Human Resource for Health Mainstreamed in Health Systems, through Strengthened Advocacy Capacity of CSOs

Baseline Report

Knowledge, Practice and Coverage Survey on ASRH Services 2012

THE BRITAIN NEPAL MEDICAL TRUST (BNMT)
Kathmandu, Nepal.

Baseline Knowledge, Practice and Coverage Survey on ASRH services

The Britain Nepal Medical Trust
Kathmandu, Nepal

Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
AHW	Auxiliary Health Worker
ANC	Ante natal Checkup
ANM	Auxiliary Nurse Midwife
APH	Ante Partum Hemorrhage
ASRH	Adolescent Sexual and Reproductive Health
BNMT	Britain Nepal Medical Trust
BPKHF	BP Koirala Health Foundation
CHD	Child Health Division Health
CI	Confidence Interval
DDC	District Development Committee
DHO	District Health Office
DPHO	District Public Health Officer
EmOC	Emergency Obstetric Care
DoHS	Department of Health Services
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FHD	Family Health Division
FPAN	Family Planning Association of Nepal
HA	Health Assistant
HF	Health Facility
HFMC	Health Facility Management Committee
HI	Health Institution
HIV	Human Immuno – virus
HRH	Human Resource for Health
HW	Health Worker
IRB	Institutional Review Board
IMR	Infant Mortality Rate
MCHW	Maternal and Child Health Worker
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOHP	Ministry of Health and population
NHRC	National Health Research Council
NHTC	National Health Training Centre
OCP	Oral Contraceptive Pills
PHCC	Primary Health Care Centre
PHN	Public Health Nurse
RHTC	Regional Health Training Centre
SPSS	Statistical Packages for Social Science

SBA	Skilled Birth Attendant
SHP	Sub Health Post
SLC	School Leaving Certificate
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UNICEF	United Nations Children's Fund
VHW	Village Development Committees
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YIC	Youth Information Centre

Executive summary

Introduction:
Adolescents in Nepal often encounter problems, which include lack of awareness and knowledge about sexual and reproductive health, early marriage, early and frequent child bearing, unsafe abortion, STIs & HIV/AIDS and substance abuse. These problems are further aggravated by poor health seeking behavior and inadequate access to information and services. Many of these problems not only affect the physical and mental health of adolescents but adolescents' long-term emotional, economic and social well being.

The objective of the study were to: to assess the perception of appropriate age at marriage, child birth and reason of suitability; to assess the knowledge and experience of physical change and source of information related to physical change; to assess the knowledge related to family planning method, emergency contraception and place to receive service; to assess the knowledge of HIV and STI, mode of transmission and testing of HIV; to assess the knowledge and practice on access and utilization of sexual and reproductive health services; to explore the sexual behavior, use & perception in seeking SRH services.

Methodology:

This assessment is a descriptive and cross-sectional study design. This represents the Knowledge, Practices and Coverage (KPC) Survey related to situation of adolescent on sexual and reproductive health of the study districts.

For the purpose of quantitative study, a sample size of 2251 respondents was calculated. It included 1164 female and 1087 male of age group 10-19 years of adolescent to assess the knowledge, practices and coverage related to sexual and reproductive health issues.

For the qualitative purpose 18 focus group discussions (FGD) in each districts from at least three in each group (adolescent male and female, fathers, mothers, HFMCs and FCHVs) were conducted. For each district level FGD, a maximum of 10 people from parents, adolescent were invited of respective group. Similarly, nice KII were conducted from each district (Health teacher-3, Stake holders-3, D/PHO-1, Media person-2).

The study included randomly selected fifty Village Development Committees (VDCs) from Bajura, Achham, Doti, Kalikot, Kailali, Dang, Kapilbastu, Nawalparashi, Sindhupalanchwok and Pachthar (5 VDCs from each district) by applying Simple Random Sampling, which was considered as Primary Sampling Unit (PSU). From selected VDCs three wards from each sampled VDC was selected applying again Simple Random Sampling. All the households from selected wards were considered as sampling frame. Among the sampling frame Secondary Sampling Unit (SSU) was selected randomly from each ward. After selection of ward the list of adolescents was prepared and 15 adolescent were randomly selected from each wards based on availability.

Findings:

The analysis of findings of quantitative and qualitative data/information conducted in randomly selected fifty VDCs from 10 districts (5 from each district) and three wards were selected using systematic random sampling from each VDC thus making a total of 150 wards. The study includes 1164 and 1087 respondents of both sexes were intercepted adolescents. The fieldwork was carried out in September 2011.

Characteristics of respondents

Majority of the respondents included in the study were holding lower secondary level education (36 percent) and about 6 percent of the total respondents had 10+2 and above level of education. Similarly, majority of the respondents were unmarried (almost 94 percent) and two female respondents were found to be single.

Knowledge on age at marriage and child birth

Majority of female respondents (60 percent), most appropriate age at marriage is before twenty years while for majority of the male respondents (63 percent), marrying after the age of twenty is appropriate. This result indicates a different level of perception between male and female regarding the marriage culture. More than 89 percent of the female respondents replied that having the first child after the age of twenty years is appropriate. Whereas about 30 percent of the male respondents replied below the age of twenty to be appropriate for the age of first child birth. The major reason for appropriate age for the first child was viewed to be physical and mental maturity by most of the respondents.

Knowledge on physical changes during adolescent

Majority of the female respondents (69 percent) replied menstruation as one of the physical changes during adolescence followed by enlargement of breast (65 percent) and appearance of hair at axilla, chest and genitalia (39 percent). Similarly, a majority of male respondents (58 percent) replied facial hair appearance followed by enlargement of genitals (38 percent) and appearance of hair at axilla, chest and genitalia (36 percent) as physical changes during adolescence.

Knowledge and practice related to family planning

In general, about 84 percent of the respondents had ever heard about family planning methods, the percent was slightly high in male compared to females. The respondents were asked about different measures of preventing pregnancy. Of those who have heard about family planning methods, about 93 percent of the male and 80 percent of female respondents replied use of contraception as a measure to prevent pregnancy followed by abstinence (32 percent), and use of medicines (25 percent) respectively.

Respondents were asked about different methods of family planning, Majority of the respondents were aware about condom (88 percent) followed by oral contraceptive pills (OCP), Depo-provera, Copper-T and Norplant respectively. The knowledge on condom was higher among males than females and vice versa on family planning devices used by women.

Government health institutions (96 percent) were the highest responded place for availability of family planning methods followed by FCHV (for female respondents) and Medical shops (for male respondents).

Similarly, respondents seem to have limited knowledge about emergency contraceptives. In general, about 87 percent have not heard of emergency contraceptives.

Knowledge related to HIV and AIDS

The study revealed that eighty eight percent of the respondents replied that they have heard of HIV and AIDS but the figure differed when compared to gender. Only about 85 percent of the female respondents have heard of HIV and AIDS while it was 91 percent for male respondents. The result indicates that compared to male adolescents, female adolescent are less aware of HIV and AIDS. When asked about different mode of transmission of HIV with multiple response options, among those who had heard of HIV and AIDS, majority of the respondents were aware that HIV is transmitted by unsafe sexual contact with PLHIV (94 percent) followed by transmission through infected needles (69 percent). Respondents seem to be less aware of mother-to-child transmission (32 percent).

Similarly, respondents were asked about different types of STIs. Almost 94 percent of the respondents were aware of HIV/AIDS as a type of STI followed by Syphilis (42 percent). A very few respondents could name Gonorrhea (14 percent) and Hepatitis (6 percent).

Preference of person to discuss on ASRH issues

The respondents were asked about the person they prefer to discuss about ASRH issues. The result shows that friends (76.5 percent) are the most preferred by adolescents to discuss about their ASRH issues. After friends, female respondents preferred parents (32 percent) to talk about their ASRH issues whereas male respondents preferred health workers (27 percent). However, from the result we can conclude that friends are the most important person for adolescent to discuss about their ASRH issues.

In the next step, the respondents were asked about the availability of ASRH services in the health facility located in their community. About 54 percent of the female respondents and 63 percent of the male respondents replied that ASRH service is available in their nearby health facility. Of those affirming the availability of ASRH services, information and counseling (69 percent) was the service mostly reported by the respondents followed by health check-up (61 percent) and supply of medicine and condom (22 percent).

Utilization of ASRH services

The study further attempted to understand the utilization of ASRH services in the last six months. The result shows that the utilization of ASRH services is very low with only about 8 percent of the female respondents and about 3 percent of male respondents visiting the health facility for ASRH service within the last six months. The most frequent reason for visiting the health facility as reported by female respondents was due to menstrual problem (45 percent). The result further indicates that the problem of more than 30 percent of the respondents was not solved even after visiting the health facilities.

Ever discuss of ASRH issues with family members

Respondents were asked if they have ever discussed ASRH issues with their family members. Out of 2252 respondents, about 85 percent have never discussed on ASRH issues with their family. The

frequency of not discussing with family was higher among male (95 percent) than female (75 percent). Among those who discussed, about 82 percent felt easy to discuss with their family members and the major reason for feeling ease as reported was because of their supportive nature.

Information related to sexual behavior

Among those who were unmarried, about 9 percent of the respondents had experienced sexual relationship and the rate was much higher in male (17 percent) as compared to female respondents (2 percent). Furthermore, among those had premarital sexual relationship, about 45 percent of the male respondents and 20 percent of female respondents had more than one sexual partner.

Regarding the use of contraception, about 30 percent of the respondents reported to have never used any contraceptive methods during their sexual relationship. The result further indicates that adolescents are likely to be influenced by their friends for sex. About 6 percent of the female respondents and 33 percent of male respondents were reported to be influenced by the friends for sexual relationship.

Similarly, respondents were asked if they have ever discussed about harmful effects of unprotected sex with their friends. The result shows that about 70 percent of the male and 51 percent of the female respondents discuss with their friends about the harmful effect of unprotected sex. It was interesting to find out that about 30 percent of the respondents discuss about sexual matters with opposite sex.

Suggestions and recommendations of respondents:

Mela bazaar (programs at night) should be banned. Awareness programs should be launched in each and every ward including schools. Teachers should be provided training on friendly behavior and counseling. Watching movies in mobiles should be prohibited. The health institutions should have skilled health workers as per sanctioned posts. The health workers need to show friendly behavior to patients and patient party. Parents also need to be friendly with their sons and daughters. For this orientation program should be launched among parents. Each village needs a center for awareness established. The curriculum of schools should also be revised to make it broad to include SRH issues.

Youth information centre should be established in each health institution and PHC outreach clinic. Awareness program should be conducted time to time for local leaders, adolescents, school drop-out children and out of school adolescents. Trainings programs should be conducted for parents regarding their behavior to their sons and daughters. It would be better if each health institution has safe abortion service facilities. There should be provision of condom box which would facilitate us for getting it easily.

It would be helpful if we could talk on phone with physicians for free regarding ASRH issues. The health workers doing illegal abortion should be strictly punished. Essential drugs should be available round the year in health institutions. Awareness programs should be launched for adolescents and the curricula should be more detail and practical. It would be better if each health institution has facility for safe abortion services. There should be strict rules for maintaining staff regularity and continuity.

Key recommendation:

1. Since knowledge on age at marriage and age at first child birth were found to be low among the respondents; effective measures to enhance knowledge on legal age at marriage and age at first child birth would be important. In this regards, all the project of BNMT and related organization should address the issue of early marriage and teen age pregnancy.

2. The knowledge related to normal changes during adolescence were not satisfactory among both male and female respondents. So, it is recommended that the program needs to empower adolescents with information related to normal changes during the adolescent period.

3. Study revealed that heard of emergency contraceptives were strikingly low among adolescents; the program need to focus on innovative approach to create awareness on emergency contraception and measures used for emergency contraception.

4. It was noted from the study, the mode of transmission of HIV (mother to child transmission) among adolescents were alarmingly low; so program needs to provide additional thrust on the mode of transmission and misconception of HIV transmission, and its prevention.

5. Since majority of adolescent respondents preferred to share information related to ASRH issues with friends; so it is recommended that peer educators and supporters group needs to be created and mobilized to tackle ASRH issues.

6. It is recommended that capacity of health institutions need to be enhanced to provide adolescent friendly and gender friendly ASRH service. Specifically, the program needs to negotiate for opening hour of health institutions, as it needs to be increased to address the problem of access to the services.

7. Radio and FM were found to be most preferred media for adolescents, so it is recommended that use of such media to crate awareness would be preferred approach.

8. It was noted that higher rate of premarital sex and multiple sexual partner among adolescents. So, it is recommended that information related to safe sex needs to be included in the program to prevent pregnancy, HIV and STI.

9. It is recommended that each VDCs need a Youth Information Center (YIC) for awareness creation and the already existing YIC needs to be capacilitated.

10. It is recommended that the curriculum of schools should also be revised incorporate SRH issues of the adolescents.

11. It is recommended that program should incorporate local leaders, school drop-out children and out of school adolescents to create awareness and reduce persistant social stigmas.

Table of Contents

Tables

Figures

Chapter I-Introduction

1.1 Background

Adolescence has been defined by the World Health Organization (WHO) as the period of life spanning the ages between 10-19 years, and youth as between 15-24 years. Young people are those between 10-24 years of age (WHO, 1997). Adolescence is the second decade of life and it is a period of rapid development. Moreover, it is a time when growth is accelerated, major physical changes take place and differences between boys and girls are accentuated (WHO, 1998). Young people constitute a significant proportion of each country's population and make up about 20% of the world's people (UNFPA, 2005).

One in every five people in the world is an adolescent, and 85% of them live in developing countries (WHO, 2008). Nearly two thirds of premature deaths and one third of the total disease burden in adults are associated with conditions or behavior that began in youth, including tobacco use, a lack of physical activity, unprotected sex or exposure to violence. Promoting healthy practices during adolescence and efforts that better protect this age group from risks will ensure longer and more productive lives for many.

Young people aged 15-24 accounts for an estimated 45% of new HIV infections worldwide in 2007 (WHO, 2008). In such an emerging threat of HIV infection, they need to know how to protect themselves from HIV and have the means to do so. Better access to testing and counseling will inform young people about their HIV status, help them get the care they need, and avoid further spread of the virus.

Promoting sexual health, combating sexually transmitted infections including HIV, and providing high-quality services for family planning are the core aspects of sexual and reproductive health services among the 5 major areas as outlined by WHO Sexual and Reproductive Health Strategy (WHO, 2004).

''About half of all HIV infections are in people under 25, with girls becoming disproportionately affected. On average, one-third of women in developing countries give birth before age 20; a large proportion of these pregnancies are unplanned. Each year, between 2 and 4 million adolescents undergo unsafe abortions" (World Bank, 2011).

The crucial nature of adolescent sexual and reproductive health had been neglected in reproductive health, population programs and studies due to the sensitivity of the issue over a long period of time. By the strong emphasize on adolescent sexual and reproductive health in 1994 ICPD in Cairo, and in Beijing Platform for Action (Fourth World Conference on Women, 1995), where a comprehensive and holistic approach towards sexuality, sexual and reproductive health was formulated as part of basic human rights. The Program of Action formulated in the conference states that the characteristics and necessities of young people/adolescent sexual and reproductive health should be included into the programs designed to improve the health conditions throughout the world (MSI, 1998).

Changing sexual and reproductive health behavior and rapidly changing social environments can put young people at different risks. The issues affecting young people‘s sexual and reproductive health status are often interrelated and complex (WHO, 2006). Growing risky sexual behavior and related threats, lack of access to youth friendly reproductive health information and services, along with environmental challenges related to poverty and unemployment threaten today‘s young people in a position of greater vulnerability. Proper information and youth friendly services are, therefore, further important to help young people to understand and adopt the healthy transition of life by protecting from risky sexual and reproductive health behavior.

The benefits of combating the threats of risky sexual behavior and promoting the sexual and reproductive health of young people are far-reaching. The interventions related to sexual and reproductive health can positively contribute to social and economic prosperity by addressing the likelihood of HIV, STIs, teenage pregnancy and their associated negative impacts. The prevention and treatment of STI and HIV/AIDS reduces social stigma and helps young people remain healthy, enabling them to better care for and invest in their families, communities and countries.

1.2 Problem and global view

Sexual and reproductive health of young people has been a major international concern today. It has been unequivocally indicated in the 1994 International Conference on Population and Development (ICPD) in Cairo. In the ICPD ‘Program of Action’ in paragraphs 7.7 and 7.8, it is stated that “reproductive health programs should be designed to serve the needs of women, including adolescents”, and that innovative programs should be developed to “ensure information, counseling and services for reproductive health accessible for adolescents and adult men” (UNFPA, 1996).

The Cairo agenda has been reaffirmed in a number of international forums such as the Fourth World Conference on Women held in Beijing in 1995, the United Nations (UN) reviews of progress towards implementation of the Cairo and Beijing agreements; declaration of world leaders in support of ICPD issued in 2004 and the adoption of a global reproductive health strategy by the World Health Assembly in 2004 (GFHR & WHO, 2007).

Despite various global commitments to sexual and reproductive health for all, inequalities and problems still exist. Many adolescents do not have access to information about sex and sexuality (GFHR & WHO, 2007). Unsafe sex is the second and ninth most important cause of morbidity or untimely mortality in the world poorest populations and in developed countries respectively (Glasier A et al, 2006). Moreover, sexually transmitted infections excluding HIV/AIDS, are the second most important cause of loss of health in women, especially young women, and are a substantial cause of mortality in men.

According to WHO 1998, 15 millions of adolescents experience pregnancy each year, and most of these pregnancies are unwanted. The same source mentioned that young women tend to have induced abortions, whether legal or not. According to WHO

projection, nearly half of the induced abortions occur under unsafe conditions. Unsafe abortions cause a serious morbidity and mortality burden for women and the risk is further magnified among adolescent girls (WHO, 1998). Globally, up to 4.4 million abortions are performed every year among women aged 10-24 years, most under unsafe conditions and conducted by unskilled providers (WHO, 1997). Unsafe abortions can result in hemorrhage, septicemia, injuries, infertility and death.

Worldwide, approximately 80% of HIV cases are transmitted sexually and a further 10% parental or during breastfeeding (Ian Askew & Marge Berer, 2003). STIs, including HIV, are predominantly diseases of young people. It is estimated that half of all new HIV infections occur in young people those between the age of 15 and 24. UNFPA estimates that this amounts to nearly 6000 young people newly infected every day (UNFPA, 2006). The importance of controlling and preventing the epidemic in young people is highlighted in the indicators for achieving. Millennium Development Goal (MDG) 6; two of the indicators relate directly to this age group: HIV prevalence among pregnant women aged 15–24 years; and percentage of the population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS. Young women and girls are disproportionately affected by HIV/AIDS epidemic (Hawkes S, 2008).

HIV/AIDS resulted in the loss of over 84 million disability adjusted life years (DALYS) in 2002. STIs and HIV constitute a huge health and economic burden, especially for developing countries where, together, they account for 17% of economic losses caused by ill-health (Mayaud & Mabey, 2004). In men, if HIV and other STIs are combined, sexually transmitted infections account for nearly 15% of all healthy life years lost in this age group (Hawkes S, 2008).

According to WHO, near to half of the HIV infections are among young people. Increasing prevalence of HIV and vulnerability of young people guides to work further for young people. Particularly, young women are at great risk of infection; as of December 2003, women accounted for nearly 50% of all people living with HIV globally (WHO, 2006). In 2007, an estimated 33.2 million people were living with HIV; 5.4 million of them were aged 15–24 years (Raoul Fransen-dos Santosa, 2009).

The best available estimates indicate that each year some 340 million new cases of syphilis, gonorrhea and Chlamydia trachomatis occur in men and women aged 15–49; overall, STI prevalence rates continue to rise in most countries, including developed countries (WHO, 2006). Sexually Transmitted Infections (STIs) are a public health issue; STIs are spreading primarily through person-to-person sexual contact and they have serious complications leading to fatal pregnancy outcome, aggravating transmission of HIV infections and infertility in men and women (WHO, 1999).

According to WHO, all cervical cancer is attributed to sexual transmission of the human papilloma virus. Cervical cancer accounts for 11% of global deaths due to unsafe sex. Almost three quarters of the global burden of unsafe sex occurs in sub-Saharan Africa, and remaining 15% in India and other countries of the South-East Asia Region. Other

STIs like syphilis, gonorrhea and Chlamydia are entirely attributable to unsafe sex (WHO, 2011).

According to World Bank‘s estimation US$0.90/capita for family planning, US$3/capita for antenatal and delivery care, and US$0.20/capita for STD care - could avert an estimated 8% of the total global burden of disease (GBD). In addition, investing US$1.70/capita in HIV/AIDS prevention could avert an additional 2% of the GBD. The adverse consequences related to sexual and reproductive health, and the benefits of good SRH extend beyond health, and have an impact at the societal level (World Bank).

Cultural taboos, beliefs that such conditions must be endured, feelings of anxiety or depression, and lack of information and resources for dealing with them contribute to the relative invisibility of many sexual and reproductive health problems not only to policymakers and health-care providers but also to family members, sexual partners and even individuals themselves (GFHR & WHO, 2007).

Sexual behavior varies between countries and regions of the world. In 2004, unsafe sex was estimated as being responsible for more than 99% of human immunodeficiency virus (HIV) infection in Africa. Throughout the world, the proportion of HIV/AIDS deaths due to unsafe sex ranges from around 50% in the low- and middle-income countries of the WHO Western Pacific Region to 90% in the low- and middle-income countries of the Americas (WHO, 2011).Therefore, the evidences show that the threats related to sexual behavior are increasing, and even more so among the adolescents/young people of the developing world.

1.3 Brief situation in South Asia

South Asia is a residence to about 350 million young people aged 12-24 years, nearly 30% of all youth in developing countries. The large numbers of young population and the socio-economic and cultural context of South Asia, which perpetuates gender stereotypes leading to discriminatory practices in overall behavior towards girls, early marriage and early pregnancy being a cultural norm. Poor access to reproductive and sexual health services and information, increasing trend in violence and sexual abuse presents a tremendous threat for addressing their development and health concerns especially reproductive and sexual health (Capoor I and Patel P, 2006).

More than half of the world's young people – about 850 million (10 and 24 years aged) live in Asia and the Pacific. In South Asia region, it comprises about 31% of the total population (Capoor I and Patel P, 2006).

Large proportion of South Asian adolescents are living below the poverty line in remote areas. Adolescents are also considered as source of income in household in many of the families. Poverty and lack of education makes them work for unskilled labor sectors for rest of their lives. For many adolescents, this scenario makes extremely vulnerable to various forms of exploitation. “Commodification of adolescents and young people” is a common phenomenon in many resource poor families in South Asian countries which

manifests in the form of trafficking, flesh trade, sexual abuse, rape and incest among the young population (Capoor I and Patel P, 2006). The growing rates of HIV/AIDS in the young population are affected by these realities.

Adolescents (10-19 years) constitute 18-25% of the population in countries of this South-East Asia Region (SEAR). The existing health services are inadequate to meet the needs of adolescents. Health polices and strategies are not directed to respond the adolescent‘s issues (WHO, 2004).

In many of the South Asian communities, patriarchal norms and values are predominant. Culturally, marriage in South Asia takes place at a very early age, before the age of 18 years (Capoor I and Patel P, 2006).

Table 1 Distribution of young population in SEAR

Country	Young People Age 10-24 (2006)		Young People Age 10-24 (2025)	
	Million	% of total population	Million	% of total population
World	1773	27	1845	23
Bangladesh	45.7	32	52.2	27
Bhutan	0.7	33	0.9	29
India	331.1	30	349.2	25
Nepal	9	33	11	28
Pakistan	54.2	34	64.8	28
Sri Lanka	5.4	26	4.7	20
South Asia	446.1	31	482.8	26

1.4 Situation in Nepal

In Nepal, young population comprises more than 30% of the total population (CBS, 2009). Owing to high fertility and a youthful population, the proportion of adolescents in the total population is likely to increase in the coming years. The majority of the adolescent girls are illiterate. Amongst adolescent girls of age 10-14 and 15-19, only 49% and 39% are literate compared to 76% and 71% amongst boys in the corresponding age groups (Pradhan A et al., 1996).

Adolescents in Nepal often encounter problems, which include lack of awareness and knowledge about sexual and reproductive health, early marriage, early and frequent child bearing, unsafe abortion, STIs & HIV/AIDS and substance abuse. These problems are further aggravated by poor health seeking behavior and inadequate access to information and services. Many of these problems not only affect the physical and mental health of adolescents but adolescents' long-term emotional, economic and social well being (MOH/FHD, 2000).

As illustrated in the figure 2[1], it shows low mean age at marriage especially among girls in Nepal. The difference in mean age at marriage for boys and girls explains the persistence of premarital sexual practices among the young people in the country.

