woman become pregnant before her menstrual period has returned?	Yes…… No…… Don't know……	1 2 98	
514	What sanitary methods can be used during menstruation? *(Multiple response possible)*	Cotton clothes..... Sanitary Pad..... Menstrual cup..... Tampon..... I don't know..... Others (Specify).....	1 2 3 4 5 96	

515	Have you ever heard about family planning methods?	Yes…….. No……..	1 2	527

516	What are the family planning methods that you have heard about?	Yes, spontaneous	Yes, after probing	No	Don't know	Knowledge on use of each methods		
						Correct	Incorrect Don't know	
	Male Condom (PROBE: Men can put a rubber sheath on their penis before sexual intercourse.)	1	2	3	98	1	2	
	Female Condom (PROBE: Female can put a rubber sheath inside their vagina before sexual intercourse.)	1	2	3	98	1	2	
	Pill (PROBE: Women can take a pill every day to avoid becoming pregnant)	1	2	3	98	1	2	
	Injectable (DEPO) (PROBE: Women can have an injection by a health provider that stops them from becoming pregnant for one or more months.)	1	2	3	98	1	2	
	IUCD/Copper-T (PROBE: Women can have a loop or coil placed inside them by a doctor or a nurse which can prevent pregnancy for one or more years.)	1	2	3	98	1	2	
	Implants (PROBE: Women can have one or more small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for three to five years.)	1	2	3	98	1	2	
	Emergency contraception (PROBE: As an emergency measure, within five days after they have unprotected sexual intercourse, women can take special pills to prevent pregnancy (like I-Pill, E-CON)	1	2	3	98	1	2	
	Female sterilization	1	2	3	98	1	2	

	(PROBE: Women can have an operation to avoid having any more children.) Male sterilization (PROBE: Men can have an operation to avoid having any more children.) Lactational amenorrhea method (PROBE: Up to six months after childbirth, before the menstrual period has returned, women use a method requiring frequent breastfeeding day and night.) Calendar method (PROBE: To avoid pregnancy, women do not have sexual intercourse on the days of the month they think they can get pregnant.) Withdrawal (PROBE: Men can be careful and pull out before climax) Others (specify)……	1 1 1 1	2 2 2 2	3 3 3 3	98 98 98 98	1 1 1 1	2 2 2 2	
517	Do you know the places and persons one can go if s/he has to access any family planning methods or has to access service for any reproductive or sexual health problem?	Yes..... No.....				1 2		519
518	What are those place and persons? (Multiple Response)	**Public sector** Government hospital..... Primary health care center..... Health post…… PHC/ORC..... Mobile camp..... FCHV..... Volunteers/Field Mobilizers/Facilitators…… Satellite clinic..... Other public facilities (specify)…… **Non-govt. (NGO) sector** FPAN..... Marie stopes..... Other NGO facilities (specify)…….. **Private medical sector** Private hospital/nursing home…….. Private clinic.....				1 2 3 4 5 6 7 8 9 10 11 12 13 14		

		Pharmacy..... Pharmacy/Clinic with Sangini outlet..... Other private medical facilities..... **Other source(specify)** Shop..... Friend/relative..... Other (specify).....	15 16 17 18 19 96	

519	Have you ever used family planning methods?	Yes..... No.....	1 2	526
520	Which family planning methods have you used? ***(Multiple response possible)***	Male Condom..... Female Condom..... Pill..... IUCD/Copper-T..... Injectable..... Implants..... Emergency contraception..... Female sterilization..... Male sterilization..... Lactational amenorrhea method..... Calendar method ..... Rhythm method..... Withdrawal..... Others (specify).....	1 2 3 4 5 6 7 8 9 10 11 12 13 96	
521	Are you or your partner currently doing something or using any family planning methods to delay or avoid getting pregnant?	Yes..... No.....	1 2	526
522	If yes, which family planning method are you currently using?	Male Condom..... Female Condom..... Pill..... IUCD/Copper-T..... Injectable..... Implants..... Emergency contraception. ..... Female sterilization..... Male sterilization..... Lactational amenorrhea method..... Calendar method ..... Rhythm method..... Withdrawal.....	1 2 3 4 5 6 7 8 9 10 11 12 13	

