Effectiveness of Sakshyam Kishor Kishori intervention on family planning (FP) uptake among married adolescent girls in selected districts of Nepal

Government of Nepal
Ministry of Health and Population
Department of Health Services
Family Welfare Division
Teku, Kathmandu

July 2021

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(Effectiveness of *Sakshyam Kishor Kishori* intervention on Family Planning uptake in Nepal)

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UKaid Nepal Health Sector Programme 3 / Monitoring, Evaluation and Operational Research Project

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and

UNFPA Nepal

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This study was carried out under the aegis of Family Welfare Division (FWD) Department of Health Services (DoHS), and Ministry of Health and Population (MoHP). In addition, United Nations Population Fund (UNFPA) and Adventist Development and Relief Agency (ADRA) Nepal supported in field implementation of the study. The UKaid Nepal Health Sector Programme 3 (NHSP3), Monitoring Evaluation and Operational Research (MEOR) project provided technical assistance in designing the study and evaluating the intervention. This study was financially supported by UKaid. This study intended to test the effectiveness of comprehensive *Sakshyam Kishor Kishori* intervention on FP service uptake among married adolescent girls in selected districts of Lumbini Province and Province 2. The views expressed in the report are of those who contributed to carry out and complete the study and do not necessarily reflect the views of MoHP, British Embassy Kathmandu, the Government of Nepal or UK Government.

Additional information about the analysis may be obtained from the FWD, DoHS, MoHP, Teku Kathmandu; Telephone: +977-1-4257765; internet: http://www.mddohs.gov.np; or NHSP3/MEOR project, email: meor@abtassoc.com.au.

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Foreword

Considering the higher rates of pregnancy related complications and deaths among adolescents, government has recognized adolescent Sexual and reproductive health (ASRH) and Family Planning (FP) as priority programme of Government of Nepal (GoN). However, evidence suggest that the interventions that may have been effective in improving uptake of FP services may not have same level of effectiveness among adolescents. Relatively stagnant contraceptive use and fertility rates among adolescents indicate the need for specially designed and targeted interventions that carefully consider the challenges adolescents face in utilizing the services.

I have learnt that, this study under the leadership of Family Welfare Division (FWD), Department of Health Services (DoHS) has attempted to add to the body of science on part of interventions that could be effective in increasing uptake of FP services among adolescents in the Nepalese context. Findings of the study, that has evaluated the effectiveness of a comprehensive *Sakshyam Kishor Kishori* intervention that strategically address the challenges adolescents face in utilizing the FP services, could be useful in designing future FP programmes, particularly targeted to adolescents.

This study was conducted under the aegis of the DoHS, MoHP with Family Welfare Division (FWD), DoHS leading and United Nations Population Fund (UNFPA) and Adventist Development and Relief Agency (ADRA) Nepal supporting the implementation of the study including implementing the FP interventions in the study sites. The UKaid Nepal Health Sector Programme 3 (NHSP3), Monitoring Evaluation and Operational Research (MEOR) project provided technical assistance in designing the study and evaluating the effectiveness of intervention.

I would like to congratulate the FWD, DoHS for successfully leading this study with technical cooperation from UNFPA, ADRA and NHSP3/MEOR. I appreciate the efforts of Dr Bhim Singh Tinkari, the then Director of FWD, and Dr Tara Pokhrel, Director of FWD as well as the whole team of FWD for successfully completing this study. This study was funded with UKaid and I appreciate British Embassy Kathmandu for the support with UKaid in completing this study.

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Acknowledgements

This operational research, aimed at assessing the effectiveness of the interventions in improving he uptake of family planning (FP) services by adolescents in Nepal, was led by Family Welfare Division (FWD), Department of Health Services (DoHS), Ministry of Health and Population (MoHP) and was a part Nepal Family Planning Project (NFPP) funded with UKaid and implemented by United Nations Population Fund and its implementing partners. The study intended to capture the changes that *Sakshyam Kishor Kishori* intervention brought on the knowledge, attitude, self-efficacy and use of FP services among married adolescent girls of 15-19 years of age. UNFPA in collaboration with Adventist Development and Relief Agency (ADRA) implemented the *Sakshyam Kishor Kishori* intervention. UKaid Nepal Health Sector Programme 3 (NHSP3), Monitoring Evaluation and Operational Research (MEOR) project led the technical part of the research process. Findings from this study can be useful in designing targeted interventions to improve perception towards and the use of FP services among adolescents.