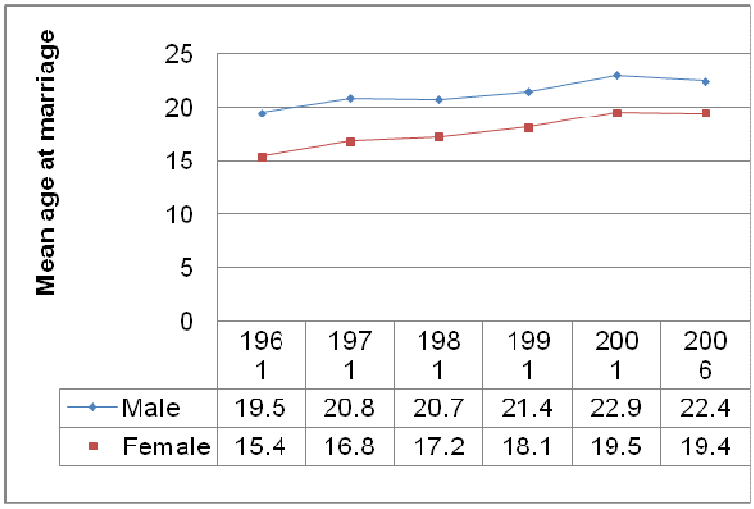

Figure 1: Trends of mean age at marriage, Nepal (1961-2006)

Various socio-cultural factors, traditional beliefs and norms operating in Nepalese societies have contributed to a high level of illiteracy, early age at marriage, adolescent fertility and their associated complications, unintended pregnancies and unsafe abortion related health risks for young people (Tamang A; Nepal B., 1998). In addition, an apparent trend to a lowering of the age of menarche, an increase in age at marriage, changes in values brought about by increasing urbanization, exposure to foreign cultures through migration, tourism and the mass media, and a decline in the prevalence of the extended family exacerbate the problems of adolescents in the country (CREPHA, 1996).

About 22% of new HIV positive cases were reported in age group < 24 years in the year 2010 (see Fig. 3)[2]. According to National Center for HIV/AIDS and STI, Nepal is considered a "low-incidence" country in terms of HIV infections. However, the sero-prevalance data suggest that HIV and STIs infections have significantly increased in the last five years.

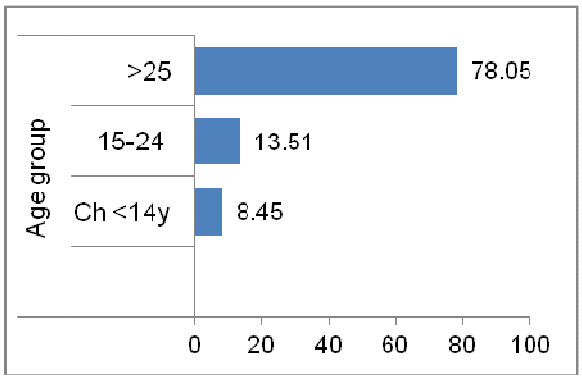

Figure 2 New HIV positive cases by age group in 2010, Nepal

Adolescents (14-19 years) comprise one sixth (13%) of all the HIV infected cases in Nepal; the proportion of adolescent girls amongst the total women infected with HIV is about one-third (NCASC/MOH, 2000). The nature and extent of sexual contacts between individuals and their non-regular partners or Sex

[1] Source: World Bank data, 2008 , Demographic Health Survey, 2001, 2006

[2] Health Management Information System -2010, Department of Health Service, Nepal

Workers (SWs) have important implications for the transmission of HIV in Nepal. One of the effective ways of preventing the spread of STIs and HIV/AIDS is by changing the sexual behavior of sexually active persons towards responsible and safe sexual practices. This could be possible by disseminating information about HIV/AIDS and encouraging the use of condoms. Unless change towards safer sexual behavior is emphasized, the spread of STIs and HIV is difficult to manage under control.

The general prevalence of HIV/AIDS in Nepal is 0.5%. However, there is an increasing prevalence in several groups like Sex Workers in Kathmandu 17.3%, Intravenous Drug Users (IDUs) 40.4% nation-wide and 68% in the capital city (NCASC/FHI, 2003). It is now evident that Nepal has entered a "concentrated epidemic" the HIV/AIDS prevalence is consistently exceeding 5% in one or more sub-groups. AIDS could become the principal cause of death in 15–49-year-olds, and 10,000–15,000 AIDS-related deaths could be expected annually in the country (Abeysena, C. and Silva de J.H., 2005). Preventing HIV and STIs among vulnerable groups and prevention of new infections among young people is one of the important strategy to keep the general prevalence less than 1% and to begin to reverse it by 2015 (NHSP-IP, 2004).

Nationally, over 50,000 cases of STIs are reported and STIs (other than HIV) comprised 78% (34118) of total counseling and testing case load in health facilities throughout the country in 2010 (DoHS, 2010). The STI cases in study district are increasing in alarming rate from 2009 (total cases 666) to 2010 (total of cases 2919).

Poverty and unemployment in rural areas is enforcing young population to migrate to the nearest cities within country; large portion of population especially from far western of Nepal migrate to India. Unless young people have safe sexual behavior and correct information, they are quite vulnerable to this pandemic of HIV/AIDS. In addition, the rapid growth of formal manufacturing sector in Nepal has led to a large influx of young people from rural areas seeking employment in Kathmandu Valley. Many young people arrive in the city unaccompanied by parents or other guardians. The problems of working young people and adolescent are further severe in regards of vulnerabilities of various kinds (CREPHA, 1996).

According to NCASC Nepal 2008 data, total HIV positive cases reported in Nepal including AIDS are 11,501 (68% were men and 32% were women), of which 16% people had already developed AIDS (NCASC/MOH, 2008).The source showed 3 in 4 of the total HIV positive cases were attributable to the unsafe sexual practices and 20% of the total HIV cases were contributed by young people of 15-24 years.

Nepal Demographic Health Survey (NDHS) 2006 showed median age at first sexual intercourse was 17.2 years among women aged 20-49 years and 19.6 years among men aged 25-49 years. Median age at marriage for women and men was 17.2 years and 20.2 years respectively (NDHS, 2006). This finding suggests increasing premarital sexual relationship. The time period between age at first sex and age at marriage is often a time of sexual experimentation, which can increase the risk of HIV, unwanted pregnancy and other STIs.

The same survey showed high risk sexual intercourse was common among men in age group 15-19 years. The age group of 15-19 years is the period of higher secondary or secondary level of education according to the education system of Nepal.

1.5 Objective of study

1. To assess the perception of appropriate age at marriage, child birth and reason of suitability
2. To assess the knowledge and experience of physical change and source of information related to physical change.
3. To assess the knowledge related to family planning method, emergency contraception and place to receive service
4. To assess the knowledge of HIV and STI, mode of transmission and testing of HIV
5. To assess the knowledge and practice on access and utilization of sexual and reproductive health services
6. To explore the sexual behavior, use & perception in seeking SRH services.

Chapter II- Methodology

2.1 Study Design and Instrumentation

This assessment was a descriptive and cross-sectional study design. This represents the Knowledge, Practices and Coverage (KPC) Survey related to situation of adolescent on sexual and reproductive health of the study districts.

The study design was explored the level of indicators, which will be beneficial in planning, programming and developing health promotion activities related to adolescent reproductive and sexual health. This assessment is a blend of both qualitative and quantitative research methods. The research instruments was prepared, pre-tested and modified to address the specific objectives of assessment. The major qualitative data collection tools was included focus group discussions, and key informants interview. The quantitative data collection tools were included household survey. The concerned stakeholders were also approached for the interviews.

Quantitative and qualitative data are complementary, and both can be used to guide program improvements. While quantitative indicators are essential for measuring results and gauging impact; qualitative indicators can provide a more nuanced understanding of results. In this guide some of the quantitative indicators can be enhanced by qualitative data, particularly those in the "Use" section, where indicators/variables focus on documenting use and contextual information around reported use.

2.2 Indicators

The indicators are mentioned below, Indicators and variables were finalized after discussion with technical team of BNMT, FNAN, WHR and BP Koirala Health Foundation. The **main variables** were related to knowledge and practice related to knowledge of age at marriage, information relation ASRH, family planning and emergency contraception and HIV. The detail indicators are: The study mainly measured following **indicators**:

- % of respondents know about the appropriate age at child birth
- % of respondents know about normal physical changes during adolescent
- % of respondents know about family planning methods and emergency contraception
- % of respondents heard of HIV, mode of transmission of HIV and STI
- % of respondents receiving information on SRH issues
- % of respondents faced problem related to SRH
- % of respondents discuss SRH issues in family
- % of respondents had premarital sex and use of contraception
- Preferred source of information on ASRH among respondents

2.3 Sample size

For the purpose of quantitative study, a sample size of 2251 respondents was calculated. It included 1164 female and 1087 male of age group 10-19 years to assess the knowledge, practices and coverage related to sexual and reproductive health issues.

For the purpose of quantitative study following sample size was included.

Table 2 Distribution of young population in SEAR

S.N.	Group	Sample Size*
	Less that 14 Years	702
	Fourteen to sixteen years	1084
	More that sixteen years	465
	Total	2251

* the sample size was calculated by given formula* 1.5 (design effect)

Epi Info 3.3.1 statistical software was used for sample size calculation. The estimated sample size (n) is calculated, using Simple Gaussian Theory, as:

$$n = \frac{Z^2_{\alpha/2} p(1-p)N}{\delta^2(N-1) + Z^2_{\alpha/2} p(1-p)}$$

Here,
N : Population size of sampled districts/strata.
P%: Estimate of rate of characteristics occurring in the population is taken 20%
(Delivery assisted by SBA, among mother less than 20 years, 20%; NDHS, 2006).
d%: Absolute deviation from P% is considered +/- 10% of P i.e. +/- 10% of 20% (0.02%).
Z_α: At 95 % Confidence Level.
For the qualitative purpose 18 focus group discussions (FGD) in each districts from at least three in each group (adolescent male and female, fathers, mothers, HFMCs and FCHVs) were conducted. For each district level FGD, a maximum of 10 participants from parents, adolescents were invited of respective group. Similarly, nine KII were conducted from each district (Health teacher-3, Stake holders-3, D/PHO-1, Media person-2).

Table 3 Summary of tools and techniques used in qualitative and quantitative study

Method		**Tools**	**Sample size**	**Remarks**
A. Quantitative				
A1	Interviews (10-19 years)	Interview questionnaire	225/ district	5 VDCs/District 3 Wards/ VDC 15 Samples/ward

B. Qualitative				
B1	FGDs with adolescents (10-19 years old Females)	FGD guideline	3/district	1 Sec. School 1 H S School 1 Community
B2	FGDs with adolescents (10-19 years old Males)	FGD guideline	3/district	1 Sec. School 1 H S School 1 Community
B3	FGDs with Parents (Mothers)	FGD guideline	3/district	1/VDC
B4	FGDs with Parents (Fathers)	FGD guideline	3/district	1/VDC
B7	KIIs with Health Teachers	KII guideline	3/ district	1/Sec. School/VDC
B8	KIIs with organizational stakeholders	KII guideline	3/ district	1/VDC
B5	FGD with HFMC Members	KII guideline	3/ district	1/VDC's HI
B9	KIIs with D/PHO	KII guideline	1/district	1/District
B6	FGDs with FCHV	FGD guideline	3/ district	1/VDC
B10	KIIs with Media person	KII guideline	2/ district	1 News papers 1 AV/FM

2.4 Sampling Technique

Firstly, fifty Village Development Committees(VDCs) from Bajura, Achham, Doti, Kalikot, Kailali, Dang, Kapilbastu, Nawalparasi, Sindhupalchowk and Panchthar was selected randomly (5 VDCs from each district) by applying Simple Random Sampling, which was considered as Primary Sampling Unit (PSU) and from selected VDCs three wards from each sampled VDC was selected applying again Simple Random Sampling. All the households from selected wards were considered as sampling frame. Among the sampling frame Secondary Sampling Unit (SSU) was selected randomly from each ward. After selection of ward the list of adolescents was prepared and 15 adolescent were randomly selected from each wards based on availability. The selected VDCs were:

Table 4 List of sample VDC

District	MPs/VDCs
Bajura	Rugin, Kolti, Rajpur, Atichaur, Martadi
Achham	Sieudi, Mastamandu, HIchma, Kalikasthan, Mangalshen
Doti	Banlek, Lantamandu, Mudvara, Sanagaun, Barchhai
Kailali	Malakheti, Godawari, Fulwari, Hasulliya, Sahajpur
Kalikot	Ramnakot, Siuna, Kumalgaun, Bharta, Ranchuli
Dang	Saudhiyar, Duruwa, Purandhara, Kavre, Rajpur

Kapilvastu	Bad ganga, Pakadi, Kapalvastu NP, Mahagajgunja, Krishnanagar
Nawalparasi	Harpur, Jaminiya, Ratanpur, Pragatinagar, Bulingtar
Sindhupalchwok	Chautara, Jalbire, Pangretar, Banshgharka, Tekanpur
Panchthar	Tharpu, Prangbung, Yasok, Olane, Nawani dada

2.5 Approaches

Quantitative method

- Consultant finalized a detailed research methodology, design and sample size in consultation with BNMT', FPAN, WHR, BPMHF technical team.
- The tool has been prepared after through analysis and review of the tools used in similar survey in National and International survey.
- Pre testing of tools, instrument and check list was done.
- A field research plan was developed and implemented.
- Tabulation and further necessary analysis was done.

Qualitative method

- Consultant worked with the technical team of BNMT,FPAN, WRH, BPKHF for the development and finalization of tools.
- Developed focus group discussion, In-depth interview guideline, case study guidelines in consultation with BNMT, FPAN, WRH, BPKHF.
- Pre-tested the FGD and KII guidelines.
- Focus group discussions and KII was conducted using pre-designed guideline .
- Further necessary analysis done and interpretation was made on baseline status.

2.6 Training of Enumerators and Data Collection Procedure

Four days orientation training was provided to the enumerators, facilitators and supervisors. The

interviewers were trained locally to carry out the interviews using the survey questionnaires. They were also trained in interviewing, facilitating participatory group discussions and KII. In addition, they received guidance on dealing with difficult emotional situations and referring people for counseling or further sources of advice and information. After training, pre-testing of tools was carried out and amendments made on the tools incorporating the feedbacks from the pre-testing of the tools. After the training and pre-testing, both enumerators and facilitators depart to the selected districts. Letters from BNMT, FPAN, WHR, and BPMHF was provided to each of the researcher involved in the study and then after data collection process was started.

2.7 Quality Assurance of Data

Quality assurance of the data was maintained by the supervision of study team. A part from that, BNMT, FPAN, WRH, BPKHF officials and Consultants was also supervised the work of enumerators and facilitators.

2.8 Data Management

2.8.1 Management of missing value:

Missing data were characterized in terms of the degree and patterns of missing. For imputation of missing value of categorical variables, the frequency distribution was used as the basis for randomly generating a value for each observation lacking a response. For example, if education was measured in three categories -- "less than high school" (25% of complete data cases), "completed high school" (40%), or "more than high school" (35%) -- then for each observation with education missing, a random number between 0 and 1 was drawn from a uniform distribution and the missing value replaced with "less than high school" if the random number was less than or equal to 0.25, "completed high school" if the number was greater than 0.25 but less than or equal to 0.65, or "more than high school" if greater than 0.65. For imputation of numerical variable regression method was used.

2.8.2 Data entry and Analysis process:

Prior to the data entry, the data was cleaned in a meeting with the district supervisor. The cleaned data was entered into SPSS 16 version software. The statistical test analysis was done in accordance with the distribution of data. The complete database will be kept for 5 years. The findings from quantitative tools were presented in tabular and graphical forms, where frequency, percent and 95% confidence interval was calculated as per necessary.

For the qualitative method a content analysis was carried out (transcription and the notes takers' note was matched). The findings were presented in narrative forms, verbatim, comparative charts and quotations.

2.9 Ethical Considerations

Ethical consideration was maintained by rigorous review of content considering content validity, pre-testing of tools was carried out in similar setting and obtaining the verbal approval from the study participants after introduction the study purpose was explained to better undertaking and increases the likelihood that respondents will participate and answer honestly. The purpose of the study was explained in general terms to help respondents understand the importance of the interview and their part in the process. Also stated the time of interview is likely to take and reassure participants that their answers will be strictly confidential.

2.10 The Fieldwork and Study Duration

Fieldwork was started immediately after the orientation of the team members. The ten teams were responsible for covering all 10 districts. Within each team, there were 4 data enumerators. Depending upon the terrain features and distance, between 25 and 30 days was spent in each district. Regular inter-team communications were maintained to ensure uniformity of data collection and sharing of field experiences. The district program officers were spent 20 days at each district along with the Data Enumerators. BNMT Officials were also briefed about the progress of the fieldwork regularly. The total duration of fieldwork (covering ten districts) was 30 days.

Chapter III- Results

The respondents of this study represented various ethnic/caste groups of Nepal. Majority of the respondents (46 percent) were of Khas ethnicity (Brahmin, Kshetri and Shanyashi) followed by Pahad Janajati, Pahad Dalit, Terai Janajati, Terai Dalit, Terai upper caste, religious minorities and Terai relatively disadvantaged caste respectively. Similarly, majority of the respondents were found to be following Hinduism as a religion followed by Kirat, Buddhism and Islam. A very few respondents were Christian and from other religion (such as Sikhha).

Table 5 Socio-demographic distribution of respondents by gender

Variable	Gender				Total	
	Female		Male			
	n	%	N	%	n	%
Age group						
Less that fourteen Years	407	35.0	295	27.1	702	31.2
Fourteen to sixteen years	555	47.7	529	48.7	1084	48.2
More that sixteen years	202	17.4	263	24.2	465	20.7
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Caste						
Khas (Brahmin, Kshetri, Shanyashi)	553	47.5	476	43.8	1029	45.7
Pahad Dalit	144	12.4	155	14.3	299	13.3
Pahad Janajati	229	19.7	199	18.3	428	19.0
Tarai Dalit	56	4.8	49	4.5	105	4.7
Tarai Janajati	92	7.9	102	9.4	194	8.6
Tarai relatively disadvantaged caste	12	1.0	28	2.6	40	1.8
Tarai upper caste	50	4.3	49	4.5	99	4.4
Religious minorities	28	2.4	29	2.7	57	2.5
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Religion						
Hinduism	991	85.1	935	86.0	1926	85.6
Buddhism	69	5.9	39	3.6	108	4.8
Islam	35	3.0	30	2.8	65	2.9
Christianity	2	0.2	7	0.6	9	0.4
Kirat	66	5.7	76	7.0	142	6.3
Others*	1	0.1	0	0	1	0
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Educational status						
Illiterate	14	1.2	7	0.6	21	0.9

Just read and write	14	1.2	14	1.3	28	1.2
Primary level	351	30.2	286	26.3	637	28.3
Lower secondary level	427	36.7	384	35.3	811	36.0
Secondary level	286	24.6	324	29.8	610	27.1
10+2 and above	72	6.2	72	6.6	144	6.4
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Marital status						
Unmarried	1082	93.0	1036	95.3	2118	94.1
Married	80	6.9	51	4.7	131	5.8
Single	2	0.2	0	0	2	0.1
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**

** Other includes: sikhha*

Similarly among those who were enrolled for this study, majority of the respondents were holding lower secondary level education (36 percent) and about 6 percent of the total respondents had 10+2 and above level of education.

Majority of the respondents were unmarried and two female respondents were found to be single.

The respondents were asked about the most appropriate age at marriage. In general, getting married after the age of twenty years was found to be appropriate. But the disaggregated data shows that for majority of female respondents (60 percent), most appropriate age at marriage is before twenty years while for majority of the male respondents (63 percent), marrying after the age of twenty is appropriate. This result indicates a different level of perception between male and female regarding the marriage culture.

Similarly, the most appropriate age for first child birth is also viewed differently by male and female respondents. More than 89 percent of the female respondents replied that having the first child after the age of twenty years is appropriate. Whereas about 30 percent of the male respondents replied below the age of twenty to be appropriate for the age of first child birth. The major reason for appropriate age for the first child was viewed to be physical and mental maturity by most of the respondents.

Table 6 Gender-wise distribution of perception about most appropriate age at marriage

Variable	**Gender**				**Total**	
	Female		**Male**			
	n	**%**	**n**	**%**	**n**	**%**
Most appropriate age at marriage						
Less than twenty years	697	59.9	407	37.4	1004	44.6
More than twenty years	467	40.1	680	62.6	1147	51.0
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Most appropriate age at first child						

birth						
Less than twenty years	132	11.3	318	29.3	450	20.0
More than twenty years	1032	88.7	769	70.7	1801	80.0
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Reason of suitability						
Physical and mental maturity	733	63.0	746	68.6	1479	65.7
Caring and rearing of children	98	8.4	79	7.3	177	7.9
Adequate education	56	4.8	26	2.4	82	3.6
If marriage at early age than mother will be little week	55	4.7	52	4.8	107	4.8
Self dependence	65	5.6	58	5.3	123	5.5
Harmful to mother and children	46	4.0	47	4.3	93	4.1
Problem of uterine prolaspe	13	1.1	8	0.7	21	0.9
Don't know	97	8.3	62	5.7	159	7.1
No response	1	0.1	9	0.8	10	0.4
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**

Regarding the physical changes during adolescence, majority of the female respondents (69 percent) replied menstruation as one of the physical changes during adolescence followed by enlargement of breast (65 percent) and appearance of hair at axilla, chest and genitalia (39 percent). Similarly, a majority of male respondents (58 percent) replied facial hair appearance followed by enlargement of genitals (38 percent) and appearance of hair at axilla, chest and genitalia (36 percent) as physical changes during adolescence. Similarly, only 18 and 5 percent of the male respondents mentioned menstruation in females and ejaculation and wet dreams in males respectively as physical changes experienced by adolescents.

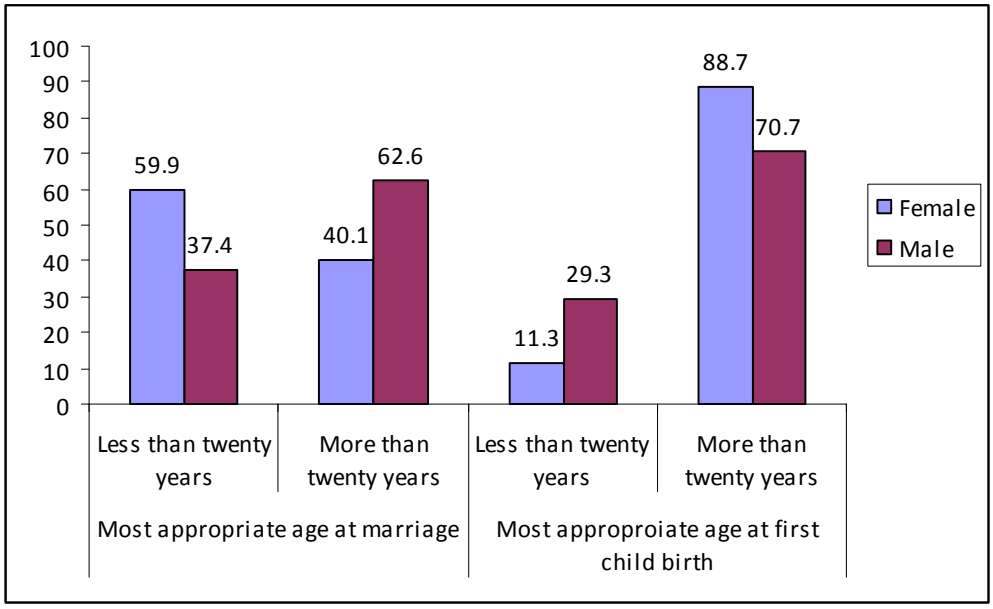

Figure 3 Percentage distribution on knowledge of most appropriate age at marriage and child birth

Table 7 Distribution of knowledge and perceived change during adolescent

Variable	Gender				Total	
	Female		Male			
	n	%	n	%	N	%
Physical change appeared during adolescent						
Yes	956	82.1	975	89.7	1931	85.8
No	208	17.8	112	10.2	320	14.2
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Knowledge on physical change of adolescent (MR)		**n=756**		**n=975**		**n=1931**
Facial hair appearance	166	17.4	562	57.6	728	37.7
Shoulders broaden	57	6.0	75	7.7	132	6.8
Appearance hair at axilla, chest and genitalia	370	38.7	347	35.6	717	37.1
Enlargement of genitals	118	12.3	370	37.9	488	25.3
Ejaculation and wet dreams	7	0.7	53	5.4	60	3.1
Pimples	89	9.3	74	7.6	163	8.4
Menstruation	661	69.1	179	18.4	840	43.5
Hip widen	24	2.5	20	2.1	44	2.3
Enlargement of breast	620	64.9	267	27.4	887	45.9
Weight gain	179	18.7	140	14.4	319	16.5

Voice change	248	25.9	304	31.2	552	28.6
Total	**956**	**100**	**975**	**100**	**1931**	**100**
Physical change experienced (MR)						
Facial hair appearance	0	0.0	410	42.1	410	21.2
Shoulders broaden	26	2.7	89	9.1	115	6.0
Appearance hair at axilla, chest and genitalia	231	24.2	269	27.6	500	25.9
Enlargement of genitals	62	6.5	361	37.0	423	21.9
Ejaculation and wet dreams	0	0.0	86	8.8	86	4.5
Pimples	29	3.0	76	7.8	105	5.4
Menstruation	699	73.1	0	0.0	699	36.2
Hip widen	21	2.2	13	1.3	34	1.8
Enlargement of breast	624	65.3	15	1.5	639	33.1
Weight gain	155	16.2	123	12.6	278	14.4
Voice change	176	18.4	337	34.6	513	26.6
Total	**956**	**100**	**975**	**100**	**1931**	**100**
Source of information on Physical change						
Teacher	553	57.8	628	64.4	1181	61.2
Friends	453	47.4	461	47.3	914	47.3
Family	264	27.6	73	7.5	337	17.5
TV	87	9.1	181	18.6	268	13.9
FM radio	170	17.8	360	36.9	530	27.4
Newspaper	56	5.9	161	16.5	217	11.2
Health workers	144	15.1	197	20.2	341	17.7
others*	123	12.9	88	9.0	211	10.9
Total	**956**	**100**	**975**	**100**	**1931**	**100**

*MR: Multiple response; * Other includes: Books, poster, pamphlets, browsers, etc.*

The respondents were also asked about the physical changes that they have experienced during adolescent period. The responses indicate that majority of female responded menstruation (73 percent) and enlargement of breast (65 percent). Whereas, majority of male responded appearance of facial hair (42 percent) as a physical change during adolescent followed by enlargement of genitals (37 percent), change of voice (35 percent) and appearance of hair at axilla, chest and genitalia (28 percent). Regarding the source of information about the physical changes during adolescents, teacher was the most important source with 61 percent reporting. Other sources of information on physical changes included friends with 47 percent reporting followed by FM radio (27 percent), health workers (18 percent), family (17 percent), TV (14 percent) and Newspaper (11 percent). The source of information when ranked, however, differed for male and females. Teachers, friends, family followed by FM radio were the major sources of information for female respondents. For male respondents teacher, friends, FM radio followed by health workers respectively were the major source of information. Only 7.5 percent of the male respondents have heard about the physical changes during adolescence from their family members.