		Others (specify).....	96	
523	Would you say that using contraception is mainly your decision, mainly your (husband's/partner's) decision, or did you both decide together?	Mainly respondent..... Mainly husband/partner..... Joint decision..... Somebody else made the decision..... Others (specify).....	1 2 3 4 5	
524	From where/whom do you get/receive your FP device/method? *(Multiple response possible)*	**Public sector** Government hospital/clinic..... Primary health care center..... Health post..... PHC out-reach clinic..... Mobile camp..... FCHV..... Volunteers/Field Mobilizers/Facilitator.. Satellite clinic..... Other public facilities (specify)..... **Non-govt. (NGO) sector** FPAN..... Marie stopes..... Other NGO facilities (specify)..... **Private medical sector** Private hospital/nursing home..... Private clinic..... Pharmacy..... Sangini outlet..... Other private medical facilities..... **Other source(specify)** Shop..... Friend/relative..... Other (specify).....	 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 96	

525	Which is your preferred place/person for receiving FP service?	**Public sector** Government hospital/clinic..... Primary health care center..... Health post. . . . . . PHC/ORC..... Mobile camp..... FCHV..... Volunteers/Field Mobilizers/Facilitators Satellite clinic.....	1 2 3 4 5 6 7 8	527

		Other public facilities (specify).....		
		Non-govt. (NGO) sector		
		FPAN.....	9	
		Marie stopes.....	10	
		Other NGO facilities (specify).....	11	
		Private medical sector		
		Private hospital/nursing Home …		
		Private clinic.....	12	
		Pharmacy.....	13	
		Sangini outlet.....	14	
		Other private medical facilities.....	15	
			16	
		Other source(specify)		
		Shop.....	17	
		Friend/relative.....	18	
		Other (specify).....	19	
526	Can you tell me why you have not used or are not using any FP method to prevent pregnancy? *(Multiple response possible)*	Not married	1	
		Never engaged in any sexual activity..	2	
		Fertility-related reasons		
		Not having sex		
		Infrequent sex	3	
		Husband away	4	
		Currently Pregnant.....	5	
		Menopausal/hysterectomy	6	
		Can't get pregnant	7	
		Not menstruated since last birth	8	
		.	9	
		Breastfeeding	10	
		Up to god/fatalistic	11	
		Opposition to use		
		Respondent opposed	12	
		Husband/partner opposed	13	
		Others opposed	14	
		Religious prohibition	15	
		Lack of knowledge		
		Knows no method	16	
		Knows no source	17	
		Method-related reasons		
		Side effects/health concerns	18	

		Lack of access/too far . . . . . . Costs too much . . . . . . Preferred method not available . . . . . . No method available . . . . . . Inconvenient to use . . . . . . Interferes with body's normal processes. . Other (Specify)……. Don't know	19 20 21 22 23 24 96 98	
	Adolescent-friendly services (AFS)			
527	In your opinion, what types of services provided by the health facilities will be suitable/ appropriate/or feel comfortable for adolescent girls and boys like you?	Feasible opening hours (before and after the school opening hour or at the evening/morning)…… Disability friendly physical structure of health institutions ……..	1 2 3	

		Physically accessible in terms of distance (within 30 minutes) …… Welcoming and comfortable environment (HF provider greeting well, not judgement about them) …… Positive attitude and friendly behavior of provider during the service delivery/counseling session …….. Maintenance of privacy (separate counseling and examination room)**……** Maintenance of confidentiality (HF provider keeping all the client's identification confidential, trustworthy) **…** Availability of family planning methods. Gender-friendly provider**……** Clear display of logo/information about the availability of AFS**……** Presence of IEC materials related to adolescent RH and sexual health (changes in puberty/developmental changes)**…..** Others (specify) …….. Don't know ……	4 5 6 7 8 9 10 11 96 98	
528	Are you aware about the places/person where adolescent friendly services are available?	Yes..... No.....	1 2	532
529	If yes, what are the places/person? *(Multiple response possible)*	**Public sector** Government hospital/clinic..... Primary health care center..... Health post…… Urban Health Clinic ……. Community Health Center …… PHC/ORC..... FCHV.....	1 2 3 4 5 6 7 8	