Table 8 Distribution of knowledge on difference of adolescent problem and reason of difference

Variable	Gender				Total	
	Female		Male			
	n	%	n	%	n	%
Problem of adolescent is different from other age group						
Yes	684	76.7	671	71.4	1355	74.1
No	184	18.1	244	24.0	428	21.1
Don't Know	296	5.1	172	4.6	468	4.9
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Reason of difference	**n=684**		**n=671**		**n=1355**	
Highly energetic age	59	8.6	35	5.2	94	6.9
Due to adolescent period	300	43.9	413	61.5	713	52.6
Inadequate maturity of organ	67	9.8	31	4.6	98	7.2
Lack of awareness	105	15.4	80	11.9	185	13.7
Opposite sex attraction	20	2.9	19	2.8	39	2.9
Others*	133	19.4	93	13.9	226	16.7
Total	**684**	**100**	**671**	**100**	**1355**	**100**

** Other includes: less maturity, lack decision making capacity, etc.*

Respondents were asked whether the problems experienced by adolescents are different from the problems of other age groups. Majority of the respondents replied that the problems faced by adolescent and other groups were different. And the major reason behind such difference was reported to be their age factor (53 percent) and lack of awareness (14 percent). A very few respondent (3 percent) replied getting attracted to opposite sex as a reason for their problem.

Table 9 Distribution of information related to family planning

Variable	Gender				Total	
	Female		Male			
	n	%	N	%	n	%
Ever heard of family planning methods						
Yes	939	80.7	944	86.8	1883	83.7
No	225	19.3	143	13.2	368	16.3
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Measures to prevent pregnancy (MR) n=939			**n= 944**		**n=1883**	
Abstinence	305	32.5	294	31.1	599	31.8
Use of contraceptive	749	79.8	876	92.8	1625	86.3

measures						
Use medicines	282	30.0	192	20.3	474	25.2
Others	64	6.8	99	10.5	163	8.7
Total	**939**	**100**	**944**	**100**	**1883**	**100**
Knowledge on method of family planning (MR)						
OCP	732	78.0	612	64.8	1344	71.4
Depo-provera	627	66.8	377	39.9	1004	53.3
Cupper T	328	34.9	257	27.2	585	31.1
Norplant	269	28.6	218	23.1	487	25.9
Condom	772	82.2	886	93.9	1658	88.1
Others*	29	3.1	33	3.5	62	3.3
Total	**939**	**100**	**944**	**100**	**1883**	**100**
Knowledge on place of family planning methods (MR)						
Government. Health Institutions	886	94.4	928	98.3	1814	96.3
Pvt. Clinic	153	16.3	276	29.2	429	22.8
Medical shop	224	23.9	344	36.4	568	30.2
FCHV	325	34.6	249	26.4	574	30.5
Others	10	1.1	66	7.0	76	4.0
Total	**939**	**100**	**944**	**100**	**1883**	**100**
Ever heard of emergency contraceptives						
Yes	122	13.0	124	13.1	246	13.1
No	817	87.0	820	86.9	1637	86.9
Total	**939**	**100**	**944**	**100**	**1883**	**100**

*MR: Multiple response; * Other includes: abstinence, calendar method, male withdrawal, etc.*

The study attempted to understand respondent's knowledge regarding the family planning services. In general, about 84 percent of the respondents had ever heard about family planning methods, the percent was slightly high in male compared to females. The respondents were asked about different measures of preventing pregnancy. Of those who have heard about family planning methods, about 93 percent of the male and 80 percent of female respondents replied use of contraception as a measure to prevent pregnancy followed by abstinence (32 percent), and use of medicines (25 percent) respectively.

Respondents were asked about different methods of family planning. Majority of the respondents were aware about condom (88 percent) followed by oral contraceptive pills (OCP), Depo-provera, Copper-T and Norplant respectively. The knowledge on condom was higher among males than females and vice versa on family planning devices used by women. Government health institutions (96 percent) were the highest responded place for availability of family planning methods followed by FCHV (for female respondents) and Medical shops (for male respondents). Similarly, respondents seem to have limited knowledge about emergency contraceptives. In general, about 87 percent have not heard of emergency contraceptives.

The study tried to understand the level of awareness on HIV and AIDS among the adolescents. Eighty eight percent of the respondents replied that they have heard of HIV and AIDS but the figure differed when compared to gender. Only about 85 percent of the female respondents have heard of HIV and AIDS while it was 91 percent for male respondents. The result indicates that compared to male adolescents, female adolescent are less aware of HIV and AIDS. Respondents were asked about different mode of transmission of HIV with multiple response options. Among those who had heard of HIV and AIDS, majority of the respondents were aware that HIV is transmitted by unsafe sexual contact with PLHIV (94 percent) followed by transmission through infected needles (69 percent). Respondents seem to be less aware of mother-to-child transmission (32 percent). Similarly, respondents were asked about different types of STIs. Almost 94 percent of the respondents were aware of HIV/AIDS as a type of STI followed by Syphilis (42 percent). A very few respondents could name Gonorrhea (14 percent) and Hepatitis (6 percent).

Table 10 Distribution of knowledge on HIV and AIDS by gender

Variable	**Gender**				**Total**	
	Female		**Male**			
	n	**%**	**N**	**%**	**N**	**%**
Ever heard of HIV and AIDS						
Yes	992	85.2	990	91.1	1982	88.0
No	172	14.8	97	8.9	269	12.0
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Mode of transmission of HIV (MR) n=992			**n=990**		**n=1982**	
Unsafe Sexual contact with PLHIV	918	92.5	948	95.76	1866	94.1
Blood from PLHIV	671	67.6	543	54.85	1214	61.3
Mother to child transmission	351	35.4	285	28.8	636	32.1
Transmission through sharing of infected needles	658	66.3	666	67.3	1324	66.8
Others	49	4.9	74	7.5	123	6.2
Total	**992**	**100**	**990**	**100**	**1982**	**100**
Knowledge on types of STI (MR)						
HIV/AIDS	919	94.1	908	93.2	1827	93.6
Hepatitis	66	6.8	58	6.0	124	6.4
Syphilis	395	40.4	430	44.1	825	42.3

Gonorrhea	116	11.9	152	15.6	268	13.7
Others	50	5.1	49	5.0	99	5.1
Don't know	21	2.1	16	1.6	37	1.9
Total	**977**	**100**	**974**	**100**	**1951**	**100**
Ever heard of VCT						
Yes	529	54.1	635	65.2	1164	59.7
No	448	45.9	339	34.8	787	40.3
Total	**977**	**100**	**974**	**100**	**1951**	**100**
Source of information on STI and HIV (MR)						
Teacher	785	79.1	828	83.6	1613	81.4
Friends	371	37.4	501	50.6	872	44.0
Family	157	15.8	72	7.3	229	11.6
TV	257	25.9	251	25.4	508	25.6
FM radio	398	40.1	517	52.2	915	46.2
New paper	107	10.8	221	22.3	328	16.5
Health worker	234	23.6	277	28.0	511	25.8
Others*	83	8.4	85	8.6	168	8.5
Total	**992**	**100**	**990**	**100**	**1982**	**100**

*MR: Multiple response; * Other includes: Books, poster, pamphlets, browsers, etc.*

Similarly, for majority of the respondents (82 percent) teachers were the source of information on STI and HIV followed by FM/Radio (46 percent) and friends (44 percent).

Respondents' knowledge on sexual and reproductive health was also assessed during the study. The result shows that only about 22 percent of the respondents were aware about sexual and reproductive health. Similarly, when the respondents were asked if information on ASRH issues was available in their community, half of the respondents replied that there were no such information centers for ASRH issues. Additionally, about 70 percent of the respondents reported that they have never visited any ASRH related information centers. The most common reason as reported by the respondents for not visiting such information centers was because they never had any problems related to ASRH.

Table 11 Distribution of knowledge and practice of respondents on ASRH

Variable	**Gender**		**Total**
	Female	**Male**	

	n	%	N	%	n	%
Knowledge on sexual and reproductive health						
Yes	233	20.9	231	22.3	464	21.6
No	931	79.1	856	77.7	1787	78.4
Total	1164	100	1087	100	2251	100
Availability of information centre for ASRH issue						
Yes	565	48.7	534	49.3	1099	49.0
No	599	51.2	553	50.7	1152	51.0
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Ever received information from information centre						
Yes	293	39.0	272	29.0	565	30.4
No	871	68.0	815	71.0	1686	69.6
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Reason of not visiting the centers	**n=871**		**n=815**		**n=1686**	
Due to distance	57	6.5	28	3.4	85	5.0
Availability of untrained staffs	30	3.4	26	3.2	56	3.3
Lack of confidentiality	20	2.3	16	2.0	36	2.1
Not needed	447	51.3	494	60.6	941	55.8
Unavailability of service	51	5.9	85	10.4	136	8.1
Others	21	2.4	34	4.2	55	3.3
Don't know about the centre	245	28.1	132	16.2	377	22.4
Total	**871**	**100**	**815**	**100**	**1686**	**100**
Preferred person to discuss on ASRH issue (MR)						
	n=1164		**n=1087**		**n=2251**	
Friends	815	70.0	907	83.4	1722	76.5
Parents	377	32.4	44	4.0	421	18.7
Siblings	225	19.3	26	2.4	251	11.2
Teachers	72	6.2	78	7.2	150	6.7
Health workers	213	18.3	293	27.0	506	22.5
Others*	53	4.6	27	2.5	80	3.6
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**

*MR: Multiple response; * Other includes: FCHV, other family members, etc.*

The respondents were asked about the person they prefer to discuss about ASRH issues. The result shows that friends (76.5 percent) are the most preferred by adolescents to discuss about their ASRH issues. After friends, female respondents preferred parents (32 percent) to talk about their ASRH issues whereas male respondents preferred health workers (27 percent). However, from the result we can conclude that friends are the most important person for adolescent to discuss about their ASRH issues.

Table 12 Distribution of respondents ever faced problem related ASRH

Variable	Gender				Total	
	Female		Male			
	n	%	n	%	n	%
Ever faced any problem related to ASRH						
Yes	362	31.2	102	9.4	464	20.7
No	802	68.8	985	90.6	1787	79.3
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Ever discuss about the problem with anyone			**n=102**			
n=362					**n=464**	
Yes	300	82.87	77	75.49	377	44.2
No	62	17.13	25	24.51	87	9.5
Total	**362**	**100**	**102**	**100**	**464**	**100**
Person discuss on Sexual and reproductive health problem (MR)						
Friends	192	53.0	52	51.0	244	52.6
Mothers	216	59.7	19	18.6	235	50.6
Father	26	7.2	14	13.7	40	8.6
Siblings	64	17.7	4	3.9	68	14.7
Teachers	12	3.3	0	0.0	12	2.6
Health workers	63	17.4	16	15.7	79	17.0
Others*	6	1.7	4	3.9	10	2.2
Total	**362**	**100**	**102**	**100**	**464**	**100**

*MR: Multiple response; * Other includes: FCHV, other family members, etc.*

Similarly, the respondents were asked if they have ever faced any problems related to ASRH. About 91 percent of the male respondents and about 69 percent of the female respondents replied that they have never faced any problems related to ASRH. Among those who have faced the problem, about 25 percent of male respondents and 17 percent of the female respondents never discussed about their problems with anyone.

Table 13 Distribution of information related to availability and use of ASRH service

Variable	Gender				Total	
	Female		Male			
	n	%	n	%	N	%
Available health institution provide ASRH service						
Yes	623	53.6	682	63.0	1305	58.1
No	541	46.4	405	37.0	946	41.9
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Available service (MR)	**n=623**		**n=682**		**n=1305**	
Information and	405	65.0	496	72.7	901	69.0

counseling						
Health check up	404	64.8	392	57.5	796	61.0
Supply of medicine and condom	133	21.3	160	23.5	293	22.5
Others	17	2.7	27	4.0	44	3.5
Total	**623**	**100**	**682**	**100**	**1305**	**100**
Ever received ASRH service in last six months						
		n=1164	**n=1087**		**n=2251**	
Yes	88	7.6	30	2.8	118	5.3
No	1076	92.4	1057	97.2	2133	94.7
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Reason of receiving service	**n= 88**		**n=30**		**n=118**	
Problem related to reproduction and sexual organ	18	20.5	11	36.6	29	24.6
Swelling of testes	0	0.0	4	13.3	4	3.4
Menstrual problem	40	45.5	0	0.0	40	33.9
Problem related to discharge	3	3.4	2	6.7	5	4.2
Lower abdominal pain	26	29.5	1	3.3	27	22.9
Others*	1	1.1	12	40.0	13	11.0
Total	**88**	**100**	**30**	**100**	**118**	**100**
Problem resolved after visiting HI						
Yes	62	70.5	19	63.3	81	68.6
No	26	29.5	11	36.7	37	31.4
Total	**88**	**100**	**30**	**100**	**118**	**100**
Again went to HI						
Yes	27	30.7	5	16.7	32	27.1
No	61	69.3	25	83.3	86	72.9
Total	**88**	**100**	**30**	**100**	**118**	**100**

** Other includes: problem related to premature ejaculation; psychosexual problem,etc.*

In the next step, the respondents were asked about the availability of ASRH services in the health facility located in their community. About 54 percent of the female respondents and 63 percent of the male respondents replied that ASRH service is available in their nearby health facility. Of those affirming the availability of ASRH services, information and counseling (69 percent) was the service mostly reported by the respondents followed by health check-up (61 percent) and supply of medicine and condom (22 percent).

Table 14 Distribution of information on source of information and media habit by gender

Variable	**Gender**				**Total**	
	Female		**Male**			
	n	**%**	**n**	**%**	**N**	**%**
Sources of information on SRH (MR)						

School and Curriculum	833	71.6	884	81.3	1717	76.3
Friends	439	37.7	552	50.8	991	44.0
FM and Radio	642	55.2	691	63.6	1333	59.2
TV	349	30.0	310	28.5	659	29.3
Magazines	172	14.8	319	29.3	491	21.8
Internet	23	2.0	53	4.9	76	3.4
Health workers	347	29.8	383	35.2	730	32.4
Others*	100	8.6	72	6.6	172	7.6
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Most Preferred media						
FM/Radio	636	54.9	626	57.7	1262	56.2
TV	389	33.6	282	26.0	671	29.9
Paper and magazines	81	7.0	101	9.3	182	8.1
Internet	22	1.9	40	3.7	62	2.8
No response	36	2.6	38	3.4	74	2.7
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**

** Other includes: Books, poster, pamphlets, browsers, etc.*

The study further attempted to understand the utilization of ASRH services in the last six months. The result shows that the utilization of ASRH services is very low with only about 8 percent of the female respondents and about 3 percent of male respondents visiting the health facility for ASRH service within the last six months. The most frequent reason for visiting the health facility as reported by female respondents was due to menstrual problem (45 percent). The result further indicates that the problem of more than 30 percent of the respondents was not solved even after visiting the health facilities.

Table 15 Distribution of information related to ASRH in formal education program

Variable	**Gender**				**Total**	
	Female		**Male**			
	n	**%**	**n**	**%**	**N**	**%**
ASRH is included in your curriculum (only among 8 grade and above)						
Yes	653	100	703	100	1356	100
Total	**943**	**100**	**938**	**100**	**1881**	**100**
Teacher teach that lesson	**n=653**		**n=703**		**n=1356**	
Yes	639	97.9	690	98.2	1329	98.0
No	14	2.1	13	1.8	27	2.0
Total	**653**	**100**	**703**	**100**	**1356**	**100**
Content is adequate to understand ASRH	**n= 639**		**n=690**		**n=1329**	
Yes	512	80.1	522	75.7	1034	77.8
No	127	19.9	168	24.3	295	22.2
Total	**639**	**100**	**690**	**100**	**1329**	**100**

Respondents were asked about their sources of information, especially regarding ASRH information. For majority of the respondents, school/curriculum was the source of information (76 percent) followed by FM and radio for 50 percent of the respondents and Friends (44 percent). Similarly, regarding the most preferred media for information, more than half of the respondents reported FM/Radio to be the preferred media followed by TV.

Table 16 Distribution of information of ASRH with family member

Variable	Gender				Total	
	Female		Male			
	n	%	n	%	N	%
Ever discuss on ASRH issues with family members						
Yes	291	25.1	51	4.7	342	15.2
No	873	74.9	1036	95.3	1919	84.8
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Discussion of ASRH issue with family member is easy n=291 n=51					**n=342**	
Yes	245	84.2	36	70.6	281	82.2
No	46	15.8	15	29.4	61	17.8
Total	**291**	**100**	**51**	**100**	**342**	**100**
Reason of easy	**n=245**		**n=36**		**n=281**	
Supportive family	209	85.3	27	75.0	236	84.0
Others*	36	14.7	9	25.0	45	16.0
Total	**245**	**100**	**36**	**100**	**281**	**100**

** Other includes: family member help to get solution, understand there problem, etc.*

Respondents were asked if they have ever discussed ASRH issues with their family members. Out of 2252 respondents, about 85 percent have never discussed on ASRH issues with their family. The frequency of not discussing with family was higher among male (95 percent) than female (75 percent). Among those who discussed, about 82 percent felt easy to discuss with their family members and the major reason for feeling ease as reported was because of their supportive nature.

Table 17 Distribution of information of organization working on ASRH issue

Variable	Gender				Total	
	Female		Male			
	n	%	n	%	n	%
Any organization working on ASRH issues						
Yes	360	31.0	372	34.3	732	32.6
No	804	69.0	714	65.7	1518	67.4
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Types of service provided by the organization (MR)n=360 n=372					**n=732**	
Information	289	79.8	325	86.7	614	83.9

Check up	175	48.3	205	54.7	380	51.9
Counseling	185	51.1	233	62.1	418	57.1
Others*	7	1.9	17	4.5	24	3.3
Total	**360**	**100**	**372**	**100**	**732**	**100**

*MR: Multiple response; * Other includes: medicine, family planning commodities, etc.*

Information related to sexual relationship was also assessed after building good rapport with the respondent and ensuring the ethical measures because of its sensitiveness. Among those who were unmarried, about 9 percent of the respondents had experienced sexual relationship and the rate was much higher in male (17 percent) as compared to female respondents (2 percent). Furthermore, among those had premarital sexual relationship, about 45 percent of the male respondents and 20 percent of female respondents had more than one sexual partner. Similarly, regarding the use of contraception, about 30 percent of the respondents reported to have never used any contraceptive methods during their sexual relationship. The result further indicates that adolescents are likely to be influenced by their friends for sex. About 6 percent of the female respondents and 33 percent of male respondents were reported to be influenced by the friends for sexual relationship.

Table 18 Distribution of information related to sexual behavior of respondents

Variable	**Gender**				**Total**	
	Female		**Male**			
	n	**%**	**n**	**%**	**n**	**%**
Ever had sexual contact						
Yes	20	1.8	175	16.9	195	9.2
No	1062	98.2	861	83.1	1923	90.8
Total	**1082**	**100**	**1036**	**100**	**2118**	**100**
Age at first sex (mean±SD)	**14.9 ±3.5**		**15.6±7.9**		**15.5±7.4**	
Do you have more than one sexual partner	**n=20**		**n=175**		**n=195**	
Yes	4	20.0	78	44.6	82	42.1
No	16	80.0	97	55.4	113	57.9
Total	**20**	**100**	**175**	**100**	**195**	**100**
Ever use Contraception						
Yes	17	85.0	120	68.6	137	70.3
No	3	15.0	55	31.4	58	29.7
Total	**20**	**100**	**175**	**100**	**195**	**100**
Ever influenced for sex by your friends /colleague	**n=1164**		**n=1087**		**n=2251**	
Yes	67	5.9	360	33.5	427	19.3
No	1052	92.7	703	65.4	1755	79.4
No response	45	1.4	24	1.1	69	1.3
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**

Similarly, respondents were asked if they have ever discussed about harmful effects of unprotected sex with their friends. The result shows that about 70 percent of the male and

51 percent of the female respondents discuss with their friends about the harmful effect of unprotected sex. It was interesting to find out that about 30 percent of the respondents discuss about sexual matters with opposite sex.

Table 19 Distribution of information related to behavior of discussion of harmful effect of unprotected sex

Variable	Gender				Total	
	Female		Male			
	n	%	n	%	n	%
Ever discuss on harmful effects of unprotected sex with friends						
Yes	579	51.5	747	69.7	1326	60.4
No	530	47.1	312	29.1	842	38.3
No response	55	1.4	28	1.1	82	1.3
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Ever discuss among sexual matters with opposite sex						
Yes	292	25.1	372	34.2	664	29.5
No	376	32.3	465	42.8	841	37.4
No response	496	42.6	250	23.0	746	33.1
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**

The study also tried to understand the perception of adolescents regarding their preferred structure of ASRH services provided for them. Regular and confidential service (22 percent) was reported to be the most necessary service to provide ASRH services, followed by counseling service (12 percent), establishment of information center (10 percent) and delivery of information through media like FM (9 percent). Similalry, establishment of youth clubs, gender friendly staff (female provider for female client), adolescent friendly services and establishment of information center in every school were reported as necessary for providing ASRH service.

Table 20 Distribution of information related to necessary structure for providing ASRH service

Variable	Gender				Total	
	Female		Male			
	n	%	n	%	n	%
Structure necessary for providing ASRH service (MR)						
Establishment of information centre related to ASRH	124	11.1	105	9.9	229	10.5
Counseling service to adolescent	78	7.0	183	17.2	261	12.0
Establishment of adolescent friendly service	44	3.9	48	4.5	92	4.2
Establishment of information centre at every school	26	2.3	28	2.6	54	2.5
Provision of gender friendly health	55	4.9	59	5.6	114	5.2

staff (female staff for female)						
Provision of medicine and other commodities	26	2.3	25	2.4	51	2.3
Regular/ confidential service	227	20.3	245	23.0	472	21.7
Establishment of youth club	90	8.1	65	6.1	155	7.1
Information related to adolescent should be delivered through media like FM	105	9.4	86	8.1	191	8.8
Don't know	198	17.7	143	13.5	341	15.6
Others*	120	10.7	72	6.8	192	8.8
No response	71	2.1	28	0.4	99	1.3
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**
Preferred place for ASRH service (MR)						
Government. health institution	694	59.6	707	65.0	1401	62.2
Pvt. health institution	115	9.9	191	17.6	306	13.6
WDO	223	19.2	18	1.7	241	10.7
Youth clubs	91	7.8	219	20.1	310	13.8
Campus/High school	71	6.1	104	9.6	175	7.8
Independent organization	114	9.8	142	13.1	256	11.4
Total	**1164**	**100**	**1087**	**100**	**2251**	**100**

*MR: multiple response; *Other includes: increase the opening hour, decrease administrative huddles at health institution, etc.*

The study also explored the preferred place for availability of ASRH service. Majority of the respondents replied government hospital (62 percent) as a preferred place for availability of ASRH services followed by youth clubs and private health institution. However, female respondents preferred women development office after government hospital for the service.

Chapter IV -Qualitative findings

4.1 FGD findings

4.1.1 Findings from Parents

Main health problems in society

The major health problems in society are fainting, muscular cramp, abdominal pain, over bleeding during menstruation. Most of the adolescent elope at the age of 14-15 year. Most of the married women whose husbands have gone abroad keep sexual relation with other person in Mela bazaar. Other problems are Illegal abortion, unsafe abortion, fever, TB, cough, typhoid, worm infestations. Still other problems found are drop out from school.