		Other public facilities (specify)..... **Private medical sector** Private hospital/nursing Home…. Private clinic..... Pharmacy..... Other private medical facilities..... Others (Specify) ……	 9 10 11 12 96	
530	Have you ever sought adolescent friendly services?	Yes…….. No……..	1 2	532
531	If yes, what types of services did you seek? *(Multiple response possible)*	 Contraceptive use/safer sex counseling… Received contraceptive device…… Received emergency contraception... Received abortion service…….. RH problems (menstrual health problems……..) VCT for HIV……. Other specify……..	1 2 3 4 5 6 96	
	General health service utilization			
532	Where/ and whom did you prefer to go to seek health services if you feel sick? *(Multiple response possible)*	**Public sector** Government hospital/clinic..... Primary health care center..... Health post . . . . . . PHC/ORC..... Other public facilities (specify)..... **Private medical sector** Private hospital/nursing Home…. Private clinic..... Pharmacy..... Other private medical facilities..... **Others** FCHV..... Selfcare…….. Traditional healers..... Peer/educator/facilitators ……	 1 2 3 4 5 6 7 8 9 10 11 12 13	

533	How much time does it take to reach your preferred health facility?	By walking ……..(in minutes) By vehicle ……(in minutes)		

Section VI. Exposure to Family Planning/RH Information:

SN	Question	Response	Code	Skip
601	Have you ever heard/read of family planning/RH messages in the last 6 months?	Yes..... No.....	1 2	**Section VII**
602	If yes, what do you recall hearing or seeing a specific family planning/reproductive health message? *(Multiple response)*	Use of FP methods..... ANC/PNC check-up..... Menstrual hygiene..... Birth spacing..... FP service delivery point..... Adolescent friendly service centers. Have not remembered any …….. Others (specify)……..	1 2 3 4 5 6 7 96	
603	What are the sources from where you get the information of family planning and reproductive health related services? *(Multiple response)*	Radio..... Television..... Newspaper or magazine..... Textbook/curriculum book……. Social media (Facebook, Instagram, Tik Tok, YouTube etc.)..... ARH Booklet..... Brochure or flipchart, Poster, hoarding board..... Video game/Mobile apps..... Street drama..... Mother's group/teachers..... Family members..... Peers..... Online platforms..... FCHVs..... Health service providers..... Health related seminars/campaigns……. Other community level events..... Peer/educator/facilitators …… Others (specify).....	 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 96	

Section VII: Involvement in Community Group

SN	Question	Response		Code	Skip
701	Are you involved in following activities as a leader or member? ***(Probe: each statement)***	Yes	No		
	Children or youth club……	1	2		
	Social or cultural organization club or association……	1	2		
	Savings group/Microfinance organization.....	1	2		
	Sports club……	1	2		
	School management committee……..	1	2		
	Health mothers group ……..	1	2		
	Others (Specify).....	1	2		
702	Do you know the FCHV working in this community?	Yes…….		1	
		No……		2	
703	Have you ever heard of Health Mother's Group meeting?	Yes.....		1	
		No.....		2	707
704	If yes, have you ever attended Health Mother's Group meeting conducted by FCHVs? *(only for female)*	Yes.....		1	
		No.....		2	707
705	What are the topics discussed in the Health Mother's Group meeting? *(Multiple response possible)*	Received information of child feeding……		1	
		Received information on food/cooking……		2	
		Received information on gardening……		3	
		Received information on poultry……		4	
		Received information on water filtration ……		5	
		Received information on reproductive health ……		6	
		Received information on women's health care……		7	
		Watch demonstration on cooking……		8	
		Discuss about nutrition…..		9	

		Discuss about gender issues….. Discuss about handwashing... Discuss about toilet……. Discuss about family planning……. Discuss about diarrhea…… Others (Specify)……	10 11 12 13 14 96	
706	How many times have you attended the Health Mother's Group meeting in last 6 months?	……		
707	Does the FCHV mention the referral sites for the reproductive health and family planning needs/problems?	Yes..... No..... Don't know……	1 2 98	Section VIII
708	What referral sites are mentioned by the FCHVs? *(Multiple response possible)*	**Public sector** Government hospital..... Primary health care center..... Health post ……. Urban health clinic …… Community health center ……. Institutionalized family planning Clinics…….. Mobile camp..... Other public facilities (specify)... **Non-govt. (NGO) sector** Marie stopes..... Other NGO facilities (specify)…… **Private medical sector** Private hospital/nursing home …. Private clinic..... Other private medical facilities (specify)…….. Other (specify)…… Don't know.....	1 2 3 4 5 6 7 8 9 10 11 12 13 96 98	