Adolescents are demanding their rights but they do not fulfill their responsibilities. They also think that having sexual relations are their right.

Problems related to sexual and reproductive health of adolescents

The adolescents are increasingly involved in unsafe sexual relations including multiple sex partners. Unsafe sex has led to increased unwanted pregnancy resulting in the adverse social consequences to affected girls and their families. Likewise, many girls face irregular menstruation, lack proper knowledge on ASRH. The girls do not share their problems because they are afraid of being rejected in the society.

Other SRH problems are sexually transmitted infections, unwanted pregnancy and unsafe abortion. Adolescents do not have proper knowledge on ASRH.

Knowledge, attitude, practice and behavior

Unsafe sex with multiple sex partners is increasing. There is also problem of early marriage as some adolescents marry as early as the age of 13 years. Mobile phones have spoiled our children to a great extent .They spend most of their time in watching pornographic movies and sending text messages in mobile phones. They spend around 1500 rupees in their mobiles in a month. So we want the government to prevent accessibility of all those unwanted movies. They knowingly pretend do not understand.

Smoking and drinking alcohol is seen in most of the boys. Most of the adolescent have knowledge but they do not use in practical.

SRH service delivery from government and non government sector

The organizations working on ASRH area are schools, health institutions, Women Development Office (WDO) and FM radio. Though some organizations are working on ASRH, the youth-friendly services are still inadequate. The health institutions provide general check up, some medicines, contraceptive, counseling, advice and trainings to the adolescents.

Types of services provided

The services provided to adolescents are general check up, medicine, contraceptive distribution, advice and counseling and sometimes training.

Quality of services

The service quality is very poor. Separate services for adolescents do not exist so there is problem of confidentiality. Still unsafe abortions are taking place.

First approach for service seeking

Most of girls do not share their ASRH problems due to the fear of social stigma. Boys usually go to HI for contraceptives. Only if problem becomes serious, do adolescents visit health institutions. Most of the adolescents visit His outside their own district or private clinic or hospital for maintaining their privacy.

> *"Praya gari yahaka kishoreeharu aafna shamashya lukayera baschhan sabai bhanda yahi thulo shamshya ho .... "*

Problems faced by adolescent boys and girls

Adolescents have reproductive health problems, however they have not availed services because they feel lack of privacy. They also feel ashamed to go to health institutions with reproductive health problems. They also fear rejection from society if found with issues of reproductive health.

Attempts to enhance access and utilization

Public as well as private sectors do not seem to take seriously ASRH problems and issues. Community leaders lack knowledge on adolescent ASRH issues. Hence access and utilization of quality service is limited.

HRH

Staff do not present regularly in health institutions. Youth friendly service is lacking because of lack of capacity of staff. Also, local staff are not recruited which hampers the friendly service and privacy provided.

Suggestions and recommendations

Mela bazaar (programs at night) should be banned. There should be no provision of abortion in the villages because this leads to perversion among girls. Awareness programs should be launched in each and every ward including schools. Teachers should be provided training on friendly behavior and counseling. Watching movies in mobiles should be prohibited. The health institutions should have skilled health workers as per sanctioned posts. The health workers need to show friendly behavior to patients and patient party. Parents also need to be friendly with their sons and daughters. For this orientation program should be launched among parents. There should be punishment for those who are doing unsafe abortion. Each village needs a center for awareness established. The curriculum of schools should also be revised to make it broad to include SRH issues.

4.1.2 Findings from FCHVs

Main health problems in society

The main health problems in our society are pneumonia, diarrhea, uterine prolapsed, worm infestations, irregular menstruation with heavy bleeding and TB.

Sexual and reproductive health problems of adolescents

Sexual transmitted infections, unsafe sex, unsafe abortion, smoking, alcoholism, school drop-out and early marriage are prevailing problems of adolescents. Likewise, rampant mobile use and indulgence in watching movies in mobiles and sending unnecessary messages are other problems in adolescents.

Knowledge, attitude, practice and behavior

Most of the adolescents have knowledge regarding reproductive and sexual health but they do not practice them. Some of them pretend not knowing anything about these matters. Adolescents' behavior is not improving because of parents' negligence also. The adolescents think that making sexual relation is their right.

SRH service delivery from government and non government sector

The schools, health institutes, FM radio are involved in delivery of services and information to the adolescents.

Types of services provided

The services provided to adolescents are general check up, medicine, contraceptive distribution, advice and counseling and sometimes training.

Quality of services

There is not separate service for adolescents thereby affecting their privacy.

First approach for services

Some of the youths approach first to traditional healers whereas others visit health institutions, private clinic or hospital and NGO run service facilities in case of having health problems.

Problems faced by adolescent boys and girls

Adolescents have many problems but they don’t disclose due to their lack of faith in the service provided or they fear exclusion from society. There is also problem of unsafe abortion resulting excessive bleeding and other complications. Girls are having unsafe abortion because of lack of proper advice, counseling and treatment. Some girls have to be taken to outside district for treatment of complications due to unsafe abortion.

Attempt to enhance access and utilization

Public as well as private sectors do not seem to take seriously ASRH problems and issues. Community leaders lack knowledge on adolescent ASRH issues. Hence access and utilization of quality service is limited.

HRH

Staff do not present regularly in health institutions. Youth friendly service is lacking because of lack of capacity of staff. The staff at health institutions is not local which hampers the friendly service and privacy provided.

Suggestions and recommendations

The boys should be looked after by male health workers and the girls should be looked after by the female health workers. Youth information centre should be established in each health institution and PHC outreach clinic. Awareness program should be conducted time to time for local leaders, adolescents, school drop-out children. Trainings programs should be conducted for parents regarding their behavior to their sons and daughters. It would be better if each health institution has safe abortion service facilities.

4.1.3 Findings from adolescent boys and girls

Main health problems in society

Most of the adolescents have problems of pimples, lower stomach pain, cough, gastritis, low blood pressure and sometimes rape cases. Other problems are early marriage leading to early pregnancy. They also face discrimination by society. School dropout, drinking alcohol and smoking are problems especially among adolescent boys.

Due to poor sanitation, different diseases like dysentery, scabies, and diarrhea are occurring often. Likewise, *deuki pratha, chhaupadi,* mental illness and malnutrition are also main health problems. There is discrimination and inequalities with regards to gender.

Problems related to sexual and reproductive health of adolescents

The girls suffer from venereal diseases with symptoms like burning micturition, foul smelling white discharge from vagina. Still other problems are irregular menstruation, itching in breasts and nodules in breast. In some cases, menarche has not occurred even at the age of 22 years. Physical development occurred is not matching with the age in some adolescent girls because of poor nutritional status. Unsafe sex leading to unwanted pregnancy has resulted in refusal of girls by society for marriage.

The boys also suffer from STIs due to unsafe sexual relations. They watch pornographic movies. Drug addiction is seen in both boys and girls. The problem of drug addiction has led to criminal activities. Other SRH problems are cancer of uterus, rashes in body and genitals and child marriage.

Knowledge, attitude, practice and behavior

There is gender discrimination in society and family. Adolescents go to private service providers in case of treatment of sexual diseases. The education that we get in school is only theoretical. We lack sufficient knowledge in ASRH. Traditional practices still prevail, however there is growing tendency to seek services from modern health facilities.

SRH service delivery from government and non government sector

We get services from FM radio, school and health institutions. We also get orientation on ASRH sometimes. KIRDARC has provided programs related to access to education in

health related issues. Only minor treatment and referral services are provided by the health post. Health post also provides SRH information upon request.

Types of services provided

The health institutions provide general physical check up, medicines, contraceptives, counseling, advices and sometimes training. Only a few adolescents have got information on SRH.

Quality of services

We think that the quality is poor because there is no privacy or separate service for adolescents. Only general suggestions, health education and simple treatments of STI are provided. No separate service is provided for adolescents.

First approach for services

If we have health problems, we first approach to health institutions because of free services and sometimes also private clinics and hospitals. We also approach Maryland, an NGO for availing services. Some of adolescents are first going to private clinics because of availability of better medicines and better treatment.

Problems faced by adolescent boys and girls

We have many private things to take advice upon but we don't have reliable persons for that. We are ashamed to get check up for STIs even though we are affected. We have many problems but no one seems to care for that. There is lack of adequately skilled human resources and lack of medicines and equipment. Negative attitude of health workers is one of the problems faced by adolescents.

"स्वास्थ्य संस्थामा धेरै मान्छे हुन्छन हाम्रा आफन्त पनि आएका हुन्छन भन्नै लाज हुन्छ अनि त्यतिकै टाउको दुखेको औषधी मागेर लिएर आउछौ ।"

Attempts to enhance access and utilization

We have not felt that government, public and private sectors are taking any serious attempt to address our problems. There is also lack of knowledge in community leaders regarding our needs.

"साच्चै भन्नु पर्दा हाम्रो लागी भनेर कुनै सेवा लिने ठाउ छैन हाम्रो त कुनै समस्या नै हुदैन नत घरमा बाबा आमा ले नै मैत्री व्यावहार गर्नु हुन्छ नत स्वास्थ्य कर्मीले,नत विधालयमा शिक्षकले अनि हामीले कहा जाने? को संग भन्ने? के हामी मा समस्या हुदैनन् र? विरामी परेर सुत्न मात्र समस्या हो?खै त सरकार को ध्यान पुगेको?"

- An adolescent from Tharpu

HRH

The staffs are fulfilled only in paper. Those who are present in health institutions do not take our problems seriously, staffs are not present regularly. Absenteeism and irregularity in work are also HRH problems affecting service delivery. The capacity of staff to provide service is also lacking. The staffs working in health institutions are not local staff.

Suggestions and recommendations

Government should establish Youth Information Centre (YIC) separately. There should be provision of condom box which would facilitate us for getting it easily. The male staff should deal with the male adolescents and female staff should deal with the female staff.

> "साथी संगको मनको कुरा कार्यक्रम एफ एम रेडियो मार्फत ASRH सम्बन्धि जानकारी पाए राम्रो हुने थियो।"
>
> - An adolescent from Panchthar

It would be helpful if we could talk on phone with physicians for free regarding ASRH issues. The health workers doing illegal abortion should be strictly punished. Essential drugs should be available all the year in health institutions. Awareness programs should be launched for adolescents and the curricula should be more detail and practical. It would be better if each health institution has facility for safe abortion services.

4.1.4 Findings from HFMC members

Main health problems in society

The main health problems in our society are jaundice, asthma, fever, cough, diarrhea, worms and pneumonia. Likewise, headache, stomach pain, high blood pressure, tuberculosis, fainting of some girls in schools and diabetes are also problems in our society.

Problems related to sexual and reproductive health of adolescents

The SRH problems of adolescents are unsafe sex leading to unwanted pregnancy which ultimately results in refusal of girls for marriage purpose. Early marriage and early pregnancy are prevalent among girls. These have also resulted in poor quality of life of women. Multiple sex partners and unsafe sex are also problems among adolescents. Some of adolescents are watching pornographic movies and indulge in texting unnecessary messages most of the time. Other ASRH problems are illegal and unsafe abortion, alcoholism, smoking and school dropout.

Knowledge, attitude, practice and behavior

Many adolescents lack knowledge on SRH issues. They only study to pass exams. However, some adolescents knowingly pretend not to know or understand ASRH issues and they do not utilize their knowledge. Some adolescents use contraceptive.

SRH service delivery from government and non government sector

The health institutes provide limited services to adolescents.

> "किशोर किशोरीहरुको यौन तथा प्रजनन् स्वास्थय समस्या समाधानका लागी प्रदान गरिने कुनै पनि सेवाहरु छैनन् । तर सामान्य समस्या लिएर आएमा सेवाहरु पाइ राखेका छन।"

Types of services provided

The services provided are general check up, medicine and contraceptive devices distribution, general counseling, referral service and sometimes training.

Quality of services

No separate service and privacy for adolescents is available. General health education and simple treatment of STI and RH are provided.

First approach for services

Adolescents first contact health institutions as well as private clinic, hospital and Maryland clinic (NGO run clinic).

Problems faced by adolescent boys and girls

The girls only complaint of fever, stomach ache, and headache which might be because of being ashamed to disclose their SRH problems. Hence they are facing problems and not being able to seek solutions.

Attempts to enhance access and utilization

The HFMC has not yet initiated for establishment of separate ASRH services and counseling. The future plan is to ask DDC and VDC for providing space to provide services to adolescents. Since the government's regular program has not addressed ASRH issues, there have not been serious attempts and we are also not clear on what should be done.

HRH

The regularity of staff in health institutions is a problem. We have forwarded application to the district authorities for fulfillment of vacant posts but we haven't received any reply yet.

"हे.पो. मा जम्मा १ जना अ.हे.व छ त्यो पनी कति दिन गायव हुन्छ हामीलाइ थाहै हुदैन बैठक मा सोध्यो भने जिल्लामा तालिम थियो भन्छ १ हप्ता हे पो मा वसेर १ महिनाको पुरै सहि गर्छ त्यहि १जना भएको पनि हिड्ला भनेर केहि भन्दैनौ । हजूर, नमस्ते भन्दै राखेका छौ ।"

Suggestions and recommendations

Government should facilitate establishing youth friendly information and counseling centre in each health institute and conduct training to health workers. There should be strict rules for maintaining staff regularity and continuity.

Case 1: Blind faith of parents on their children can result in negative consequences

It is an incident from Prangbung VDC of Panchthar district. This VDC can be reached by two days walk from Phidim, the headquarters of the district. There is no road access (for vehicles) yet. One day, an adolescent girl from this VDC told her parents that she was not feeling well. She complained of headache and anorexia. The parents thought it was due to the wrath of gods and goddesses and resorted to treatments from traditional healers. They were consulting and getting treatment from the traditional healers until when it was nine months and the girl delivered a baby. This shows the blind faith of parents on their children by even not suspecting of pregnancy for whole nine months.

Case 2: The message from mobile caused her to be hospitalized

It is a case from Tharpu VDC, Panchthar district. One woman in her post-partum was resting in her home. One day, an sms was delivered in her husband's mobile and she happened to open that message. From that message she came to know that her husband had love affair with another girl. She then scolded the girl over phone immediately. There was also quarrel with her husband later. After a few days, that girl came to her home and beat her badly. There was no one else in home that day. Later that day, there was complication including vaginal bleeding. They took her to the nearby health institution but it also could not treat her hence referred to the district hospital Phidim. There she was treated for a week under supervision of a female physician. Finally she got well.

Because of the message of mobile there was not only physical assaults but also endangered the relationship of the husband and wife.

4.2 Findings from stakeholders KII

General health situation

The overall health condition is poor. The same is the health condition of adolescents. Health status of adolescents is poorer in rural areas compared to urban areas of district. Traditional healers' practices and witchcraft is seen in high numbers. Common problems are diarrhea, worm infestations and pneumonia in children. Likewise, prevalent problems for women are anemia, cough, asthma, mass hysteria, diseases due to lack of hygiene and problems related to menstruation. Other problems generally affecting all the age or sex groups are TB, arthritis, joint problem and malnutrition. There is also high problem of school drop-out. Smoking and alcohol drinking are problems especially for adolescent boys.

Early marriage practice is still found in high numbers. **Girls** usually get married within **14-16 years boys** within **18-20 years**. Problems are more concentrated on adolescent girls as compared to adolescent boys. Girls and women in poorer families suffer from nutrition and urinary tract infection problems. Though events of sexual abuse do not come to our notice but sometimes they do occur. Some cases of illegal abortion are still found. During menses girls are required to stay in ***chaupadi goth***.

Problems related to sexual and reproductive health of adolescents

Early marriage and early child bearing is prevalent especially among socially and economically disadvantaged groups. They also suffer from psychological stress during menstruation. They lack adequate knowledge on sex education and family planning. Adolescent girls are facing problems of unsafe abortion as a result of unwanted pregnancy. Even married adolescents are doing abortion. Other problems of girls are abdominal pain, fainting and odd behavior. There is still *'chhaupadi pratha'* in some districts in Far West in which girls are required to live in chhaupadi goth, cattle sheds or other unsuitable places.

Due to unsafe sex some adolescents are getting STIs. Though FP devices are easily accessible in health institutions, adolescents do not take them from health facilities because of social taboos. Though events of sexual abuse do not come to our notice but sometimes they do occur. Some cases of illegal abortion are still found.

Some 3 or 4 couples per month marry by eloping and some of them again return to schools. Many adolescents leave schools after grades 6 or 7. In addition to the problems related to poverty, there are also sexual health problems. There is problem of alcoholism and cigarette smoking. Adolescents are out of guardian's control. Psychiatric problems are also observed sometimes. People are harboring disease because of shyness to disclose their problem. Many people are unaware about the adverse consequences of unsafe sex.

Because of unsafe sexual behaviors and unwanted pregnancy the practice of unsafe abortion is prevalent. Our society has put restriction on discussion regarding psychosexual matters hence there are problems of gonorrhea and conversion disorders. Four years back there was a case of eating crushed glass in an attempt to abort fetus. The woman died later. Multiple sexual partner and unsafe sexual practices are seen among adolescents. Mobile phones have spoiled the adolescents. They watch pornographic movie clips in mobile and indulge in unnecessary and excessive messaging. Problems of

gonorrhea and syphilis are also diagnosed in health institutions. Drug abuse and sexual violence are also seen.

Knowledge, attitude, practice and behavior

There is little change in views about age at marriage. Not all have access to formal education. Those who go to school know much about SRH issues yet do not always practice. Even those adolescents who have passed tenth grade feel embarrassed to talk about SRH issues.

There is gender discrimination with girls mostly limited to household chores and very less participation in social activities. Gender based violence is high in this district.
Early marriage practice is decreasing. Likewise knowledge on family planning is increasing among adolescents leading to fewer cases of abortion these days. Trend of going for foreign employment is increasing. There is still negative attitude towards HIV and AIDS. The practice of love marriage is higher than arranged marriage. Girls are still considered untouchable during their menstrual periods.

Though most of the adolescents have knowledge on SRH issues, they do not bring it in practice. They study with the objective of only passing the exams. They knowingly pretend as not knowing anything. However, some of the adolescents are having safe sexual practices. In an incident, three adolescent girls had come to hospital at sixth month of pregnancy but they did not know anything about their pregnancy. This shows how poor our adolescents are in knowledge on SRH matters. The adolescents study up to 12 class and then go abroad for foreign employment.

Although adolescents of urban and semi-urban areas do not usually marry before 20, early marriage is still prevalent in backward areas. In those areas, adolescents cannot oppose parents' decision and get married as early as 17 years. The adolescents know that early marriage is not a good practice. Most of adolescents do not have knowledge in life skills. Only about one-tenth of the adolescents have knowledge on life skills. Some of the adolescents have knowledge that safe abortion services are available. They receive ASRH information from school and media. Suicide cases among adolescents are increasing; the reason may be lack of information on stress management or in some cases due to rejection of their love by society. Smoking and alcoholism is found in some of adolescent boys.

Source of information on ASRH

The major sources of information are schools, health posts, parents and NGOs. Other sources are FM radio, TV, text books and newspapers. Likewise, FCHVs, private clinics, DACAW program of UNICEF and ayurveda hospitals are other sources of information. School going adolescents get their information mainly from the schools. Besides, many health-related NGOs are also working on adolescent issues. Government health institutions are also contributing on that. Some organizations, mostly paralegal, provide information to adolescents. Radio and television are also other sources of information. However, no information centres are formally established.

HRH

Health institutions do not have required human resources. Those who are present do not take ASRH issues seriously. They do not have necessary skills on dealing ASRH issues. Human resources are lacking even in District Health Office, which means this problem is more severe in remote areas of district. Those who are present do not provide service for the full office time. The village health worker of health post is often seen drunken. Staff nurse are lacking, however the physicians are available to some extent because of contractual employment of them.

Because of weak government, many health workers do not stay in health institutions. The sanctioned posts are not fulfilled. The staffs have lack of sense of responsibility. Though some of the staffs are loyal and have sense of responsibility there is no reward to them hence they are demotivated. Health workers make their transfer to urban areas with source of political parties; hence people in remote areas are lacking service.

Vacant posts are sometimes managed through the local level recruitment of health workers. Health workers need additional training and orientation on SRH issues. Number of female health workers is very low hindering the provision of gender-sensitive service. There are also health workers from NGO which need well coordination with the district health office.

First approach for service seeking

Adolescents first approach their friends and relatives. Educated friends bring them to health institutions while others stay at home hiding their problems until it gets worse. A few adolescent girls also approach first to private clinics and pharmacy shops especially because they cannot see a female health worker in government health institutions. Still others consult first to traditional healers, especially the illiterate ones. Using herbs on their own are also practiced. The trend of visiting modern health facilities is increasing. Most of the adolescents' first choice is modern health facilities including both public and private health care centers. Still a few people first approach to traditional healers but if the problem does not improve then they consult modern health facilities.

Most of adolescents of rural areas go to nearby health facilities. However, due to poor quality of health services in government health institutions, a few people also visit private health facilities. Adolescents of semi-urban areas prefer to go to hospital or private clinics whereas adolescents of remote area first consult to traditional healers due to cultural practices. In case of fainting and seizures, most people visit traditional healers.

SRH service delivery from government and non government sector

District health office and its health institutions, district education office, women and child welfare office, district development committee are conducting different kinds of programs for adolescents. Non government organizations working on these issues are KIRDARC in Kalikot, *Dalit Utthan Samaj*, are prominent ones. NGOs frequently provide SRH trainings. Health posts also provide RH training, mobile camps in remote areas to promote awareness on maternal health and family planning. The programs run by health institutes are inadequate since they don't have specifically designed ASRH programs. It

seems that neither government nor the NGOs have interest in SRH services. Nevertheless, some of health workers are trained in providing friendly services to adolescents. Peer group formation and education about family planning by this group has brought effective results.

Awareness activities are conducted by Women Development Office(WDO). Some NGOs are implementing activities for adolescents in the district. The quality of service is very poor. Services are not focused on specific needs of adolescents especially in local health institutions. General check up and medicine, contraceptives are distributed. Referral is done for complex cases. Some schools provide orientation of SRH issues in classes. In hospitals there are specific services like abortion, laboratory services and VCT.

Quality of services

General check-up, counseling and information about family planning and distribution of contraceptives and medicines are done in health institutions. No specific ASRH services are available.

Access to and utilization of ASRH services

Health services are still not accessible to all people and out of reach to different parts of the district. Topographical difficulties and lack of appropriate road access and vehicle services are major challenges. Lack of adequate number of female health workers has also limited access to services to adolescent girls. There are privacy and confidentiality issues and economic inaccessibility to receive services.

Many people need to walk 1-2 hours to reach to nearby health post. Some remote villages are even in a day's walking distance from their nearest health post. Also, health posts are not well equipped; hence people are not happy with the services provided. Because of these reasons, people are forced to visit private clinics and pay high fees.

Access to services is very poor. Among adolescents, the boys have more access and utilization as compared to girls. Many adolescents are not using services because of shyness. This problem is aggravated by the unavailability of counseling room. They seek services for problems other than SRH but hesitate to go to health institutions with SRH problems. Some adolescents visit health institutions to avail condoms.

Advocacy on issues and problems of ASRH (media person)

The role of media on ASRH issues is essential. We are very much interested in advocacy and communication on ASRH issues. We are 100% positive on these issues. We believe that sexual issues should not be hidden, it should be made open and well managed. Orientation and interaction programs in villages and 'toles' should be conducted. It would be better if we could provide suggestions through phones on ASRH issues.

Published articles about ASRH through local news (media person)

"कार्यक्रम योजना बनाएर सबै संघ संस्था को संजाल बनाउने र गाउ गाउ देखि समस्या घट्ना ल्याएर कथाको रुपमा समाचारको रुपमा,गितको रुपमा ,कुराकानीको माध्यमवाट ASRH सम्बन्धी संन्देशहरु समुदाय सम्म नै पुरयाउनु पर्छ।"

We have covered news and articles on why sexual problems arise and what is its importance in our newspapers. We are publishing articles on issues in life, sex and society. But we have not been able to cover the whole society.

Media persons trained on ASRH

Till now we have not received any training or have participated in interactions. We are writing articles as per our review of literature.

Overall suggestions and recommendations

Human resources for health including more female health workers, establishment of a VCT center at least in each Ilaka health post are necessary. Infrastructure development and training of health workers on specific ASRH issues are also essential to improve services. School curriculum needs to be revised to incorporate ASRH issues. Families, especially mothers, need to be given education about SRH issues so that they can counsel their children. Peer group formation in schools and community and school health program need to be increased and improved.

Awareness programs to parents and students are needed to change attitude towards SRH in society. Ward-wise information centers need to be established. Health workers should provide youth friendly services.

School teachers should not hesitate to teach the SRH topics of the curriculum. Parents should be aware of SRH and provide knowledge to their children frankly. The SRH services should be provided from separate room in health institutions to maintain privacy and confidentiality.

Programs should involve active participation of adolescents. Adolescents' problems should be first identified through survey and needed programs should be launched to cater for their needs. Credibility and confidentiality of services should be maintained. There is need to change the perspective that the society is having regarding sexuality. If BNMT could launch its program nationwide, it would be more effective.

There should be network of government and non government organizations working on ASRH issues. The programs should be launched through this network for effective program planning and implementation. Peer education program should be launched. It would be more effective if there were counseling center and a peer educator in each of health institutions.

The health workers in the districts need to be provided training on ASRH issues. The training and workshops of NGOs should also incorporate these issues. Capacity building of adolescents needs to be done through group formation and establishment of youth information centers. Health facilities need to offer adolescent friendly services with provision of separate health worker to look after

'Being a guardian I am planning to change the structure of my house to keep my daughter during her menstruation. In community, I will involve in sharing my knowledge and idea to improve girls' situation. I suggest adolescents to seek care from modern health facility rather than traditional healers. We should start changing things from our homes.'

- A guardian (household head) from Achham

them. Likewise, parents, teachers and adolescents need to be oriented ASRH issues. Political parties should be mobilized to address ASRH issues and a share of VDC budget should be allocated for ASRH programs. Sound coordination between schools and health facilities is needed to avoid duplication and make program more sustainable.

'I am planning to make conducive environment in the hospital territory so that adolescents can express their problems. I can tell health workers to check up patients attending OPD separately so that privace and confidentiality is maintained.'

- A health facility in-Charge in Achham

Chapter V- Conclusions and recommendations

4.1 Conclusions

The analysis of findings of quantitative and qualitative data/information conducted in randomly selected fifty VDCs from 10 districts (5 from each district) and three wards were selected using systematic random sampling from each VDC thus making a total of 150 wards. The study includes 1164 and 1087 respondents of both sexes were intercepted adolescents. The fieldwork was carried out in September 2011.

Characteristics of respondents

Majority of the respondents included in the study were holding lower secondary level education (36 percent) and about 6 percent of the total respondents had 10+2 and above level of education. Similarly, majority of the respondents were unmarried (almost 94 percent) and two female respondents were found to be single.

Knowledge on age at marriage and child birth

Majority of female respondents (60 percent), most appropriate age at marriage is before twenty years while for majority of the male respondents (63 percent), marrying after the age of twenty is appropriate. This result indicates a different level of perception between male and female regarding the marriage culture. More than 89 percent of the female respondents replied that having the first child after the age of twenty years is appropriate. Whereas about 30 percent of the male respondents replied below the age of twenty to be appropriate for the age of first child birth. The major reason for appropriate age for the first child was viewed to be physical and mental maturity by most of the respondents.

Knowledge on physical changes during adolescent

Majority of the female respondents (69 percent) replied menstruation as one of the physical changes during adolescence followed by enlargement of breast (65 percent) and appearance of hair at axilla, chest and genitalia (39 percent). Similarly, a majority of male respondents (58 percent) replied facial hair appearance followed by enlargement of genitals (38 percent) and appearance of hair at axilla, chest and genitalia (36 percent) as physical changes during adolescence.

Knowledge and practice related to family planning

In general, about 84 percent of the respondents had ever heard about family planning methods, the percent was slightly high in male compared to females. The respondents were asked about different measures of preventing pregnancy. Of those who have heard about family planning methods, about 93 percent of the male and 80 percent of female respondents replied use of contraception as a measure to prevent pregnancy followed by abstinence (32 percent), and use of medicines (25 percent) respectively.

Respondents were asked about different methods of family planning, Majority of the respondents were aware about condom (88 percent) followed by oral contraceptive pills (OCP), Depo-provera, Copper-T and Norplant respectively. The knowledge on condom was higher among males than females and vice versa on family planning devices used by women.
Government health institutions (96 percent) were the highest responded place for availability of family planning methods followed by FCHV (for female respondents) and Medical shops (for male respondents).
Similarly, respondents seem to have limited knowledge about emergency contraceptives. In general, about 87 percent have not heard of emergency contraceptives.

Knowledge related to HIV and AIDS
The study revealed that eighty eight percent of the respondents replied that they have heard of HIV and AIDS but the figure differed when compared to gender. Only about 85 percent of the female respondents have heard of HIV and AIDS while it was 91 percent for male respondents. The result indicates that compared to male adolescents, female adolescent are less aware of HIV and AIDS. When asked about different mode of transmission of HIV with multiple response options, among those who had heard of HIV and AIDS, majority of the respondents were aware that HIV is transmitted by unsafe sexual contact with PLHIV (94 percent) followed by transmission through infected needles (69 percent). Respondents seem to be less aware of mother-to-child transmission (32 percent).

Similarly, respondents were asked about different types of STIs. Almost 94 percent of the respondents were aware of HIV/AIDS as a type of STI followed by Syphilis (42 percent). A very few respondents could name Gonorrhea (14 percent) and Hepatitis (6 percent).

Preference of person to discuss on ASRH issues
The respondents were asked about the person they prefer to discuss about ASRH issues. The result shows that friends (76.5 percent) are the most preferred by adolescents to discuss about their ASRH issues. After friends, female respondents preferred parents (32 percent) to talk about their ASRH issues whereas male respondents preferred health workers (27 percent). However, from the result we can conclude that friends are the most important person for adolescent to discuss about their ASRH issues.

In the next step, the respondents were asked about the availability of ASRH services in the health facility located in their community. About 54 percent of the female respondents and 63 percent of the male respondents replied that ASRH service is available in their nearby health facility. Of those affirming the availability of ASRH services, information and counseling (69 percent) was the service mostly reported by the respondents followed by health check-up (61 percent) and supply of medicine and condom (22 percent).

Utilization of ASRH services
The study further attempted to understand the utilization of ASRH services in the last six months. The result shows that the utilization of ASRH services is very low with only

about 8 percent of the female respondents and about 3 percent of male respondents visiting the health facility for ASRH service within the last six months. The most frequent reason for visiting the health facility as reported by female respondents was due to menstrual problem (45 percent). The result further indicates that the problem of more than 30 percent of the respondents was not solved even after visiting the health facilities.

Ever discuss of ASRH issues with family members

Respondents were asked if they have ever discussed ASRH issues with their family members. Out of 2252 respondents, about 85 percent have never discussed on ASRH issues with their family. The frequency of not discussing with family was higher among male (95 percent) than female (75 percent). Among those who discussed, about 82 percent felt easy to discuss with their family members and the major reason for feeling ease as reported was because of their supportive nature.

Information related to sexual behavior

Among those who were unmarried, about 9 percent of the respondents had experienced sexual relationship and the rate was much higher in male (17 percent) as compared to female respondents (2 percent). Furthermore, among those had premarital sexual relationship, about 45 percent of the male respondents and 20 percent of female respondents had more than one sexual partner.

Regarding the use of contraception, about 30 percent of the respondents reported to have never used any contraceptive methods during their sexual relationship. The result further indicates that adolescents are likely to be influenced by their friends for sex. About 6 percent of the female respondents and 33 percent of male respondents were reported to be influenced by the friends for sexual relationship.

Similarly, respondents were asked if they have ever discussed about harmful effects of unprotected sex with their friends. The result shows that about 70 percent of the male and 51 percent of the female respondents discuss with their friends about the harmful effect of unprotected sex. It was interesting to find out that about 30 percent of the respondents discuss about sexual matters with opposite sex.

Suggestions and recommendations from qualitative study

Mela bazaar (programs at night) should be banned. Awareness programs should be launched in each and every ward including schools. Teachers should be provided training on friendly behavior and counseling. Watching movies in mobiles should be prohibited. The health institutions should have skilled health workers as per sanctioned posts. The health workers need to show friendly behavior to patients and patient party. Parents also need to be friendly with their sons and daughters. For this orientation program should be launched among parents. Each village needs a center for awareness established. The curriculum of schools should also be revised to make it broad to include SRH issues.

Youth information centre should be established in each health institution and PHC outreach clinic. Awareness program should be conducted time to time for local leaders, adolescents, school drop-out children and out of school adolescents. Trainings programs

should be conducted for parents regarding their behavior to their sons and daughters. It would be better if each health institution has safe abortion service facilities. There should be provision of condom box which would facilitate us for getting it easily.

It would be helpful if we could talk on phone with physicians for free regarding ASRH issues. The health workers doing illegal abortion should be strictly punished. Essential drugs should be available round the year in health institutions. Awareness programs should be launched for adolescents and the curricula should be more detail and practical. It would be better if each health institution has facility for safe abortion services. There should be strict rules for maintaining staff regularity and continuity.

Key recommendation:

1. Since knowledge on age at marriage and age at first child birth were found to be low among the respondents; effective measures to enhance knowledge on legal age at marriage and age at first child birth would be important. In this regards, all the project of BNMT and related organization should address the issue of early marriage and teen age pregnancy.

2. The knowledge related to normal changes during adolescence was not satisfactory among both male and female respondents. So, it is recommended that the program needs to empower adolescents with information related to normal changes during the adolescent period.

3. Study revealed that heard of emergency contraceptives were strikingly low among adolescents; the program need to focus on innovative approach to create awareness on emergency contraception and measures used for emergency contraception.

4. It was noted from the study, the mode of transmission of HIV (mother to child transmission) among adolescents were alarmingly low; so program needs to provide additional thrust on the mode of transmission and misconception of HIV transmission, and its prevention.

5. Since majority of adolescent respondents preferred to share information related to ASRH issues with friends; so it is recommended that peer educators and supporters group needs to be created and mobilized to tackle ASRH issues.

6. It is recommended that capacity of health institutions need to be enhanced to provide adolescent friendly and gender friendly ASRH service. Specifically, the program needs to negotiate for opening hour of health institutions, as it needs to be increased to address the problem of access to the services.

7. Radio and FM were found to be most preferred media for adolescents, so it is recommended that use of such media to create awareness would be preferred approach.

8. It was noted that higher rate of premarital sex and multiple sexual partner among adolescents. So, it is recommended that information related to safe sex needs to be included in the program to prevent pregnancy, HIV and STI.

9. It is recommended that each VDCs need a Youth Information Center (YIC) for awareness creation and the already existing YIC needs to be capacilitated.

10. It is recommended that the curriculum of schools should also be revised incorporate SRH issues of the adolescents.

11. It is recommended that program should incorporate local leaders, school drop-out children and out of school adolescents to create awareness and reduce persistent social stigmas.

Referencies

1. Abeysena, C. and Silva de J.H. (2005). HIV in South Asia. Volume 33 (Issue 6), Pages 42-43.
2. Capoor I and Patel P. (2006). Adolescent and Young People's issues and concerns in South Asia : Challenges Ahead. The International Conference on Best Practices for Scaling Reproductive Health and Family Planning Programme and Reducing Maternal and Neonatal Mortality on 20-21 November 2006 at Islamabad, Pakistan.
3. CREHPA. (1997). Sexual risk behaviour and knowledge and attitude towards condom use and HIV/AIDS transmission among men in five boarder towns of Nepal.
4. CREPHA. (1996). Reproductive Health Care Knowledge, Attitidue and Practice among Adolescent in program Areas of PLAN International; Kathmandu, Nepal.
5. GFHR, & WHO. (2007). Research Issues in Sexual and Reproductive Health for Low and Middle Income Countries. Global Forum for Health Research and World Health Organization 2007.
6. Glasier A et al. (2006). Sexual and reproductive health: a matter of life and death, The lancet, sexual and reproductive health series. The Lancet .
7. Gubhaju BB. (2002). Adolescent Reproductive Health in Asia: Paper presented at the 2002 IUSSP Regional Population Conference " South-East Asia's Population in a Changing Asian Context". Bangkok, Thailand.
8. Hawkes S. (2008). Addressing Sexually Transmitted Infections (STIs), including HIV/AIDS, in the context of sexual health. International Journal of Sexual Health , 20 (1-2).
9. Inter Agency Youth Working Group. (2010). Young People Most at Risk of HIV.
10. MOH/FHD. (2000). Nepal Adolescent Health and Development Strategy. Kathmandu, Nepal: Ministry of Health.
11. MSI. (1998). Adolescent and Reproductive Health. Vol 3 (No.6).
12. NCASC/FHI. (2003). National Estimates of Ault HIV Infections. Kathmandu: NCASC/Ministry of Health, Nepal.
13. NCASC/MOH. (2000). National Estimates of Ault HIV Infections. Kathmandu, Nepal.
14. NCASC/MOH. (2008). NCSAC/ MOH, Cumulative HIV/AIDS situation of Nepal, National Center of AIDS and STD Control. Kathmandu: NCASC.
15. NHSP-IP. (2004). Nepal Health Sector Program-Implementation Plan (2004-2009). Ministry of Health and Population, Kathmandu, Nepal.
16. Pradhan A et al. (1996). Nepal Family Health Survey 1996. Kathmandu, Nepal, Ministry of Health, Calverton, Maryland, NEW Era and Macrointernational Inc.
17. Raoul Fransen-dos Santosa. (2009). Young People Sexual & Reproductive Health and HIV. Bulletin of World Health Organization , 87, 877-879.
18. Tamang A; Nepal B. (1998). Providing Adolescent Health Services: the Nepalese Experience. A paper presented at Internatioal Conference on Reproductive Health March 15-19, 1998. India.
19. UNFPA. (1996). Program of Action adopted at the International Conference on Population and Development. USA.
20. UNFPA. (2005). The case for investing in young people as part of a national poverty reduction strategy. Reference notes on population and poverty reduction. Paper Commissioned by UNFPA, New York.

21. WHO. (2008). 10 Facts on Adolescent Health. Retrieved February 3, 2011, from http://www.who.int/features/factfiles/adolescent_health/facts/en/index.html
22. WHO. (1997). Adolescence, the Critical Phase, the Challenges and the Potential,WHO:Regional Office for South East Asia. New Delhi: WHO:Regional Office for South East Asia.
23. WHO. (2004). Adolescent Friendly Health Service in South-East Asia Region: Report of a Regional Consultation 9-14 February 2004, Bali, Indonesia.
24. WHO. (2006). Global Strategy for the prevention and control of sexually transmitted infections: 2006-2015, Key message.
25. WHO. (2011). Health Statistics and Health Information System: Global Health Risks. Retrieved Februray 23 , 2011, from World Health Organization: http://www.who.int/healthinfo/global_burden_disease/global_health_risks/en/index.html
26. WHO. (2006). "Investing in our future: a framework for accelerating action for the sexual and reproductive health of the young people".
27. WHO. (2003). Orientation program on adolescents health for health care providers, Department of Child and Adolescents and Development, World Health Organization, Geneva.
28. WHO. (2004). Reproductive health strategy, 2004 : paragraphs 35-41.
29. WHO. (1998). Strategies for Adolescent Health and Development South East Asia Region, New Delhi. New Delhi: WHO: SEAR.
30. WHO. (2003). Towards adulthood: exploring the sexual and reproductive health of adolescents in South Asia.
31. WHO. (1998). World Health Report, A vision for all in the 21st Century. Geneva.
32. WHO. (1997). Young people and sexually transmitted diseases. Geneva, World Health Organization (WHO Fact Sheet no. 186).

Annex -1 - Interview question

स्वास्थ्यका लागि मानव संसाधन परियोजना
जिल्लाहरुको वस्तुगत अध्ययन :
किशोर/किशोरीहरुको सर्वेक्षणका लागि प्रश्नावली (१० - १९ वर्ष)

(ठिक उत्तरको अंकलाई गोलो चिन्ह लगाउने)

परिचय र मन्जुरी

नमस्ते मेरो नाम ..... हो । म ..... बाट आएको हुँ। यस अध्ययनले किशोर/किशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सम्बन्धि ज्ञान र व्यवहारबारे आवश्यक तथ्यांङ्क संकलन गर्ने काम गर्दछ । यो अध्ययनको उद्धेश्य किशोर/किशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सम्बन्धि ज्ञान र व्यवहार कस्तो छ भन्ने बारे सूचना संकलन गर्नु रहेको छ । तपाईले दिनु भएको सूचनाले यस संस्था तथा स्थानीय स्वास्थ्य संस्थाहरुलाई कार्ययोजना बनाई कार्यान्वयन गरेर स्वास्थ्य सुधार गर्नमा मद्दत गर्दछ । तपाई यस अध्ययनको लागि छानिनु भएको छ । तपाईलाई सोधिने केही प्रश्नहरु नितान्त व्यक्तिगत पनि हुनसक्छन् । तपाईले दिनु भएको सबै सूचनाहरु एकदमै गोप्य राखिने छ र यस अध्ययन प्रयोजनका लागि मात्र प्रयोग गरिने छ भन्ने विश्वास दिलाउन चाहन्छु । यो अन्तरवार्ताका लागि ३० मिनेट देखि ४५ मिनेट सम्म समय लाग्नेछ ।

तपाईलाई यस अध्ययनको बारेमा केही सोध्नु छ ?

के तपाई यस अध्ययनमा सहभागी हुन इच्छुक हुनुहुन्छ ?

छु ..... १ (अन्तरवार्ता शुरु गर्ने)

छैन ..... २ (अन्तरवार्ता यहि टुंग्याउने, धन्यवाद)

अन्तरवार्ता लिने व्यक्तिको नाम : मिति : -.....

कोड नं : .....

अन्तरवार्ता दिने व्यक्तिको नाम (ऐच्छिक) : .....

जिल्ला : ..... गा.वि.स/न.पा. : ..... वार्ड नं. : .....

टोल : .....

इकाई १ : सामाजिक तथ्याङ्क र पारिवारिक पृष्ठभूमि (अवस्था)

क्र.सं	प्रश्नहरु	उत्तरहरु
१.१	अन्तरवार्ता दिने व्यक्तिको लिङ्ग	महिला ..... १ पुरुष ..... २ तेस्रो लिङ्गी ३
१.२	अन्तरवार्ता दिने व्यक्तिको उमेर	..... (पुरा गरेको वर्ष राख्ने)
१.३	जाति	.....
१.४	धर्म	हिन्दू ..... बौद्ध ..... इस्लाम ..... ईसाई ..... किराँत ..... अन्य .....
१.५	शैक्षिक योग्यता	निरक्षर ..... साक्षर

		- सामान्य लेखपढ ..... - .....(कक्षा) पास गरेको .....
१.६	वैवाहिक स्थिति ***(एकल भन्नाले श्रीमान वा श्रीमती वितेको व्यक्तिलाई जनाउ"छ)***	अविवाहित (प्र.नं.१.७ मा जाने) ..... विवाहित ..... पारपाचुके ..... एकल .....
१.६.१	तपाईको विवाह हुदाँ तपाई कति वर्षको हुनुहुन्थ्यो ?	..... (पुरा गरेको वर्ष राख्ने)
१.६.२	तपाईका छोराछोरी छन् ?	छन् ..... छैनन् (प्र.नं.१.७ मा जाने) .....
१.६.३	यदि छन् भने, कति जना छन् ?	छोरा ..... छोरी .....
१.६.४	पहिलो बच्चा हुँदा तपाईं कति वर्षको हुनुहुन्थ्यो ?	..... (पुरा गरेको वर्ष राख्ने)
१.७	तपाईको विचारमा विवाह गर्ने उपयुक्त उमेर कति हो ?	..... वर्ष (पुरा भएको)
१.७.१	तपाईको विचारमा महिलाको लागि पहिलो बच्चा जन्माउने उपयुक्त उमेर कति हो ?	..... वर्ष (पुरा भएको)
१.७.२	किन त्यो उमेर तपाईलाई ठीक लाग्छ ?	....

इकाई २: यौन र प्रजनन् स्वास्थ्य सम्बन्धि ज्ञान र धारणा

क्र.सं	**प्रश्नहरु**	**उत्तरहरु**
२.१	तपाईको विचारमा के किशोर/ किशोरीहरु यौवनावस्थामा प्रवेश गर्दा शारीरिक परिवर्तन अनुभव गर्छन् ?	गर्छन् .....१ गर्दैनन् (प्र.नं.२.४ मा जाने) २
२.१.१	यदि गर्छन् भने त्यस्ता परिवर्तन के के होलान् ?	क) ..... ख) ..... ग) ..... घ) .....
२.१.२	तपाई आफैले के कस्ता परिवर्तन अनुभव गर्नुभयो ?	क) ..... ख) ..... ग) .....
२.२	के तपाईको विचारमा किशोर/किशोरीका प्रजनन् स्वास्थ्यका समस्या अन्य उमेरका मान्छे भन्दा फरक हुन्छन् ?***(प्रजनन् स्वास्थ्य समस्या भन्नाले किशोर किशोरीहरुमा आउने शारीरिक परिवर्तन मात्र नभई मानसिक, व्यवहारगत समस्याहरु जस्तै कुलतमा फस्ने र अन्य सामाजिक समस्याहरु)***	हुन्छन् ..... १ हुँदैनन् (प्र.नं.२.४मा जाने) २
२.२.१	यदि हुन्छ भने, के कारणले फरक हुन्छ ?	.....
२.३	तपाईले शारीरिक परिवर्तन सम्बन्धि यस्ता जानकारीहरु कहाँबाट पाउनु भयो ?	शिक्षक ..... १ साथीसंगीहरु ..... २ परिवार ..... ३ टेलिभिजन ..... ४ एफ.एम./रेडियो ..... ५ पत्रपत्रिका ..... ६ स्वास्थ्यकर्मी ..... ७ अन्य (खुलाउने) ८
२.४	तपाईको विचारमा गर्भ रहन नदिन के गर्न सकिन्छ ?	यौन क्रियाकलाप नगरेर ..... १ गर्भनिरोधक विधि अपनाएर ..... २ औषधि/जडिबुटी ..... ३ अन्य (खुलाउने) ४

२.५	तपाईले परिवार नियोजनका साधनहरुका बारेमा सुन्नु भएको छ ?	छ ..... १ छैन (प्र.नं.२.६मा जाने) २
२.५.१	यदि छ भने, कस्ता किसिमका साधनहरुका बारेमा सुन्नु भएको छ ?	खाने चक्की वा पिल्स ..... १ संगिनी सुई (डिपो प्रोभेरा) ..... २ कपर टी ..... ३ नरप्लान्ट ..... ४ कण्डम ..... ५ अन्य (खुलाउने) ६
२.५.२	तपाईको विचारमा यस्ता साधानहरु कहाँबाट प्राप्त गर्न सकिन्छ ?	अस्पताल/प्रा.स्वा.के./स्वा.चौ./उ.स्वा.चौ. १ निजी क्लिनिक ..... २ औषधि पसल ..... ३ महिला स्वा.स्वं.से. ..... ४ अन्य (खुलाउने) ५
२.६	के तपाईले आकस्मिक गर्भनिरोधकको बारेमा सुन्नु भएको छ ? ***९आकस्मिक गर्भनिरोधक साधन भन्नाले कुनै पनि परिवार नियोजनका साधन प्रयोग नगरि यौन सम्पर्क भएको ७२ घण्टा भित्र गर्भ रहन नदिन प्रयोग गरिने परिवार नियोजन को साधनलाई जनाउछ)***	छ ..... १ छैन (प्र.नं.२.७ मा जाने) २
२.६.१	तपाईलाई आकस्मिक गर्भनिरोधकको बारेमा के थाहा छ ?	....
२.७	के तपाईले एच.आइ.भी./एड्सको बारेमा सुन्नु भएको छ ?	छ ..... १ छैन -ईकाइ ३ मा जाने) २
२.७.१	यदि छ भने, एच.आइ.भी./एड्स कसरी सर्दछ ? ***(बहुउत्तर आउनसक्ने)***	संक्रमित व्यक्तिसंगको यौन सम्पर्कबाट..... १ संक्रमित व्यक्तिको रगत लिदा..... २ संक्रमित आमाबाट जन्मेको बच्चामा..... ३ संक्रमित व्यक्तिले प्रयोग गरेको सुइ पुनः प्रयोग गरेमा .... ४ अन्य (खुलाउने) ५
२.७.२	तपाईले एच.आइ.भी./एड्स सम्बन्धी परामर्श तथा रगत जाँचको वारेमा सुन्नु भएको छ ?	छ ..... १ छैन -(प्रश्न न. २.७.४ मा जाने)..... २
२.७.३	एच.आइ.भी./एड्स सम्बन्धि परामर्श तथा जाँच कुन कुन ठाउ"मा हुन्छ ?	क) ..... ख) ..... ग) ..... घ) ..... ङ) .....
२.७.४	यौन सम्पर्कबाट सर्ने कस्ता किसिमको रोगहरुको बारेमा सुन्नु भएको छ ?	क) ..... ख) ..... ग) ..... घ) ..... ङ) .....
२.७.५	एच.आइ.भी./एड्स र अन्य यौन सम्पर्कजन्य संक्रमणको बारेमा तपाईले कहाँबाट थाहा पाउनुभयो?	शिक्षक ..... १ साथीसंगीहरु ..... २ परिवार ..... ३ टेलिभिजन ..... ४ एफ.एम./रेडियो ..... ५ पत्रपत्रिका ..... ६ स्वास्थ्यकर्मी ..... ७ अन्य (खुलाउने) ८