	(Do not read aloud) Note to the interviewer: What is the disability status of respondents?	 Yes..... No.....	 1 2	
709	*Note: For disable only and those who have attended HMG's meeting.* Do other participants support you or treat you well during that meeting?	 Yes..... No.....	 1 2	
710	Do you feel comfortable attending those meetings?	Yes..... No.....	1 2	Section VIII
711	If not, what are the reason for feeling uncomfortable to attend those meetings? ***(multiple response possible)***	Seating place was not disable friendly…….. Conversation was not disable friendly…… The members of HMG were not welcoming……. Other (specify)……	1 2 3 96	

Section VIII: Menstrual Hygiene Practices (Only for girls)

SN	Question	Response	Code	Skip
801	Have you experienced menstruation?	Yes..... No.....	1 2	901
802	How old were you when you had your first menstruation?	…….. (Age in complete years)		
802.1	What is your period cycle?	26-32 days …….. Earlier than 26 days …….. Later than 32 days …… Irregular ……..	1 2 3 4	
802.2	Do you think your period cycle is normal?	Yes …….. No …….. Don't know ……..	1 2 98	803
802.3	If no, have you tried anything to fix it?	No …….. Yes, I have consult with the doctor …… Yes, I have talk about it with my family.. Yes, I have talk about it with my friends.. I have searched in internet about it ……	1 2 3 4 5	

803	How do you track your menstrual cycle?	Calendar method…… Cycle beads methods…… Mobile apps…….. I don't track……. Others (specify)……	1 2 3 4 96	
804	What do you generally use as absorbent during the menstruation?	Cotton clothes..... Sanitary Pad..... Cotton cloth and sanitary pad both ……. Menstruation Cup..... Tampon..... Others (Specify).....	 1 2 3 4 96	
805	Do you reuse the absorbent materials? (cotton clothes, menstrual cup) (For those who are using cotton cloth and menstrual cup)	Yes..... No.....	1 2	808
806	While reusing the cotton clothes/menstrual cup do you wash it with soap and water?	Yes..... No.....	1 2	
807	When reusing cotton clothes, how do you dry them?	Outside house in sunlight..... Inside house..... Outside house without sunlight.....	1 2 3	
808	How often do you change your absorbent during menstruation?	Every three hour..... Every four hour..... Every five hour..... Every six hour..... Once in a day..... As per need..... Others (Specify).....	1 2 3 4 5 6 96	
809	How often do you change your underwear during menstruation?	Every time with pad..... Once in a day..... Whenever it gets dirty..... Others (Specify).....	1 2 3 96	
810	During your last menstrual period were you able to wash and change in privacy while at home?	Yes..... No.....	1 2	
811	Where do you dispose the used absorbent at home?	Burn it..... Throw it in routine waste..... Flush it..... Bury it underground.....	1 2 3 4	

	(Note: for those we use sanitary pads and tampons only)	Throw it in the environment..... Other (specify).....	5 96	
811.1	Have you experienced any kind of discrimination when you were in you menstruation?	Yes ..... No	1 2	812
811.2	If yes, what kind of discrimination have you experienced?	Deprived of going temple and worshipping ..... Deprived of going kitchen ..... Deprived of going out of home ..... Only limited to certain place ..... Others (specify)	1 2 3 4 96	
	Among the girls who are currently attending school			
812	Do you go to school during your menstruation?	Yes..... Sometimes..... No.....	1 2 3	814
813	What are the reasons for not going to school during menstruation? (Multiple response)	Lack of private separate toilet for girls..... Lack of access to absorbents at school.... Lack of sanitary pad disposal facility at school..... Abdominal discomfort..... Cultural taboos..... Others (specify).....	1 2 3 4 5 96	813.1
813.1	What do you do to reduce stomach pain when you have stomach pain during menstruation?	Use of hot bag ..... Drink a lot of water ..... Take medicine ..... Take rest ..... I don't do anything ..... Others (specify)	1 2 3 4 5 96	
814	If your school provide sanitary pad, do you use the pad provided by the school?	Yes..... No.....	1 2	
815	Is there a separate bin placed at your school toilet for disposing used menstrual pads?	Yes..... No.....	1 2	901
816	If no, how do you/menstruating girls manage the used menstrual pads?	Bring it back to home..... Throw in the environment..... Flush it.....	1 2 3	