इकाई ३: किशोर किशोरीहरुको यौन तथा प्रजनन् स्वास्थ्यबारे व्यवहार

क्र.सं	प्रश्नहरु	उत्तरहरु
३.१	प्रजनन् स्वास्थ्य भन्नाले तपाई के बझ्नुहुन्छ ?	
३.१	तपाईलाई यौन तथा प्रजनन् स्वास्थ्य सम्बन्धि समस्या परेमा सबैभन्दा पहिले कहाँ जानुहुन्छ ?	साथीहरु ..... १ आमा/बुवा ..... २ दाजुभाई/दिदीबहिनी ..... ३ महिला स्वा.स्वं.से. ..... ४ अस्पताल/प्रा.स्वा.के./स्वा.के/उप.स्वा.चौ..... ५ वैद्य/धामी/झाँक्री ..... ६ निजी क्लिनिक ..... ७ औषधि पसल ..... ८ कतै पनि जाने गरेको छैन ९
३.२	तपाईको समुदायमा किशोर/किशोरीहरुले यौन तथा प्रजनन् स्वास्थ्य र अन्य विषयहरुका सम्बन्धमा सूचना वा जानकारी पाउन सक्ने कुनै ठाउँ छ ?	छ ..... १ छैन २
३.३	त्यस्ता सूचना केन्द्र वा जानकारी पाउन सक्ने ठाउँ कहाँ छ ?	(ठाउँ उल्लेख गर्ने) ....
३.४	तपाई त्यस्ता ठाउँहरुमा जानु भएको छ ?	छ (प्र.नं.३.६ मा जाने) ..... १ छैन २
३.५	तपाई किन त्यस्ता ठाउँहरुमा जानु भएको छैन ?	टाढा भएर १ सल्लाह दिने र जाँच गर्ने दक्ष व्यक्ति नभएर २ गोपनियता नभएर ३ समस्या नपरेर/जरुरत नभएर ४ समुदायमा यस्तो सेवा नभएर ५ अन्य (खुलाउने) ६
३.६	यौन तथा प्रजनन् स्वास्थ्यका समस्याहरुको बारेमा तपाईलाई कोसँग कुराकानी गर्न सजिलो लाग्छ ?	साथी ..... १ आमा/बुवा ..... २ दाजु/दिदी/भाइ/बहिनी ..... ३ शिक्षक/शिक्षिका ..... ४ स्वास्थ्यकर्मी ..... ५ अन्य (खुलाउने) ६
३.७	के तपाईले किशोर अवस्था (१० देखि १९ वर्ष) मा कुनै किसिमका समस्या अनुभव गर्नु भएको थियो ? ***(समस्या भन्नाले प्रजनन् स्वास्थ्य समस्या मात्र नभएर अन्य समान्य समस्या हरु जस्तै सुचनाको कमि, मनो सामाजिक समस्या र अपाएकता कुराहरुलाई बुझ्ने)***	थियो ..... १ थिएन (प्र.नं.३.८ मा जाने) २
३.७.१	यदि थियो भने, के कस्तो समस्या अनुभव गर्नु भएको थियो ?	क) ..... ख) ..... ग) .....
३. ७.२	उक्त समस्याको बारेमा तपाईले कसैसँग कुरा गर्नु भएको थियो ?	थियो ..... १ थिएन .....(प्र.नं ३.८ मा जाने) २
३.७.३	आफ्ना समस्याका बारेमा कोसँग कुरा गर्नु भएको थियो ?	साथी ..... १ आमा ..... २ बुबा ..... ३ दाजु/दिदी/भाइ/बहिनी ४

		शिक्षिक/शिक्षिका ..... ५ स्वास्थ्यकर्मी ..... ६ अन्य (खुलाउने) ७
३.८	के तपाईको समुदायमा भएको स्वास्थ्य संस्थाले यौन तथा प्रजनन स्वास्थ्य सेवाहरु दिन्छ ?	दिन्छ ..... १ दिँदैन (प्र.नं.३.९ मा जाने) २
३.८.१	यदि दिन्छ भने, किशोर र किशोरीहरुका लागि कस्तो किसिमको सेवा दिएको छ ?***(सेवा भन्नाले सुचना प्रवाह, चेक जाँच, परामर्श तथा उपचारलाई बुझिन्छ)***	क) ..... ख) ..... ग) ..... घ) ..... ङ) .....
३.९	तपाईले विगत ६ महिनामा यौन तथा प्रजनन स्वास्थ्य सेवा लिनको लागि स्वास्थ्य संस्थामा जानु भएको थियो ?	थियो ..... १ थिएन (प्र.नं.४ मा जाने) २
३.९.१	यदि थियो भने, कुन समस्या लिएर जानु भएको थियो ?	क) ..... ख) ..... ग) ..... घ) ..... ङ) .....
३.९.२	स्वास्थ्य संस्थामा गएपछि के तपाईको समस्या समाधान भयो ?	भयो ..... १ भएन २
३.९.३	के तपाई स्वास्थ्य संस्थामा फेरी जानु भयो ?	गएँ ..... १ गइनँ (प्र.नं.३.९.३.२ मा जाने) २
३.९.३.१	यदि जानु भयो भने, किन जानु भयो ?	..... (प्र.नं.४ मा जाने)
३.९.३.२	यदि जानु भएन भने, किन जानु भएन ?	क) ..... ख) ..... ग) .....

इकाई ४ : किशोर /किशोरीको यौन तथा प्रजनन् स्वास्थ्य सम्बन्धि जानकारी प्राप्त गर्ने माध्यम

क्र.सं	प्रश्नहरु	उत्तरहरु
४.१	तपाईले यौन तथा प्रजनन् स्वास्थ्य सम्वन्धि सूचना कहाँबाट प्राप्त गर्नु हुन्छ ? (बहुउत्तर आउनसक्ने)	विद्यालय/पाठ्यपुस्तक ..... १ साथीहरु ..... २ एफ.एम./रेडियो ..... ३ टिभी ..... ४ पत्रपत्रिका ..... ५ इन्टरनेट ..... ६ स्वास्थ्य कार्यकर्ता ..... ७ अन्य (खुलाउने) ८
४.१.१	तपाईलाई सबैभन्दा बढी कुन संचार माध्यम मनपर्छ ?	एफ.एम./रेडियो ..... १ टिभी ..... २ पत्रपत्रिका ..... ३ इन्टरनेट ..... ४ अन्य (खुलाउने) ५
४.२	के यौन तथा प्रजनन स्वास्थ्य सम्वन्धि पाठहरु तपाईको पाठ्यक्रममा समावेश गरिएका छन् ? ***(कक्षा ८,९,१० का विद्यार्थीलाई मात्र सोध्ने)***	छन् ..... १ छैनन् (इकाई ५ को प्रश्नहरुमा जाने) २
४.२.२	के शिक्षकहरुले विद्यालयमा यौन तथा प्रजनन् स्वास्थ्य सम्बन्धि पाठ पढाउनु हुन्छ ?	हुन्छ..... १ हुदैन..... २
४.२.३	के तपाईलाई पुस्तकमा किशोर/ किशोरीको यौन तथा प्रजनन् स्वास्थ्य सम्बन्धि विषय समावेश भएकोमा ठीक लाग्छ ?	लाग्छ ..... १ लाग्दैन २

४.२.३	ठीक लाग्छ/लाग्दैन भने किन ?	क) ..... ख) ..... ग) .....
४.२.४	हाल पाठ्य पुस्तकहरुमा प्रजनन् स्वास्थ्य सम्बन्धि दिएका जानकारी पर्याप्त छ वा छैन ? छ छैन छैन भने, के कस्ता नयाँ कुरा समावेश गरिनु पर्दछ ?	....

इकाई ५: किशोर/किशोरीको यौन तथा प्रजनन् स्वास्थ्य सम्बन्धि विषयहरुमा परिवार र संघ-संस्थाको संलग्नता

क्र.सं	प्रश्नहरु	उत्तरहरु
५.१	तपाईले आफ्नो यौन तथा प्रजनन् स्वास्थ्य समस्याका बारेमा परिवारका सदस्यसँग कहिल्यै कुरा गर्नुभएको छ ?	छ ..... १ छैन (प्र.नं. ५.२ मा जाने) २
५.१.१	यदि छ भने, पछिल्लो पटक कहिले आफ्नो समस्याका बारेमा परिवारसँग कुरा गर्नुभएको थियो?	....
५.१.२	यदि छ भने, तपाईले कुन विषयमा कुरा गर्नुभयो ?	....
५.१.३	के तपाईलाई परिवारका सदस्यहरु वा अभिभावक (आमा बुवा, दिदी, बहिनी, दाइ) संग कुरा गर्न सजिलो भयो ?	भयो ..... १ भएन २
५.१.४	सजिलो भयो र भएन भने किन ?	....
५.२	तपाईको समुदायमा कुनै संघ-संस्थाले यौन तथा प्रजनन् समस्याका बारेमा सूचना, परामर्श वा जाँच सेवा दिने गरेको छ?	छ ..... १ छैन २
५.२.१	यदि छ भने, कस्तो सेवा प्रदान गरेको छ ?	सूचना ..... १ जाँच ..... २ परामर्श ..... ३ अन्य (खुलाउने)..... ४

ईकाई ६: यौन तथा प्रजनन् स्वास्थ्य सम्बन्धि व्यवहार (यदि उत्तरदाताले तलका प्रश्न सहजता पूर्वक दिन चाहेको खण्डमा मात्र सोध्ने)

६.१	अविवाहित भए, तपाईको कसैसंग यौन सम्पर्क भएको छ कि छैन ? ***(प्रश्नदाता ले माथिका प्रश्नबाट यौन सम्बन्ध रहेको कुरा थाहा भएमा पुन यो प्रश्न नसोधि सिधै तलका प्रश्नमा जाने)***	छ .....१ छैन.....२
६.१.१	तपाईले पहिलो शारीरिक सर्म्पक कति वर्षको उमेरमा गर्नु भएको थियो ? ***(यदि भएको भए मात्र)***	....वर्ष
६.१.२	के तपाईको १ भन्दा बढी यौन साथीहरु छन् ?	छन्.....१ छैनन्.....२
६.१.३	तपाईले यौन सम्बन्ध राख्दा गर्भ निरोधक साधनहरु प्रयोग गर्नुहुन्छ ?	गर्छु.....१ गर्दिन (प्र न. ६.२ मा जाने).....२

६.१.४	यदि गर्नुहुन्छ भने कुन कुन ?	खाने चक्की वा पिल्स ..... १ संगिनी सुई (डिपो प्रोभेरा) ..... २ कपर टी ..... ३ नरप्लान्ट ..... ४ कण्डम ..... ५ अन्य (खुलाउने) ६
६.१.५	के तपाईलाई सो साधनको सही प्रयोग गर्ने विधि थाहा छ ?	छ..... १ छैन..... २
६.२	तपाईलाई अहिले सम्म तपाईको सहकर्मी वा अन्य साथीहरुले यौन सम्बन्धि कियाकलापमा सहभागी हुन प्रेरित गरेका छन् ?	छन्.....१ छैनन्..... २
६.२.१	यदि छन् भने, त्यस्तो अवस्थामा के गर्नु भयो ?	
६.२.२	असुरक्षित यौन सम्पर्कबाट हुन सक्ने सम्भाव्य जोखिमहरुको बारेमा तपाईहरुको साथीभाइ बीच छलफल हुन्छ ?	हुन्छ..... १ हुदैन..... २
६.२.३	हुन्छ भने, के यस्ता छलफल केटा वा केटी साथीहरुसग" पनि हुन्छ ?	हुन्छ..... १ हुदैन..... २
६.३	तपाईको विचारमा किशोर/ किशोरीहरुको प्रजनन् स्वास्थ्य सम्बन्धि सेवा दिने कस्तो खालको संरचना हुनु पर्दछ ?	....
६.४	यी तलका मध्य तपाईलाई सो सेवा दिन /लिन कुन ठाउ" उपयुक्त लाग्छ ?	सरकारी अस्पताल.....१ निजि स्वास्थ्य संस्थाहरु.....२ महिला विकास शाखा.....३ युवा क्लवहरु.....४ क्याम्पस/ हाईस्कूल .....५ छुट्टै स्वतन्त्र निकाय.....६

अन्तरवार्ता लिने व्यक्तिको सही .....
अन्तरवार्ता लिने व्यक्तिको नाम .....
मिति : ...../...../.....

(अन्तरवार्ता सकिएपछि सहभागीलाई धन्यवाद दिनुहोस् र कुनै प्रश्न वा जिज्ञासा छ भने सोध्नुहोस्)

Annex -II - FGD Guideline adolescents

B1+B2

लक्षित समुह छलफल निर्देशिका

(१० देखि १९ वर्ष भित्रका किशोर किशोरीहरु)

समुहको किसिम:	**किशोर**	**किशोरी**
गाविस/नपा:	**वडा नं.**	**गाउ**
सहजकर्ता:		**प्रतिवेदक:**
मिति:	**समय:**	**स्थान:**

प्रथम चरण: परिचय सहित छलफल कार्यक्रमको उदघाटन

नमस्कार मेरो नाम.....म यहा..... को तर्फबाट तपाईको क्षेत्रमा किशोर किशोरीहरुको यौन तथा प्रजनन स्थास्थ्य सम्बन्धी आधारभूत जानकारी संकलन गर्न उपस्थित भएको छु ँ तपाईहरुले दिएको जानकारीबाट नेपाल सरकारले विभिन्न निकायहरुको सहयोगमा तयार पारिएको कार्यान्वयन निर्देशिका वमोजिम स्थानिय स्वास्थ्य संस्थाहरु मार्फत किशोर किशोरी मैत्री सेवाको कार्यान्वयन गर्न मद्यत पुग्नेछ । तपाई सहभागीहररुको सहमतिका आधारमा म यो छलफलको सुरुवात गर्न चाहन्छु । कृपया सजिलो महसुस गरी छलफल कार्यक्रममा भाग लिनुहोस साथै तपाईहरुलाई कुनै जिज्ञासा लागेमा सोध्न सक्नु हुने छ ।

- सहभागीहरुलाई स्वागत गर्नुहोस, आफनो र प्रतिवेदकको परिचय दिनुहोस ।
- सहभागीहरुलाई तलदिएको विवरण भर्न अनुरोध गर्नुहोस । विवरण भर्नका लागि सहयोग गर्नुहोस् ।

सहभागीहरुको विवरण

क्र.सं.	उमेर	लिङ्ग	जाती/जनजाति	शिक्षा	पेशा	वैवाहिक अवस्था	कैफियत
१.							
२.							
३.							
४.							
५.							
६.							
७.							
८.							
९.							
१०.							

आवश्यकता अनुसार थप्ने

.....

.....

द्वितृय चरण: मुख्य विषयहरु

क) सामान्य स्वास्थ्य र किशोर किशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सम्वन्धी समस्याहरु

१. यस समुदायमा किशोर किशोरीहरुको सामान्य स्वास्थ्यको अवस्था कस्तो रहेको छ ?

- छलफलबाट निकाल्नु पर्ने कुराहरु, उनिहरु सामान्यतया कस्ता किसिमका स्वस्थ्य समस्याहरुबाट पीडित भएका छन जस्तै मानसिक, शारिरीक, सामाजिकीकरण र अन्य कुनै पनि हुन सक्छन् ।

२. कृपया तपाईहरुको समुदायमा किशोर किशोरीहरुले भोग्दै आएका यौन तथा प्रजनन स्वास्थ्यसंग सम्वन्धित समस्याहरुका वारेमा वताई दिनुहोस ? (कशोर किशोरी भन्नाले १० देखि १९ वर्ष सम्मका किशोर किशोरी हरुलाई जँनुदछ)

- केटा (किशोर) हरुले यौन तथा प्रजनन् समन्धी कस्ता समस्याहरु भौग्दै आएकँ छन् ? सवै कुराको जानकारी लिने।
- केटी (किशोरी) हरुले यौन तथा प्रजनन समन्धी कस्ता समस्याहरु भौग्दै आएका छन ?

३। केटीहरुले भोग्दै आएका (किशोर किशोरी) यौन तथा प्रजनन स्वास्थ्य सम्वन्धि समस्याहरु निम्नलिखित हुन सक्छन् ।

महिनावारी हुँदा सरसफाईमा कमी, अलगै फोहर ठाउ वा गोठमा सुत्नु पर्ने, खाना थोरै दिने, विशेष किसिमका भोजनहरु (दुध, दही,), मा प्रतिवन्ध पौष्टिकता नभएको खाना, स्वास्थ्यलाई प्राथमिकता नदिने, बाल विवाह, असुरक्षित गर्भपतनको अवस्था कस्तो छ, यौन दुर्व्यवहार र हिंसाको अवस्था आदि ।

ख) ज्ञान, धारणा र गलत धारणा

१. तपाईको समुदायका किशोर किशोरी (केटा/केटी) हरुको अवस्था कस्तो छ ?

छलफल गरी अवस्थाको जानकारी लिने ।

- किशारी (केटी) हरु प्रतिको लैंगिक विभेद, सामाजिक कृयाकलापहरुमा सहभागिता, निर्णय प्रक्रियामा सहभागिता आदि सम्वन्धी धारणा/मान्यता र वुझाई कस्तो छ ।
- यौन तथा प्रजनन स्वास्थ्य लगायत यौन संक्रमण, एच आई भी, एडस, प्रजनन स्वास्थ सम्वन्धी अधिकार, गर्भपतन आदि सम्वन्धि ज्ञानको जानकारी लिने ।
- यौन तथा प्रजनन स्वास्थ्य सम्वन्धि धारणा (किशोर किशोरीहरुको) साथै यौन, प्रजनन र विवाहको उमेरका सम्वन्धमा शिक्षक, अभिभावक, समुदाय र स्वास्थ्यकर्मीहरुको धारणा के छ , उनिहरुले के सोच्दछन (किशोर किशारीहरुसंग छलफल गरी निकाल्ने)
- हस्तमैथुन, विवाह पूर्व यौन सम्वन्ध र कण्डोमको प्रयोग सम्वन्धी धारणा
- गर्भपतन, गर्भपतन सम्वन्धी कानूनी व्यवस्था र गर्भपतन गराउने स्थान सम्वन्धी जानकारी
- विवाहको उपयुक्त उमेर र कानुनले तोकेको उमेर
- यौन तथा प्रजनन स्वास्थ्य सम्वन्धी समस्याहरुको समाधानका लागि अपनाइने विधीहरु (परम्परागत विधिहरु)

२. किशोर किशोरीहरुले सामना गर्नु परिरहेका खतरायुक्त यौन कृयाकलापहरुको अवस्थाको बारेमा वताईदिनुहोस न ? (यसमा खतरायुक्त यौन कृयाकलाप अन्तर्गत दवावमा परेर राखिने यौन सम्वन्ध, असुरक्षित यौन सम्वन्ध, अनिच्छित यौन सम्वन्ध र जवर्जस्ती करणी (बलात्कार)

- केटीहरुका लागि खतरायुक्त यौन सम्वन्धको अवस्था जस्तो बल प्रयोगबाट गरिने/दवावका कारण गरिने/गलत तरिकाबाट गरिने (अवस्था पत्ता लाउने)

- केटाहरुका लागि खतरायुक्त यौन सम्वन्धको अवस्था जस्तो बल प्रयोगबाट गरिने/दवावका कारण गरिने/गलत तरिकाबाट गरिने (अवस्था पत्ता लाउने)
- कस्ता किसिमका मानिसहरुले जवर्जस्ती यौन सम्वन्ध राख्न दवाव दिन्छन र कारण के होला ?

ग) किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सेवाको खोजी (आवश्यकता), पहुच र उपयोग

१. तपाईको समुदायमा किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सम्वन्ध कस्ता कार्यक्रमहरु संचालन भईरहेका छन ?

- जानकारी लिनु होस, त्यस्ता कार्यक्रमहरु कस्ले उपलव्ध गराएका हो ? (सरकारी अस्पताल, प्राथमिक स्वास्थ्य केन्द्र, हेल्थ पोष्ट, सव हेल्थपोष्ट) गैरसरकारी (एन जि ओ, आइ अएन जि ओ, निजी अस्पताल, क्लिनिक आदी)

२. त्यस्ता संस्थाहरु तथा कार्यक्रमहरुबाट किशोर किशोरीका यौन तथा प्रजनन स्वास्थ्य सम्वन्धी कस्ता सेवाहरु उपलव्ध गराइएका छन ?

- सरकारी र निजीस्तरका संस्थाहरुबाट उपलव्ध गराइएका किशोर किशोरीका यौन तथा प्रजनन स्वास्थ्य सेवाहरुका बारेमा जानकारी लिने।
- सहभागीहरुलाई सोध्नु होस, ती संस्थाहरुले किशोर किशोरीका यौन तथा प्रजनन स्वास्थ्य सम्वन्धी कस्ता किसिमका सेवाहरुलाई समावेश गरेका छन -मनोवैज्ञानिक, एचआईभी, विभिन्न यौन संक्रमण, परिवार नियोजन सेवाहरु, गर्भपतन सेवाहरु र किशोर किशोरीहरुको विशेष हेरविचार सम्वन्धी)

३. तपाई र तपाईका साथीहरुले सामान्यतया स्वास्थ्य र यौन तथा प्रजनन स्वास्थ्य सम्वन्धी सेवा कहाँ बाट लिने गर्नुभएको छ ?

- सरकारी वा निजी कस्तो किसिमको स्वास्थ्य संस्थाा बाट सेवा लिने गरेको जानकारी लिने
- उनिहरु सरकारी स्वास्थ्य केन्द्र वा अस्पतालबाट किन सेवा लिन्छन ?
- तिनीहरुले नीजी स्वास्थ्य केन्द्र वा अस्पतालबाट किन सेवा लिन्छन ?
  (पहुँच (भौगोलिकरुपमा नजिक, सस्तो वा निशुल्क सेवा), गोपनियता र विश्वसनियता, छरितो र गुणस्तरीय स्वास्थ्य सेवा भएको कारण)

४. तपाई किशोर किशोरीहरुले आफनो समुदायमा यौन तथा प्रजनन स्वास्थ्य संग सम्वन्धीत सुचना तथा जानकारीहरु कहाँबाट प्राप्त गर्नुहुन्छ ?

- जाकारी लिनुहोस, सूचनाका मुख्य श्रोतहरु के के हुन जस्तै आमा, वुवा, स्वास्थ्य स्वयंसेविका, स्वास्थ्यकर्मीहरु, शिक्षक, रेडियो, टिभी, सिनेमा, चेतनामुलक अभियानहरु, किताव, समाचार पत्र, पत्रिका आदि र कसरी प्राप्त गर्छन ?

५. यौन तथा प्रजनन स्वास्थ्य सेवामा पहुँचको अवस्था के छ ? र यौन तथा प्रजनन स्वास्थ्य सेवा लिनका लागि कस्ता किसिमका कठिनाईहरु छन ?

- पहु"च अन्तर्गत दुरी, स्वास्थ्य केन्द्रमा जान प्रयोग हुने साधन, लाग्ने रकम, वहन गर्न सकिने नसकिने के हो जानकारी लिने ।
- त्यस पछी यौन तथा प्रजनन स्वास्थ्य सेवामा पहुँचका लागि कठिनाई तथा अवरोधहरु के के हुन ।

६. तपाईको नजिकको हेल्थपोपोष्टबाट प्राप्त हुने यौन तथा प्रजनन स्वास्थ्य सम्वन्धी सेवाको गुणस्तरीयतालाई कसरी मुल्याङ्कन गर्नु हुन्छ ?

- मुल्याङ्कन गर्दा सेवाको गुणस्तर, उनिहरुले प्राप्त गर्ने यौन तथा प्रजनन स्वास्थ्य सेवाबाट उनिहरुको सन्तुष्टि कस्तो छ, स्वास्थ्यकर्मीको व्यवहार, भौतिक संरचना, किशोर किशोरी मैत्री सेवाको वातावरण आदि, यसमा स्वास्थ्य संस्थाहरको आधारमा पनि गर्न सकिन्छ (सरकारी विरुद्ध गैर सरकारी सेवा कस्तो छ)

७. तपाईको विचारमा तपाईको समुदायमा यौन तथा प्रजनन स्वास्थ्य सेवाको उपयोग र पहुँचलाई राम्रो बनाउन कस्ता किसिमको पहल गरिएका छन् ? जसका कारणले सेवा सजिलो संग उपलव्ध भएको छ र पहुँच पुगेको छ ।

- उपरोक्त कुराहरुलाई भौतिक पूर्वाधार, तालीम प्राप्त स्वास्थ्य कार्यकर्ता, गुणस्तरीय सेवा र औषधी आदीको आधारमा पुष्टयाई गराई जानकारी लिनु पर्ने छ ।

तेश्रो चरण : छलफल कार्यको समापन

अव हामी छलफल कार्यक्रमको अन्त्य तिर पुगेका छौ अन्तमा यौन तथा प्रजनन स्वास्थ्य सेवा लाई तपाईको समुदायमा पहु"च योग्य, उपयोगी र गुणस्तरीय बनाउनका लागि कुनै सुझाव छ भने २ मिनेट भित्र दिन सक्नु हुन्छ ।

क).....