		Not applicable (not menstruating yet)... Others (specify).....	4 96	

Section IX: Access to Digital technology

SN	Question	Response	Code	Skip
	Basic digital Literacy			
901	Do you have your own mobile phone?	Yes..... No.....	1 2	 903
902	If yes, what type of mobile phone do you use?	Smart phone..... Feature phone.....	1 2	 904
903	If you don't have your own phone, whose mobile phone do you use?	No one..... Mother/mother-in-law..... Father/father-in-law..... Brother/brother-in-law..... Sister/sister-in-law..... Husband/wife ..... Other (Please specify).....	1 2 3 4 5 6 96	907
904	How many hours in a day on an average do you use your mobile phone?	Less than an hour ..... 1-2 hrs..... 3-5 hrs..... More than 5 hours ..... Only for calls.....	1 2 3 4 5	
905	Do you use other devices apart from a smartphone? *(Multiple response possible)*	Tablet..... Laptop..... PC..... None.....	1 2 3 4	
906	What do you normally do on a mobile phone? *(Multiple response possible)*	Audio and video calls..... Watch entertainment videos..... Make entertainment videos (tiktok)..... Watch educational/informational content..... Listen to songs..... Play games..... Social Media.....	1 2 3 4 5 6 7	

		Watch health related messages/information ……. Others (specify) ……	8 96	
	Internet and Data usage			
907	Do you use the internet or data?	Yes…… No……	1 2	913
908	If yes, how do you access internet/data? *(Multiple response possible)*	Data packs …….. Monthly WIFI subscription … Pay for a shared connection … Use only at free spots (for example; restaurant, friend, relatives' house)…….. Others (Please specify)…….	1 2 3 4 96	
909	If yes, what do you use it for the most? *(Multiple response possible)*	Browse Social Media ……. Watch video streams…….. Audio/ Video Calls……. Play online games……. Others (Please Specify)…….	1 2 3 4 96	
909.1	Do you use mobile phone/data/internet for educational purposes?	Yes …… No ……	1 2	911
910	If you access the phone for educational purpose, what types of topics do you usually look for?	RH and sexual health related topics…….. For online classes …… Others (specify)……..	 1 2 96	
911	How much money do you spend on the internet and data per month?	…… (NRs) Don't know, my parents pay the money for internet……	 98	913
912	How do you pay for internet services? *(Multiple response possible)*	Fonepay…….. Esewa…….. Khalti…….. IME pay…….. Mobile banking…….. Cash to Service Provider……	1 2 3 4 5 6	
	Games-fit questions			
913	Do you play digital games?	Yes…….. No……	1 2	End

914	If yes, in what device do you play the digital games? *(Multiple response possible)*	On mobile phone…… On Tablet…… On PC or Laptop…… In cyber …… Others (specify) ……	1 2 3 4 96	
915	If yes, which game do you play the most? *(Multiple response possible)*	Garena Free Fire…… PUBG…….. Ludo…….. Candy Crush…… Minecraft……. Temple Run……. Subway Surfer…… Digital card game- marriage call break …….. Others (Please specify)……..	1 2 3 4 5 6 7 8 96	
916	How did you come to know about mobile games/apps? *(Multiple response possible)*	Out of school friends circle…… School friends…… Family Members…….. From videos ……. Others (specify) ……	1 2 3 4 96	
917	What did you like most about the game? *(Multiple response possible)*	The Concept/The story…… The gameplay (for eg. challenges and levels) …….. Graphics quality/ Characters and artwork……. Reward system…….. A good time pass…….. Chatting with other players……. Others (Please specify) …….	1 2 3 4 5 6 96	
918	How much time do you spend in a day playing your preferred game?	Less than an hour…….. 1-2 hrs/day…… More than 2 hrs/day……..	1 2 3	
919	Would you like to get information (academic/non-academic) through games?	Yes …… No……	1 2	
920	Would you like to learn FP/RH topic through games?	Yes…… No……	1 2	

Note for the interviewee……..