ख).....

ग).....

छलफलबाट निस्केका कुराहरुलाई सारांशमा सहभागीहरुलाई सुनाउने र थप्ने वा घटाउने के हो जानकारी लिने यदि जस्ता त्यस्तै ठिक छ भन्छन भने केही गरी राख्नु परेन र उनिहरुको सहभागिताको लागि धन्यवाद दिएर छलफल कार्यक्रमको अन्त्य गर्ने।

धन्यवाद

Annex-III- FGD guideline HFMC

B5

लक्षित समूह छलफल निर्देशिका

समुह: **स्वास्थ्य संस्था व्यवस्थापन समिती, स्वास्थ्य संस्थाको प्रमुख (प्राविधिक वा प्रसाशनिक)**
गाविस/नपा: **वडा नं.** **गाउँ:**
सहजकर्ता: **प्रतिवेदक:**
मिति: **समय:** **स्थान:**

प्रथम चरण: परिचय सहित छलफल कार्यक्रमको उदघाटन

नमस्कार मेरो नाम.....म यहाँ..... को तर्फबाट तपाईको क्षेत्रमा किशोर किशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सम्बन्धी आधारभूत जानकारी संकलन गर्न उपस्थित भएको छुँ । तपाईहरुले दिएको जानकारीबाट नेपाल सरकारले विभिन्न निकायहरुको सहयोगमा तयार पारिएको कार्यान्वयन निर्देशिका वमोजिम स्थानिय स्वास्थ्य संस्थाहरु मार्फत किशोर किशोरी मैत्री सेवाको कार्यान्वयन गर्न मद्यत पुग्ने छ । तपाई सहभागीहरको सहमतीका आधारमा म यो छलफलको सुरुवात गर्न चाहन्छु । कृपया सजिलो महसुस गरी छलफल कार्यक्रममा भाग लिनुहोस साथै तपाईहरुलाई कुनै जिज्ञासा लागेमा सोध्न सक्नु हुने छ ।

- सहभागीहरुलाई स्वागत गर्नुहोस, आफनो र प्रतिवेदकको परिचय दिनुहोस ।
- सहभागीहरुलाई तलदिएको विवरण भर्न अनुरोध गर्नुहोस । विवरण भर्नका लागि सहयोग गर्नुहोस ।

सहभागी विवरण

क्र.सं.	उमेर	लिङ्ग	जाती/जनजाति	शिक्षा	पेशा	वैवाहिक अवस्था	कैफियत
१.							
२.							
३.							
४.							
५.							
६.							
७.							
८.							
९.							
१०.							

आवश्यकता अनुसार थप्नुहोस ।.....

दोश्रो चरण: मुख्य प्रस्नहरु

क) सामान्य स्वास्थ्य र किशोर किशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सम्वन्धी समस्याहरु

१. तपाईलाई जानकारी भए सम्म यस गाविस वा यस सामान्य स्वास्थ्यको अवस्था कस्तो छबताई दिनुहोस ?

- बालबालिका, किशोरकशोरी, आमाहरु, वृद्धवृद्धा, प्रौढ आदिको स्वास्थ्य अवस्थाका बारेमा जानकारी लिने।

२. यस समुदायमा किशोर किशोरीहरुले यौन तथाा प्रजनन स्वास्थ्य सम्वन्धिकस्ता किसिमका समस्याहहरुको सामना गरिरहेका छन ?

- किशोर किशारीहरुका समस्याहरु पत्ता लाउनुस् ।

३. तपाईको अनुभव र अवलोकनमा (हेराई)मा यस समुदायमा किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सम्वन्धि ज्ञान, धारणा, बानी के छ ?

- यसमा हालको विवाहको उमेर सम्वन्धी प्रचलन (केटा र केटीमा फरक), यौन र यौन धारणा, सुरगिर्भपतन र यौन तथा प्रजनन स्वास्थ्य सम्वन्धि अन्य समस्याहरु र यस्ता समस्याहरुबाट मुक्ति पाउन अवलम्वन गरिएका उपायहरु, जिवन उपयोगी बिषयहरु केही छन् भने राख्ने ।

ख) किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सेवा माथिको पहुँच र उपयोग

१. यस समुदायमा सरकारी र निजी स्तरबाट उपोरी यौन तथा प्रजनन स्वास्थ सेवाकाअवस्था कस्तो छ ?

- सरकारी स्वास्थ्य संस्था, गैसस, अन्तर्राष्टिय गैसस इत्यादी बाट प्राप्त किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सम्वन्धि सेवा बारेमा जानकारी हासिल गर्ने ,
- त्यस्ता कुन कुन संस्थाहरुहुन जस्ले किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सम्वन्धी सेवा उपलब्ध गराउँछन् ?

२. तपाईको स्वास्थ्य संस्थामा उपलब्धता प्राप्त किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सम्बन्धिसेवाहरु के के हुन ?

- सहभागीहरुलाई सोध्नु होस, ती संस्थाहरुले किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सम्वन्धी कस्ता किसिमका सेवाहरुलाई समावेश गरेका छन परामर्ष, -मनोवेज्ञानिक, एचआईभी, विभिन्न यौन संक्रमण, परिवार नियोजन सेवाहरु, गर्भपतन सेवाहरु र किशोर किशोरीहरुको विशेष हेरविचार सम्वन्धि)

३. तपाईको स्वास्थ्य संस्थाबाट उपलव्ध गराइएका किशोर किशोरीको यौन स्वास्थ्य तथा प्रजनन स्वास्थ्य सेवाको गुणस्तरीयताका बारेमा टिप्पणी गर्नुहोस ?

- किशोर किशोरीका यौन तथा प्रजनन स्वास्थ्य सम्वन्धि गुणस्तरीय सेवा भित्र तालिम प्राप्त स्वास्थ्यकर्मी, निरन्तर सेवा उपलव्ध छ छैन, भौतिक संरचना, सेवा प्रतिको सन्तुष्टि, पर्याप्त उपकरण र औषधी, स्वास्थ्य सेवा लिन आउने क्रम कस्तो छ आदी कुराहरुमा छलफल गरी जानकारी लिने ।

४. तपाईको अनुभवमा किशोर किशोरीका यौन तथा प्रजनन स्वास्थ्यसंग सम्वन्धीत समस्या भएमा तपाईको समुदायका किशोर किशोरीहरु प्रथम पटक सामान्यतया कहा जान्छन र किन ?

- यसमा आधुनिक स्वास्थ्य सेवामा जान्छन भने किन जानकारी लिनुहोस

- यदि आधुनिक भन्दा अन्य किसिमका सेवा लिन जान्छन यसमा घरमा उपचार गर्ने कार्य पनि समावेश गर्ने र किन त्यसो गर्छन ।

५. तपाईको अनुभवमा किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सेवाको पहुँच र उपयोगका सम्वन्धमा किशोर किशोरीहरुले मुख्य गरी कस्ता किसिमका समस्याहरु सामना गरिरहेका छन ? (केटा र केटीमा तुलनात्मक जानकारी लिने)

- सामाजिक र सांस्कृतिक परिवेशबारे जानकरी लिने जस्तोः गलत धारण, आमावुवा र परिवारके सहयोग,संस्कृतिक हारहरु, सामान्यताहरु आदी
- उनिहरुलाई भौतिक बाधाहरु, हेल्थ पोष्टको खराव भौतिक संरचना, यौन तथा प्रजनन स्वास्थ्य सम्वन्धि एकदम कम ज्ञान र चेतना, अपर्याप्त तालिम प्राप्त स्वास्थ्यकर्मी, औषधी र उपकरण आदी
- यसा किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सेवाको सुधार गर्न र हरु हटाउनका लागि हामिले के गर्नु पर्ला ?

६. तपाईको विचारमा तपाईको समुदायमा किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सेवाको उपयोग र पहुँचलाई राम्रो बनाउन कस्तो किसिमको पहल गरिएकृ छन्? जसका कारणले सेवा सजिलो संग उपलव्ध भएको छ र पहुँच पुगेको छ ।

- उपरोक्त कुराहरुलाई भौतिक पूर्वाधार, तालिम प्राप्त स्वास्थ्य कार्यकर्ता, गुणस्तरीय सेवा र औषधी आदीको आधारमा पुष्टयाई गर्नु पर्ने छ ।

७. स्वास्थ्य क्षेत्रमा कार्यरत जनशक्ति सम्वन्धी जानकारी

- **तपाईको स्वास्थ्य संस्थामा दरवन्दी अनुसारको पदहरु परिपूर्ति गरिएका छन कि छैनन् ? कुनै कर्मचारी स्वास्थ्य केन्द्र व्यवस्थापन समितिको तर्फबाट पनि खटाइएको छ वा छैन ?**
- **गा वि स र जिविस बाट स्थानिय स्वास्थ्य संस्थालाई आर्थिक सहयोग गरिएको छ की विस्तृतमा भनि दिनुहोस ? यदि वजेटमा वृद्धी गर्नु पर्ने भएमा कुन कार्यक्रमलाई केन्दीत गर्नु पर्ने होला ?**
- **के कर्मचारीहरु स्वास्थ्य संस्थामा निरन्तर हाजिर हुन्छन ? यदि हुदैनन भने हाजिर नहुनुको कारण के होला ? (काज, तालिम, इत्यादी)**

तेश्रो चरण : छलफल कार्यको समापन

अव हामी छलफल कार्यक्रमको अन्त्य तिर पुगेका छौं अन्तमा यौन तथा प्रजनन स्वास्थ्य सेवा लाई तपाईको समुदायमा पहुँच योग्य, उपयोगी र गुणस्तरीय बनाउनका लागि कुनै सुझाव छ भने २ मिनेट भित्र दिन सक्नु हुन्छ ।

क).....
....
ख).....
.....
ग).....
.....

छलफलबाट निस्केका कुराहरुलाई सारांशमा सहभागीहरुलाई सुनाउने र थप्ने वा घटाउने के हो जानकारी लिने यदि जस्ता त्यस्तै ठिक छ भन्छन भने केही गरी राख्नु परेन र उनिहरुको सहभागिताको लागि धन्यवाद दिएर छलफल कार्यक्रमको अन्त्य गर्ने।

धन्यवाद

Annex IV- FGD Guideline parents

B3 + B4

लक्षित समुह छलफल निर्देशिका

समुहको किसिम: **आमा / बुवा**
गाविस/नपा: **वडा नं.** **गाउँ:**
सहजकर्ता: **प्रतिवेदक:**
मिति: **समय:** **स्थान:**

प्रथम चरण: परिचय सहित छलफल कार्यक्रमको उदघाटन
नमस्कार मेरो नाम.....म यहाँ को ..... तर्फबाट तपाईको क्षेत्रमा किशोर किशोरीहरुको यौन तथा प्रजनन स्थाास्थ्य सम्बन्धि आधारभूत जानकारी संकलन गर्न उपस्थित भएको छुँ । तपाईहरुले दिएको जानकारीबाट नेपाल सरकारले विभिन्न निकायहरुको सहयोगमा तयार पारिएको कार्यान्वयन निर्देशिका वमोजिम स्थानिय स्वास्थ्य संस्थाहरु मार्फत किशोर किशोरी मैत्री सेवाको कार्यान्वयन गर्न मदत पुगने छ । तपाई सहभागीहररुको सहमतीका आधारमा म यो छलफलको सुरुवात गर्न चाहन्छु । कृपया सजिलो महसुस गरी छलफल कार्यक्रममा भाग लिनुहोस साथै तपाईहरुलाई कुनै जिज्ञासा लागेमा सोध्न सक्नु हुने छ ।

- सहभागीहरुलाई स्वागत गर्नुहोस, आफनो र प्रतिवेदकको परिचाय दिनुहोस ।
- सहभागीहरुलाई तलदिएको विवरण भर्न अनुरोध गर्नुहोस । विवरण भर्नका लागि सहयोग गर्नुहोस ।

सहभागीहररुको विवरण

क्र.सं.	उमेर	लिङ्ग	जाती/जनजाति	शिक्षा	पेशा	वैवाहिक अवस्था	कैफियत
१.							
२.							
३.							
४.							
५.							
६.							
७.							
८.							
९.							
१०.							

आवश्यकता अनुसार थप्नुहोस ।

दोश्रो चरण: मुख्य प्रश्नहरु
क) सामान्य स्वास्थ्य र किशोर किशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सम्वन्धि समस्याहरु

१. तपाईलाई जानकरीमा यस गाविस वा यस किशोर किशोरीहरुको सामान्य स्वास्थ्यको अवस्था कस्तो छ बताई दिनुहोस ?

- किशोरकशोरीहरुको (केटा र केटी) सामान्य स्वास्थ्य अवस्थाका बारेमा जानकारी हासिल गर्नुहोस ?

२. तपाईको जानकारी वा ज्ञानमा यस समुदायमा किशोर किशोरीहरुले यौन तथाा प्रजनन स्वास्थ्य सम्वन्धि कस्ता किसिमका समस्याहहरुको सामना गरिरहेका छन ?

- किशोर किशोरीहरुका समस्याहरुकाबारेमा जानकारी हासिल गर्नुहोस जस्तै: महिनावारी, वृद्धी र विकास, किशोरावस्थाको विकास, बाल वा किशोरावस्थामा विवाह, यौन सम्वन्धी दुर्व्यवहार र ज्यादती, जवर्जस्ती करणी, किशोरावस्थामा गर्भाधान, सुरक्षित यौन शिक्षा, गर्भपतन, परिवार नियोजन आदी ।

३. तपाईको अनुभवमा यस समुदायका किशोर किशोरीहरुमा यौन तथा प्रजनन स्वास्थ्य सम्वन्धि ज्ञान, धारणा, बानी व्यहोरा र व्यवहार कस्तो देख्नु भएको छ ?

- हालको विवाहको उमेर सम्वन्धि प्रचलन (केटा र केटीमा फरक), यौन र यौन शिंपतन र यौन तथा प्रजनन स्वास्थ्य सम्वनी अन्य समस्याहरु र यस्ता समस्याहरुबाटमुक्ती पाउन अवलम्वन गरिएका उपायहरु, जिवन उपयोगी षिपहरु केही छन भने राख्ने यस कुराको जानकारी लैंगिकता (महिला र पुरष), आमावुवाको आर्थिक सामाजिक र शैक्षिक अवस्थाको पेशाको आदि को आधारमा लिने ।

४. तपाईको समुदायमा किशोर किशोरीहरुले यौन तथा प्रजनन स्वास्थ्य सम्वन्धि जानकारी वा सूचना प्राप्त गर्ने मुख्य श्रोत के के हुन र कसरी प्राप्त गर्छन ?

जाकारी लिनुहोस, सूचनाका मुख्य श्रोतहरु के के हुन जस्तै आमा, वुवा, स्वास्थ्य स्वयंसेविका, स्वास्थ्यकर्मीहरु, शिक्षक, रेडियो, निमा, एफ एम, चेतनामुलक अभियान, किताव, समाचार पत्र, पत्रिका आदि कसरी प्राप्त गर्छन ?

५. तपाईको ज्ञान, जानकारी वा अनुभवमा किशोर किशारी यौन तथा प्रजनन स्वास्थ्य सम्वन्धि समस्या परेमा किशोर किशोरीहरु सामान्यतया उपचार र सहयोगका लागि कहाँ जान्छन ?

- किशोर किशोरीहरुले यौन तथा प्रजनन स्वास्थ्य सम्वन्धि सेवा पाउन कहाँ जान्छन जानकारी हासिल गर्नु होस जस्तैः परम्परागत उपचार पद्धति, स्वास्थ्य स्वयंसेविका, स्वास्थ्य कार्यकर्ता, सरकारी अस्पताल, हेल्थपोष्ट, सवहेल्थपोष्ट, प्राथमिक स्वास्थ्य केन्द्र, परिवान नियोजन संघ, मेरी स्टोप्स इत्यादी

ख) किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सेवामा पहुँच र उपयोग

१. यस समुदायमा सरकारी र निजी स्तरबाट उपलव्ध गराइ एको प्रजनन स्वास्थ्य सेवाको अवस्था कस्तो छ ?

- सरकारी स्वास्थ्य संस्था, गैसस, अन्तर्राष्ट्रिय गैसस इत्यादी बाट प्राप्त यौन तथा प्रजनन स्वास्थ्य सम्वन्धी सेवा बारेमा जानकारी हासिल गर्ने
- त्यस्ता कुन कुन संस्थाहरुहुन जस्ले यौन तथा प्रजनन स्वास्थ्य सम्वन्धि सेवा उप

२. यस समुदायमा यौन तथा प्रजनन स्वास्थ्य सेवामा पहुँचको अवस्था कस्तो छ ?

- पहुँच अन्तर्गत दुरी, स्वास्थ्य केन्द्रमा जान प्रयोग हुने साधन, लाग्ने रकम, आर्थिकरुपमा वहन गर्न सकिने नसकिने के हो, किशोर किशोरीका यौन तथा प्रजनन स्वास्थ्य सेवामा पहुँचमा सजिलो अप्ठेरो आदिका बारेमा जानकारी लिने ।
- यस क्षेत्र किशोर किशोरीका यौन तथा प्रजनन स्वास्थ्य सम्वन्धि गुणस्तरीय सेवाका लागि कस्तो किसिमको सुधार गर्न सकिन्छ र बाधारुबाट पार लाग्न सकिन्छ ।

३. तपाईको विचारमा तपाईको समुदायमा किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सेवाको उपयोग र पहुँचलाई राम्रो बनाउन कस्तो किसिमको पहल गरिएकृ छ ? जसका कारणले सेवा सजिलो संग उपर पहुँच पुगेको छ ।

- उपरोक्त कुराहरुलाई भौतिक पूर्वाधार, तालीम प्राप्त स्वास्थ्य कार्यकर्ता, गुणस्तरीय सेवा र औषधी आदीको आधारमा पुष्टयाई गराई जानकारी लिनु पर्ने छ ।

४. तपाई आमावुवा/समुदायको नेतृत्व गर्नेको नाताले किशोर किशोरीहरुको स्थ्य अवस्थाको संवर्द्धनका लागि किशोर किशोरीहरुलाई कसरी सहयोग गर्ने विचार गर्नु भएको छ ?

- जानकारी हासिल गर्नुहोस त्यस्तो योगदान र सहयोगीव्यवहार र प्रेम, विवाहको उपयुक्त उमेरकोसन्दर्भम सहयोग, मनोवैज्ञानिक परामर्ष, शिाामा सहयोग, भोजना र पोषणम सहयोग, निर्णय प्रक्रियामा सहभागी गराएर सहयोग, किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सेवाको पहुँच र उपयोग सम्वन्धि प्रवर्द्धन आदी हुन सक्छ ।

तेश्रो चरण : छलफल कार्यको समापन

अव हामी छलफल कार्यक्रमको अन्त्य तिर पुगेका छौं अन्तमा यौन तथा प्रजनन स्वास्थ्य सेवा लाई तपाईको समुदायमा पहुँच योग्य, उपयोगी र गुणस्तरीय वनाउनका लागि कुनै सुझाव छ भने २ मिनेट भित्र दिन सक्नु हुन्छ ।

- क).....
- ख).....
- ग).....

- छलफलवाट निस्केका कुराहरुलाई सारांशमा सहभागीहरुलाई सुनाउने र थप्ने वा घटाउने के हो जानकारी लिने यदि जस्ताको त्यस्तै ठिक छ भन्छन भने केही गरी राख्नु परेन र उनिहरुको सहभागिताको लागि धन्यवाद दिएर छलफल कार्यक्रमको अन्त्य गर्ने।
  धन्यवाद

Annex V- FGD Guideline FCHV

B6

लक्षित समुह छलफल निर्देशिका

समुह: **महिला स्वास्थ्य स्वयंसेविका (८-१२)**
गाविस/नपा: **वडा नं.** **गाउँ:**
सहजकर्ता: **प्रतिवेदक:**
मिति: **समय:** **स्थान:**

प्रथम चरण: परिचय सहित छलफल कार्यक्रमको उदघाटन

नमस्कार मेरो नाम.....म यहाँ..... को तर्फबाट तपाईको क्षेत्रमा किशोर किशोरीहरुको यौन तथा प्रजनन स्थाास्थ्य सम्बन्धी आधारभूत जानकारी संकलन गर्न उपस्थित भएको छुँ । तपाईहरुले दिएको जानकारीबाट नेपाल सरकारले विभिन्न निकायहरुको सहयोगमा तयार पारिएको कार्यान्वयन निर्देशिका वमोजिम स्थानीय स्वास्थ्य संस्थाहरु मार्फत किशोर किशोरी मैत्री सेवाको कार्यान्वयन गर्न मदत पुग्ने छ । तपाई सहभागीहरुको सहमतीका आधारमा म यो छलफलको सुरुवात गर्न चाहन्छु । कृपया सजिलो महसुस गरी छलफल कार्यक्रममा भाग लिनुहोस साथै तपाईहरुलाई कुनै जिज्ञासा लागेमा सोध्न सक्नु हुने छ ।

- सहभागीहरुलाई स्वागत गर्नुहोस, आफनो र प्रतिवेदकको परिचाय दिनुहोस् ।
- सहभागीहरुलाई तलदिएको विवरण भर्न अनुरोध गर्नुहोस । विवरण भर्नका लागि सहयोग गर्नुहोस् ।

सहभागी विवरण

क्र.सं.	उमेर	लिङ्ग	जाती/जनजाति	शिक्षा	पेशा	वैवाहिक अवस्था	कैफियत
१.							
२.							
३.							
४.							
५.							
६.							
७.							
८.							
९.							
१०.							

आवश्यकता अनुसार थप्नुहोस्

दोश्रो चरण: मुख्य प्रश्नहरु

क) सामान्य स्वास्थ्य र किशोर किशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सम्वन्धि समस्याहरु

१. तपाईलाई जानकरी भए सम्म यस गाविस वा यस सामान्य स्वास्थ्यको अवस्था कस्तो छ बताई दिनुहोस ?

- बालबालिका, किशोरकशोरी, आमाहरु, वृद्धवृद्धा, प्रौढ आदिको स्वास्थ्य अवस्थाका बारेमा जानकारी हासिल गर्नुहोस।

२. यस समुदायमा किशोर किशोरीहरुले यौन तथाा प्रजनन स्वास्थ्य सम्वन्धि कस्ता किसिमका समस्याहहरुको सामना गरिरहेका छन ?

- किशोर किशारीहरुका समस्याहरु पत्ता लाउनुस्

३. तपाईको अनुभव र अवलोकनमा (हेराई)मा यस समुदायमा यौन तथा प्रजनन स्वास्थ्य सम्वन्धी ज्ञान, धारणा, बानी व्यवहारको अवस्था के छ ?

- यसमा हालको विवाहको उमेर सम्वन्धी प्रचलन (केटा र केटीमा फरक), यौन र यौन यौन गर्भपतन र यौन तथा प्रजनन स्वास्थ्य सवन्धि अन्य समस्याहरु र यस्ता समस्याहरुबाट मुक्ति पाउन अवलम्वन गरिएका उपायहरु, जिवन उपयोगी षिपहरु केही छन भने राख्ने ।

ख) किशोर किशोरीमा यौन तथा प्रजनन स्वास्थ्य सेवा माथीको पहुँच र उपयोग

१. यस समुदायमा सरकारी र निजी स्तरबाट उप किशोर किशोर का यौन तथा प्रजनन स्वास्थ्य सेवाको अवस्था कस्तो छ ?

- सरकारी स्वास्थ्य संस्था, गैसस, अन्तर्राष्ट्रिय गैसस इत्यादी बाट प्राप्त यौन तथा प्रजनन स्वास्थ्य सम्वन्धी सेवा बारेमा जानकारी हासिल गर्ने ।
- त्यस्ता कुन कुन संस्थाहरुहुन जस्ले यौन तथा प्रजनन स्वास्थ्य सम्वन्धि सेवा उप **संस्थामा उपलब्ध वा प्राप्त किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सेवाहरु के के हुन ?**
- सहभागीहरुलाई सोध्नु होस, ती संस्थाहरुले किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सम्वन्धि कस्ता किसिमका सेवाहरुलाई समावेश गरेका छन परामर्ष, -मनोवेज्ञानिक, एचआईभी, विभिन्न यौन संक्रमण, परिवार नियोजन सेवाहरु, गर्भपतन सेवाहरु र किशोर किशोरीहरुको विशेष हेरविचार सम्वन्धि)

३. तपाईको अनुभवमा किशोर किशोरीका यौन तथा प्रजनन स्वास्थ्यसंग सम्वन्धीत समस्या भएमा तपाईको समुदायका किशोर किशोरीहरु सामान्यतया सुरुमा कहा जान्छन् र किन ?