Note for the interviewer ……..

Thanks for your valuable time and response!

BASELINE STUDY FOR ADOLESCENT REPRODUCTIVE HEALTH (ARH) PROGRAM

Questionnaire for Parents of Adolescent

Roster Code number of the selected parents:

Sex of the respondent	Male …… Female …….. Others (specify) ……	1 2 96

Section I: School going status of children

S. N	Questions	Responses		Code	Skip
101	Do any of your children who are of school-going age (4-19 years) currently not go to school?	Yes..... No.....		1 2	110
102	If yes, number of daughters and sons in your HH not going to school?	Number of daughters Number of sons Number of disable daughters Number of disable sons			
103	If yes, why did your daughter (s) stop going to school? *(Multiple responses possible)*	Marriage..... Had to do household chores ……. Financial crisis in family..... School is far from home..... Have to take care of toddlers/siblings at home..... School environment was not child-friendly ……. School environment was not disable friendly..... School environment was not safe (bullying/harassment)..... Corporal punishment..... Others (Specify) ……		1 2 3 4 5 6 7 8 9 96	
104	If yes, why did your son(s) stop going to school?	Marriage..... Had to do household chores ……. Financial crisis in family.....		1 2 3	

	(Multiple responses possible)	School is far from home..... Have to take care of toddlers/siblings at home..... School environment was not child-friendly ..... School environment was not disable friendly..... School environment was not safe (bullying/harassment)..... Corporal punishment..... Others (Specify)		4 5 6 7 8 9 96	
105	If yes, do you need any support to continue sending your children to formal education?	Yes..... No.....		1 2 ▼	107
106	If yes, please specify the type of support needed?	Financial support ..... Family support ..... Others (Specify).....		1 2 96	
107	Do your children who are not going to school want to re-join the formal education system?	Yes..... No.....		1 2 ▼	109
108	If yes, how many of your sons and daughters who are out of school want to re-join school?	Number of daughters Number of sons			
109	If no, how many of your sons and daughters who are out of school do not want to re-join school?	Number of daughters Number of sons			
110	Do they want to join any vocational trainings?	Yes..... No.....		1 2 ▼	Section II
111	What is their preferred vocational training that they want to join? *(Multiple response possible)*	Tailoring/Embroidery..... Electrician..... Driving..... Livestock farming..... Carpentry..... Plumbing..... Beautician/beauty parlor..... Art and craft..... Mobile repairing.....		1 2 3 4 5 6 7 8 9	

		Others (Specify).....		96	

Section II: Social Norms for RH behavior

READ ALOUD: The set of questions are about the lives and experiences of girls in your community and how community members consider adolescents' behavior. I will read a few statements. Thinking about the people of your community, please say whether you fully agree, agree, disagree, or fully disagree with each of the following statement [SHOW AGREE/DISAGREE CARD]. There are no right or wrong answers. We are just interested to learn about your opinions.

		READ ALOUD					DO NOT READ ALOUD		
		Fully agree	Partly agree	Neutral	Partly disagree	Fully disagreed	Don't understand	Don't know	Refused
201	Most people in my village thinks a married adolescent girl should give birth to a child right after the marriage to prove her fertility.	1	2	3	4	5	97	98	99
202	Most people in our village will <u>approve</u> of a girl under 20 getting married.	1	2	3	4	5	97	98	99
203	Most people in my village will <u>approve</u> if adolescent girl discusses about her marriage options with the parents.	1	2	3	4	5	97	98	99

204	Most people in my village will approve if a girl has a relationship or a love marriage.	1	2	3	4	5	97	98	99
205	Most people in my village will approve if a boy has a relationship or a love marriage.	1	2	3	4	5	97	98	99
206	Most people in my village will approve if a girl (10-19) goes to the bazaar without any family member accompanying her.	1	2	3	4	5	97	98	99
207	Most people in my village will approve of a unmarried girl visits health facility to receive RH information.	1	2	3	4	5	97	98	99
208	Most of the people in my village will approve if a girl speaks openly about menstruation.	1	2	3	4	5	97	98	99
209	Most of the people in my village believe menstruation is impure thus girls should stay away from others during their periods.	1	2	3	4	5	97	98	99
210	Most of the people in my village will approve if girls take active role in	1	2	3	4	5	97	98	99