- यसमा आधुनिक स्वास्थ्य सेवामा जान्छन भने किन जानकारी लिनुहोस
- यदि आधुनिक बैज्ञानिक सेवा सम्बन्धि भन्दा अन्य किसिमका सेवा लिन जान्छनभने (यसमा घरमा उपचार गर्ने कार्य पनि समावेश गर्ने) त्यस्तो सेवा लिन किन जान्छन्।

४. तपाईको अनुभवमा यौन तथा प्रजनन स्वास्थ्य सेवाको पहुँच र उपयोगका सम्वन्धमा किशोर किशोरीहरुले मुख्य गरी कस्ता किसिमका समस्याहरु सामना गरिरहेका छन ? (केटा र केटीममा तुलनात्मक जानकारी लिने)

- सामाजिक र सांस्कृतिक परिवेशबारे जानकरी लिने जस्तो: गलत धारण, आमाबुवा र परिवारको सस्कृतिक यावहारहरु, सामाजिक मुल्य र मान्यताहरु आदी
- उनिहरुलाई भौतिक वाधाहरु, हेल्थ पोष्टको खराव भौतिक संरचना, यौन तथा प्रजनन स्वास्थ्य सम्वन्धी एकदम कम ज्ञान र चेतना, अपर्याप्त तालिम प्राप्त स्वास्थ्यकर्मी, औषधी र उपकरण आदी

- यस प्रजनन स्वास्थ्य सेवाको सुधार र व्यावधानहरु हटाउनका लागि हामीले के गर्नु पर्ला ?
- **तपाईको समुदायमा किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य सेवाको उपयोग र पहुँचलाई राम्रो बनाउन कस्तो किसिमको पहल गरिएकाृ छन्, जसका कारणले सेवा सजिलो संग उपलव्ध भएको छ र पहुँच पुगेको छ ।**
  - उपरोक्त कुराहरुलाई भौतिक पूर्वाधार, तालिम प्राप्त स्वास्थ्य कार्यकर्ता, गुणस्तरीय सेवा र औषधी आदीको आधारमा पुष्टयाई गराई जानकारी लिनु पर्ने छ ।

तश्रो चरण : छलफल कार्यको समापन

अव हामी छलफल कार्यक्रमको अन्त्य तिर पुगेका छौ अन्तमा यौन तथा प्रजनन स्वास्थ्य सेवा लाई तपाईको समुदायमा पहुँच योग्य, उपयोगी र गुणस्तरीय बनाउनका लागि कुनै सुझाव छ भने २ मिनेट भित्र दिन सक्नु हुन्छ ।

- क).....
- ख).....
- ग).....
-
- छलफलबाट निस्केका कुराहरुलाई सारांशमा सहभागीहरुलाई सुनाउने र थप्ने वा घटाउने के हो जानकारी लिने यदि जस्ता त्यस्तै ठिक छ भन्छन भने केही गरी राख्नु परेन र उनिहरुको सहभागिताको लागि धन्यवाद दिएर छलफल कार्यक्रमको अन्त्य गर्ने।

धन्यवाद

Annex VI - KII Guideline D/PHO

B9

सम्बन्धित जानकारब्यक्तिसँगको अन्तरर्वार्ता निर्देशिका

९क्ष्क्ष०

(जिल्ला स्वास्थ्य/जनस्वास्थ्य प्रमुखका लागि)

नाम.....

जिल्ला.....**गा.वि.स/न.पा**.....**वडान.**रु.....

स्वास्थ्य संस्थाको नाम .....

सहजकर्तारु ..... **टिपोटकर्ता**रु .....

मितिरु **समय**रु **स्थान**रु

चरण १ : परिचय तथा शुरुवात

नमस्ते म.....को तर्फबाट तपाईंको क्षेत्रमा यौन तथा प्रजनन स्वास्थ्यसँग सम्बन्धित किशोरकिशोरमैत्री स्वास्थ्य सेवा (युवामैत्री स्वास्थ्य सेवा) को आधारभूत अवस्थाबारे जानकारी संकलन गर्न आएको हुँ । यस अघि नै नेपाल सरकारले विभिन्न सम्बन्धित निकायहरूको सहकार्यमा *किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्य कार्यान्वयन निर्देशिका* ल्याइसकेको /लागू गरिसकेको छ । सोही निर्देशिकामा उल्लेख भए अनुसार स्थानीय स्तरका स्वास्थ्य संरचनाहरुबाट युवामैत्री स्वास्थ्य सेवा लागू गर्नका लागि तपाईंले दिनुभएका सुझाव तथा सूचनाहरु महत्वपूर्ण हुनेछन् । तपाईंको सहमति लिएर *अन्तर्वार्ता* शुरु गर्न चाहन्छु । छलफलको क्रममा नबुझेका कुराहरु अप्ठ्यारो नमानी सोध्न सक्नुहुनेछ ।

- अभिवादन गर्नुहोस् र तपाईं र नोटटेकरको परिचय दिनुहोस् ।
- सूचनाकर्ताको परिचय सोधेर नोटप्याडमा लेख्नुहोस् ।

(सम्भव भए अन्तर्वार्ता/छलफल रेकर्ड गर्नुहोस्)

चरण २ : मुख्य प्रश्नहरु

क. सामान्य स्वास्थ्य तथा किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्यसम्बन्धि समस्याहरु

१. तपाईंको विचारमा यस गा.वि.स./समुदायका किशोर किशोरीहरुको स्वास्थ्य स्थिति कस्तो छ ?

- किशोरकिशोरीहरुको समग्र स्वास्थ्य स्थितिबारे जानकारी लिने।

२. तपाईंको अनुभवमा यस समुदायका किशोरकिशोरीहरुले कस्ता प्रकारका यौन तथा प्रजनन स्वास्थ्य समस्याहरु सामना गरिरहेका छन् /गर्छन् ?

- महिनावारी, किशोरकिशोरीहरुमा हुने हर्मोनको विकास तथा वृद्धि, किशोरावस्थामा गरिने विवाह, यौन दुर्व्यवहार, जबजस्तिकरणी, किशोरी गर्भवास्था, सुरक्षित यौन शिक्षा, गर्भपतन, परिवार नियोजन, शारीरिक, मनोवैज्ञानिक, सामाजिक समस्याहरु र किशोरावस्तामा हुने समस्याका बारेमा सोध्ने ।

३. तपाईको अनुभवमा यस समुदायका किशोरकिशोरीहरु र युवामा किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सम्बन्धि ज्ञान, धारणा, बानी, व्यवहार कस्तो देख्नुभएको छ ?

- विवाह उमेर, यौन व्यवहार प्रति धारणा, सुरक्षित यौन शिक्षा, गर्भपतन, जीवन उपयोगि सिपको विकास, लिङ्गका आधारमा, अभिभावकको सामजिक आर्थिक अवस्था, शौक्षिक स्थिति र पेसा, आदिका बारेमा अहिलेको स्थिति कस्तो छ जानकारी लिने॥

४. तपाईको समुदायमा किशोरकिशोरी र युवाले किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सम्बन्धि सुचनाहरु पाउने मुख्य स्रोत कुन कुन हुन् ? र कसरी ?

- मुख्य स्रोतहरु जस्तै; अभिभावक (आमा अथवा बुवा), महिला स्वास्थ्य स्वयम् सेविका, स्वास्थ्य कार्यकर्ता, शिक्षकहरु, रेडियो, टि.भी., ः, फिल्म, जनचेतना अभियान, पत्रपत्रिका, हरुको बारेमा जानकारी लिने।

५. तपाईको अहिले सम्मको ज्ञान र अनुभवका आधारमा, सामान्यतय, किशोरकिशोरीहरु र युवाहरु यौन तथा प्रजनन सम्बन्धि कुनै उपचार र सहयोगका लागि कहाँ जान्छन् ?

- किशोरकिशोरी र युवाहरु जानसक्ने ठाउँहरु जस्तै; धामी झाँक्री, महिला स्वास्थ्य स्वयम सेविका, स्वास्थ्य कार्यकर्ता, सरकारी अस्पताल, उप/स्वास्थ्य चौकी, प्राथमिक स्वास्थ्य चौकी, नेपाल परिवार नियोजन क्लिनिक, मेरी स्टोपस्, आदि का बारेमो जानकारी लिने।

ख. किशोरकिशोरीको यौन तथा प्रजनन स्वास्थ्य सेवामा पहुँच तथा उपयोग

१. यस जिल्लामा सरकारी तथा गैरसरकारी स्वास्थ्य संस्थाहरुबाट किशोरकिशोरीहरुका लागि कस्ता प्रकारका यौन तथा प्रजनन स्वास्थ्य सेवाहरु उपलब्ध छन् ?

- सरकारी स्वास्थ्य संस्था, गैरसरकारी तथा अन्तर्राष्ट्रिय गैरसरकारी संस्थाबाट उपलब्ध किशोरकिशोरीको यौन तथा प्रजनन स्वास्थ्य सेवा (ASRH Services) बारे जानकारी लिने।

- ASRH सेवा दिने संस्थाहरु कुन कुन हुन ?

२. तपाईको समुदायमा किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सेवाहरुको पहुचँ कस्तो छ ?

- पहुचँ भन्नाले दुरी, स्वास्थ्य संस्था जादा प्रयोग हुने साधन, लागत, सुलभता, किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सेवाहरु लिन सजिलो/असजिलो बारे सोध्ने ।

- यस समुदायमा किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सेवाहरुको गुणस्तरमा भएका कठिनाइ तथा अभावहरु सुधार गर्न वा समस्या समाधान कसरी गर्न सकिन्छ भनी सोध्ने ।

३. तपाईको विचारमा समुदायमा किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सेवाहरुको पहुँच तथा उपयोगमा वृद्धि गर्न के कस्ता कुराहरुमा ध्यान दिनुपर्छ, जसले गर्दा यी सेवाहरुको सुलभ पहुँच र सजिलै प्राप्त हुन्छन् ?

- भौतिक पूर्वाधार, तालिम प्राप्त स्वास्थ्यकर्मी, गुणस्तरीय सेवा तथा औषधि आदि बारे खोतल्ने ।

४.अभिभावक/सामुदायिक अगुवा/शिक्षक भएको नाताले तपाईको विचारमा किशोरकिशोरी र युवाको स्वास्थ्य स्थिति प्रर्वधन गर्नको लागि किशोरकिशोरी र युवालाई कसरी सहयोग गर्न सकिन्छ ?

- सहयोगी व्यवहार/माया र ममता, ढिला विवाह गर्नकोलागि सहयोग, खाना तथा पोषणमा सहयोग, आत्मनिर्णयमा सहयोग, किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सेवाहरुको पहुचँ, आदि बारे सोध्ने ।

चरण ३ : अन्तर्वार्ताको समाप्ति

अब हामी छलफलको अन्त्यमा आएका छौं । तपाईको समुदायमा गुणस्तरीय किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सेवाहरुको पहुँच तथा उपभोगिता बढाउने बारेमा तपाईको केही सुझावहरु छन् भने दुई मिनेट समयमा भन्नुहोस् ।

क).....

ख) .....

अन्तर्वार्ता अन्त्य गर्दागर्दै .....

- अन्तर्वार्ता का मुख्य बुँदा तथा निष्कर्षहरूलाई संक्षेपमा बताउने ।

- अन्तर्वार्ता मा सहभागिता र सहयोगका लागि धन्यवाद ज्ञापन गर्ने ।

नोट : विश्वसनियताका लागि सूचनाकर्तालाई छलफल/अन्तर्वार्ताको सारसंक्षेप दुई मिनेटभन्दा बढी समय नदिई दोहोऱ्याउने ।

धन्यवाद ।

Annex VII - KII Guideline stake holders

B8

सम्बन्धित जानकारब्यक्तिसँगको अन्तरर्वार्ता निर्देशिका
KII

(अन्य सरोकारवालाहरूका लागि)

जिल्ला ..... गाविस/नपा ..... वडा .....
नाम .....
सहजकर्ता ..... नोट टेकर .....
मिति ..... समय ..... **स्थान "**

चरण १ : परिचय तथा शुरुवात

नमस्ते म..... को तर्फबाट तपाईंको क्षेत्रमा यौन तथा प्रजनन स्वास्थ्यसँग सम्बन्धित किशोरकिशोरीमैत्री स्वास्थ्य सेवा (युवामैत्री स्वास्थ्य सेवा) को आधारभूत अवस्थाबारे जानकारी संकलन गर्न आएको हुँ । यस अघि नै नेपाल सरकारले विभिन्न सम्बन्धित निकायहरूको सहकार्यमा *किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्य कार्यान्वयन निर्देशिका* ल्याइसकेको छ । सोही निर्देशिकामा उल्लेख भए अनुसार स्थानीय स्तरका स्वास्थ्य संरचनाहरुबाट युवामैत्री स्वास्थ्य सेवा लागू गर्नका लागि तपाईंले दिनुभएका सुझाव तथा सूचनाहरु महत्वपूर्ण हुनेछन् । तपाईंको सहमति लिएर *अन्तर्वार्ता* शुरु गर्न चाहन्छु । छलफलको क्रममा नबुझेका कुराहरु अप्ठ्यारो नमानी सोध्न सक्नुहुनेछ ।

- अभिवादन गर्नुहोस् र तपाईं र नोटटेकरको परिचय दिनुहोस् ।
- सूचनाकर्ताको परिचय सोधेर नोटप्याडमा लेख्नुहोस् ।

(सम्भव भए अन्तर्वार्ता रेकर्ड गर्नुहोस्)

चरण २ : मुख्य प्रश्नहरु

क. सामान्य स्वास्थ्य तथा किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्यसम्बन्धि समस्याहरु

१. तपाईंको विचारमा यस गाविस/समुदायका किशोरकिशोरीहरूको स्वास्थ्य अवस्था कस्तो छ ?

- किशोर र किशोरीहरूको समग्र स्वास्थ्य स्थितिबारेजानकारी लिने ।

२. तपाईंको विचारमा यस समुदायमा सामान्यतया: किशोरकिशोरीहरुले कस्ता प्रकारका यौन तथा प्रजनन स्वास्थ्य समस्याहरु सामना गरिरहेका छन् /गर्छन् ?

- किशोर र किशोरीहरूको यौन तथा प्रजनन स्वास्थ्य समस्याहरू जस्तै: महिनावारी, किशोरावस्थामा हुने हर्मोन तथा शारीरिक वृद्धिविकास, कम उमेरमा/किशोरावस्थामा हुने विवाह, यौनहिंसा/यौनदुर्व्यवहार, बलात्कार, किशोरी गर्भवती, सुरक्षित यौनसम्बन्धी शिक्षा, गर्भपतन, परिवार नियोजन आदिबार जानकारी लिने।

३. तपाईंको अनुभवमा, यहाँका किशोरकिशोरीहरूको यौन तथा प्रजनन स्वास्थ्यमा कस्तो प्रकारको ज्ञान, धारणा, बानीव्यहोरा र चालचलन/अभ्यासहरू पाउनुहुन्छ ?

- दुवै (किशोर र किशोरी) को हाल विवाह गर्ने उमेरप्रतिको धारणा, यौन तथा यौनव्यवहारप्रतिको धारणा, सुरक्षित यौनसम्बन्धी शिक्षा/अभ्यास, गर्भपतन, जीवनोपयोगीको सीपको विकास, तनाव व्यवस्थापन क्षमता (दुवै किशोर र किशोरीको), अभिभावकहरूको आर्थिक तथा सामाजिक स्थिति, अभिभावकहरुको शैक्षिक तथा रोजगार/व्यवसायको अवस्था आदि बारे थप जानकारी लिने।

४. किशोरकिशोरीहरूको यौन तथा प्रजनन स्वास्थ्यसम्बन्धी जानकारीको मुख्य स्रोतहरू के के हुन् र कसरी प्राप्त गर्दछन् ?

- सूचना तथा जानकारीका मुख्य स्रोतहरू जस्तै अभिभावक (आमा, बुवा), महिला स्वास्थ्य स्वयंसेविका, स्वास्थ्य कार्यकर्ता, शिक्षक, रेडियो, टेलिभिजन, चलचित्र/फिल्म, सचेतनामूलक कार्यक्रम/अभियान, पुस्तक, पत्रपत्रिका, समाचारपत्र आदिबारे र कसरी प्राप्त गर्छन् भन्ने बारेमा पनि सोध्ने ।

५.तपाईंको अनुभवमा, यहाँका किशोरकिशोरीहरू यौन तथा प्रजनन स्वास्थ्यसँग सम्बन्धित समस्या भएमा प्रायः उपचार तथा सहयोगका लागि कहाँ जान्छन् ? र, किन ?

- यौन तथा प्रजनन स्वास्थ्य सेवाका लागि किशोरकिशोरीहरू जाने स्थान/व्यक्तिहरू जस्तै, परम्परागत उपचारकर्मी, महिला स्वास्थ्य स्वयंसेविका, स्वास्थ्य कार्यकर्ता, सरकारी अस्पताल, उपस्वास्थ्य चौकी/स्वास्थ्य चौकी, प्राथमिक उपचार केन्द्रं, नेपाल परिवार नियोजन संघको क्लिनिक, मेरीस्टोप्स आदिबारे सोध्ने ।

ख. किशोरकिशोरीहरूको यौन तथा प्रजनन स्वास्थ्य सेवामा पहुँच तथा उपभोग

१. तपाईंको यस समुदाय/स्थानमा सरकारी तथा गैरसरकारी स्वास्थ्य संस्थाहरुबाट किशोरकिशोरीहरुका लागि प्रदान गरिने यौन तथा प्रजनन स्वास्थ्य सेवाहरुको अवस्था कस्तो छ ?

- सरकारी स्वास्थ्य संस्था, गैरसरकारी तथा अन्तर्राष्ट्रिय गैरसरकारी संस्थाबाट उपलब्ध किशोरकिशोरीको यौन तथा प्रजनन स्वास्थ्य सेवा ९ब्क्च्ज क्भचखष्अभक० बारे जानकारी लिने।

- ASRH सेवा दिने संस्थाहरु कुन कुन हुन ?

२. तपाईंको यस समुदायमा किशोरकिशोरीहरूको यौन तथा प्रजनन स्वास्थ्य सेवाको पहुँचको अवस्था कस्तो छ ?

- स्वास्थ्य संस्थासम्म पुग्न लाग्ने दूरी/खर्च तथा यातायातको साधन, प्रयोग गर्नसक्ने क्षमता (महङ्गो/सस्तो), सेवाहरूको पहुँचमा कत्तिको सजिलो/कठिन रहेको छ, त्यसबारे जानकारी लिने।

- यस समुदायमा किशोरकिशोरीहरूका लागि गुणस्तरीय यौन तथा प्रजनन स्वास्थ्य दिनका लागि ती समस्याहरूसमाधान कसरी गर्न सकिन्छ भनी थप सोध्ने ।

३. तपाईंको विचारमा समुदायमा किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्य सेवाहरुको पहुँच तथा उपयोगमा वृद्धि गर्न के कस्ता कुराहरुमा ध्यान दिनुपर्छ, जसले गर्दा यी सेवाहरु सुलभ सजिलै प्राप्त हुन्छन् ?

- भौतिक पूर्वाधार, तालिम प्राप्त स्वास्थ्यकर्मी, गुणस्तरीय सेवा तथा औषधि आदि बारे सोध्ने ।

४. तपाईं एक अभिभावक/सामाजिक नेता-अगुवा/शिक्षक भएको नाताले यस समुदायका युवाकिशोरकिशोरीहरूको स्वास्थ्य प्रवर्द्धनका लागि उनीहरूलाई कसरी सहयोग गर्न सक्नुहुन्छ ?

- मायाप्रेम-सद्भाव तथा राम्रो व्यवहार गरेर, ढिलो विवाह गर्न सहयोग गरेर, मनोवैज्ञानिक परामर्श तथा शिक्षामा सहयोग गरेर, खाना तथा पोषणमा सहयोग गरेर, उनीहरू आफैंलाई निर्णय गर्नसक्ने वातावरण तयार गरेर, यौन तथा प्रजनन स्वास्थ्य सेवामा उनीहरुको पहुँच तथा उपयोगमा वृद्धि गरेर आदि कुरा खोतल्ने ।

चरण ३ : अन्तर्वार्ताको समाप्ति

अब हामी छलफलको अन्त्यमा आएका छौं । तपाईको समुदायमा किशोरकिशोरीहरुको गुणस्तरीय यौन तथा प्रजनन स्वास्थ्य सेवाहरुको पहुँच तथा उपभोगिता बढाउने बारेमा तपाईको केही सुझावहरु छन् भने दुई मिनेट समयमा भन्नुहोस् ।

क).....

ख) .....

अन्तर्वार्ता अन्त्य गर्दागर्दै .....

- अन्तर्वार्ता का मुख्य बुँदा तथा निष्कर्षहरूलाई संक्षेपमा बताउने ।
- अन्तर्वार्ता मा सहभागिता र सहयोगका लागि धन्यवाद ज्ञापन गर्ने ।

नोट : विश्वसनीयताका लागि सूचनाकर्तालाई अन्तर्वार्ताको सारसंक्षेप दुई मिनेटभन्दा बढी समय नदिई दोहोऱ्याउने ।

धन्यवाद ।

Annex -VII- KII Guideline media person

B10

सम्बन्धित जानकारब्यक्तिसँगको अन्तरर्वार्ता निर्देशिका
KII
(स्थानिय संचार माध्यम)

जिल्ला ..... गाविस/नपा ..... वडा .....
सँचार माध्यमको नाम .....
सहजकर्ता ..... नोट टेकर .....
मिति ..... समय ..... **स्थान "**

चरण १ : परिचय तथा शुरुवात

नमस्ते म..... को तर्फबाट तपाईंको क्षेत्रमा यौन तथा प्रजनन स्वास्थ्यसँग सम्बन्धित किशोरकिशोरीमैत्री स्वास्थ्य सेवा (युवामैत्री स्वास्थ्य सेवा) को आधारभूत अवस्थाबारे जानकारी संकलन गर्न आएको हुँ । यस अघि नै नेपाल सरकारले विभिन्न सम्बन्धित निकायहरूको सहकार्यमा *किशोरकिशोरीहरुको यौन तथा प्रजनन स्वास्थ्य कार्यान्वयन निर्देशिका* ल्याइसकेको छ । सोही निर्देशिकामा उल्लेख भए अनुसार स्थानीय स्तरका स्वास्थ्य संरचनाहरुबाट युवामैत्री स्वास्थ्य सेवा लागू गर्नका लागि तपाईंले दिनुभएका सुझाव तथा सूचनाहरु महत्वपूर्ण हुनेछन् । तपाईंको सहमति लिएर अन्तर्वार्ता शुरु गर्न चाहन्छु । छलफलको क्रममा नबुझेका कुराहरु अप्ठ्यारो नमानी सोध्न सक्नुहुनेछ ।

- अभिवादन गर्नुहोस् र तपाईं र नोटटेकरको परिचय दिनुहोस् ।
- सूचनाकर्ताको परिचय सोधेर नोटप्याडमा लेख्नुहोस् ।

(सम्भव भए अन्तर्वार्ता रेकर्ड गर्नुहोस्)

चरण २ : मुख्य प्रश्नहरु

- किशोरकिशोरीहरुका यौन तथा प्रजनन स्वास्थ्य/सामान्य स्वास्थ्य/स्वास्थ्य क्षेत्रमा कार्यरत स्वास्थ्यकर्मीका विषयमा स्थानिय संचार माध्यमहरुमा कार्यक्रम तालिका छ कि छैन ।

केही उदाहरणहरु

- किशोरकिशोरीहरुका लागि यौन तथा प्रजननका सवालमा कुनै विशेष कार्यक्रम छ ?
- के संचारकर्मीहरु किशोरकिशोरीहरुका यौन तथा प्रजनन स्वास्थ्यका सवालहरुको वकालत गर्न इच्छुक छन ?
- स्थानिय संचार माध्यमहरुमा यौन तथा प्रजनन स्वास्थ्य सम्बन्धी लेख रचनाहरु छापिएका छन ?

- पत्रकारहरु किशोरकिशोरीहरुका यौन तथा प्रजनन स्वास्थ्य/यौन स्वास्थ्यका सवालहरुमा तालिम प्राप्त छन ?

- किशोरकिशोरीहरुका यौन तथा प्रजनन स्वास्थ्य सम्वन्धी सवालहरुलाई संचारका माध्यम मार्फत वकालत गर्न के गर्नु पर्ला ?

चरण २ : अन्तर्वार्ता समाप्ति

अब हामी छलफलको अन्त्यमा आएका छौं । तपाईको समुदायमा किशोरकिशोरीहरुको गुणस्तरीय यौन तथा प्रजनन स्वास्थ्य सेवाहरुको पहुँच तथा उपभोगिता बढाउने बारेमा तपाईको केही सुझावहरु छन् भने दुई मिनेट समयमा भन्नुहोस् ।

क).....

ख) .....

छलफल अन्त्य गर्दागर्दै .....

- अन्तर्वार्ताका मुख्य बुँदा तथा निष्कर्षहरूलाई संक्षेपमा बताउने ।

- अन्तर्वार्तामा सहभागिता र सहयोगका लागि धन्यवाद ज्ञापन गर्ने ।

नोट : विश्वसनीयताका लागि सूचनाकर्तालाई छलफल/अन्तर्वार्ताको सारसंक्षेप दुई मिनेटभन्दा बढी समय नदिई दोहोऱ्याउने ।

धन्यवाद ।