	their community to talk about their needs								
211	Most of the people in my village will approve if a recently married adolescent girl wants to access RH counseling and FP services.	1	2	3	4	5	97	98	99
211.1	Dowry should be taken at the time of son's marriage.	1	2	3	4	5	97	98	99
211.2	A dowry should be given at the time of daughter's marriage.	1	2	3	4	5	97	98	99
211.3	No matter how many daughters there are in the family, there must be at least one son.	1	2	3	4	5	97	98	99
SEXUAL AND REPRODUCTIVE HEALTH									
213	A girl who has sex before marriage does not deserve respect.	1	2	3	4	5	97	98	99
214	A mother can discuss menstruation with her daughter	1	2	3	4	5	97	98	99
215	A father can discuss menstruation with her daughter	1	2	3	4	5	97	98	99
216	A father can discuss changes in a body during puberty with his son	1	2	3	4	5	97	98	99
217	Girls and boys should be allowed to spend time	1	2	3	4	5	97	98	99

	alone with each other								
218	Condoms/FP/RH services should be made available to unmarried girls and boys	1	2	3	4	5	97	98	99
219	A man should be the one to decide when to have sex	1	2	3	4	5	97	98	99
220	Adolescents FP/RH needs are different from adults	1	2	3	4	5	97	98	99
221	An adolescent girl can decide freely to access a FP/RH services by her own	1	2	3	4	5	97	98	99
222	A girl/boy with disability can get married	1	2	3	4	5	97	98	99
223	A girl/boy with disability can have children	1	2	3	4	5	97	98	99
224	Girls/boys with disability have FP/RH concerns and they have rights to access to those services based on their needs and choices.	1	2	3	4	5	97	98	99

Section III: Gender equitable attitudes towards social norms (Gender-Equitable Men Scale)

	"Inequitable" Gender Norms					
S.N.	**Questions**	Fully agree	Partly agree	Neutral	Partly disagree	Fully disagree
301	A woman's most important role is to take care of her home and cook for her family.	1	2	3	4	5

302	Women who carry condoms on them are “easy”.	1	2	3	4	5
303	Changing diapers, giving the kids a bath, and feeding the kids are the mothers‟ responsibility.	1	2	3	4	5
304	It is a woman’s responsibility to avoid getting pregnant.	1	2	3	4	5
305	A man should have the final word about decisions in his home.	1	2	3	4	5
306	There are times when a woman deserves to be beaten	1	2	3	4	5
307	A woman should tolerate violence in order to keep her family together.	1	2	3	4	5
308	It is okay for a man to hit his wife is she won’t have sex with him.	1	2	3	4	5
309	A couple should decide together if they want to have children.	1	2	3	4	5
310	A man and a woman should decide together what type of contraceptive to use	1	2	3	4	5
311	Men can take care of children just as well as women can.	1	2	3	4	5
312	If a man sees another man beating a woman, he should stop it.	1	2	3	4	5
313	Women should be virgins until they get married.	1	2	3	4	5

Section IV. Exposure to Family Planning/RH Information:

SN	Question	Response	Code	Skip
401	Have you ever heard/read of family planning/RH messages in the last 6 months?	Yes..... No.....	1 2	**End.**
402	If yes, what do you recall hearing or seeing a specific family planning/reproductive health message? *(Multiple response possible)*	Use of FP methods..... ANC/PNC check-up..... Menstrual hygiene..... Birth spacing..... FP service delivery point..... Adolescent friendly service centers.	1 2 3 4 5 6 7	

		Not remembered any ……. Others (specify)…….	96	
403	What are the sources from where you get the information of family planning and reproductive health related services? *(Multiple response possible)*	Radio..... Television..... Newspaper or magazine..... Textbook/curriculum book……. Social media (Facebook, Instagram, Tik Tok, YouTube etc.) ..... ARH Booklet..... Brochure or flipchart, Poster, hoarding board..... Video game/Mobile apps..... Street drama..... Mother's group/teachers..... Family members..... Peers..... Online platforms..... FCHVs..... Health service providers..... Health related seminars/campaigns……..... Other community level events..... Peer/educator/facilitators ……. Others (specify).....	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 96	

Thank you.