I would like to extend my sincere thanks to Kabita Aryal, Chief of FP & RH Section, FWD and the whole team for successfully completing this study. I appreciate the tremendous effort of Dr Ghanshyam Bhatta, Sujit Kumar Shah, Durgeshwori Munankarmi and the entire team of ADRA Nepal for rolling-out the intervention and ensuring its continuity despite difficult circumstances due to COVID-19 pandemic. I am grateful towards Jagadishwor Ghimire, Amit Dhungel and Pankaj Bhattarai from UNFPA for their support during the research process. I appreciate the contribution of Dr Krishna K Aryal, Peter Godwin, Achyut Raj Pandey, Jasmine Maskey and Dikshya Sharma of MEOR project for their technical support in conducting this study. I would also like to acknowledge the contribution of Dr Raja Ram Dhungana (quantitative data analyst) and Ms Namuna Shrestha (qualitative data analyst) for their contribution to this report.

I would like to acknowledge the ongoing support from British Embassy Kathmandu on strengthening FP service delivery in Nepal with the UKaid, and sincerely appreciate the financial support for this study as well.

Dr Tara Nath Pokhrel
Director

Director

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List of Abbreviations

ADRA	Adventist Development and Relief Agency
AFIC	Adolescent friendly information corner
AFS	Adolescent friendly service
ASRH	Adolescent sexual and reproductive health
BCC	Behaviour change communication
CPR	Contraceptive prevalence rate
DoHS	Department of Health Services
DFID	Department for Internal Development
DID	Difference-in-difference
COVID	Coronavirus disease
ERB	Ethical Review Board
FCHVs	Female community health volunteers
FP	Family planning
HF	Health facility
HSP	Health service provider
IDI	In-depth interview
IEC	Information, education, and communication
IQR	Inter quartile range
IUCD	Intra-uterine contraceptive device
KII	Key informant interviews
LAM	Lactational amenorrhea method
NHRC	Nepal Health Research Council
PE	Peer educator
SD	Standard deviation
SE	Standard Error
SM	Social mobiliser
SRH	Sexual and reproductive health
STIs	Sexually transmitted infections
UK	United Kingdom
UNFPA	United Nations Population Fund
VSP	Visiting service provider

Executive Summary

Background

Adolescence is a stage of transition from childhood to adulthood when young people experience changes in puberty whilst not yet having the maturity or assuming the roles and responsibilities of adults. An adolescent is any person between 10 and 19 years of age and in this age group, the sexual and reproductive health needs mostly differ from those of adults. In Nepal, adolescents comprise 24% of the total population and adolescents often face family pressure for early marriage and childbearing which puts them at increased risk of maternal deaths and pregnancy related health consequences. Despite continuous efforts from governmental and non-governmental sectors in preventing early marriage and early childbearing, Nepal falls among the countries which have high adolescent fertility rates and high adolescent maternal death rates. Access to family planning (FP) services has become a critical public health need for delaying the first child, preventing premature maternal deaths, and improving neonatal health outcomes. However, Nepal lacks evidence on the interventions that can be effective in increasing uptake of FP services and preventing adolescent pregnancies. In this context, this study attempted to test the effectiveness of the *Sakshyam Kishor Kishori* intervention on improving knowledge, attitude, self-efficacy and use of FP services among married adolescents.

Methodology

A mixed-method, quasi-experimental study covering four districts, with Sarlahi and Arghakhanchi as the intervention districts and Sunsari and Pyuthan as control districts. The study primarily assessed changes in contraceptive use, intention to use FP and self-efficacy through baseline and the endline surveys amongst 15-19 year old married adolescent girls in the study sites. Knowledge of FP, perceived risks, perceived benefits, and perceived barriers were further assessed as secondary outcome variables.

In the baseline survey, 3,634 participants with 1,812 in intervention and 1,822 in control districts were interviewed, using a structured questionnaire between November and January 2019. After baseline data collection, the *Sakshyam Kishor Kishori* intervention was rolled out for a period of 11 months from January 2020 to November 2020 in the intervention districts. *Sakshyam Kishor Kishori* intervention used five key strategies: empowering adolescents, informing adolescents about FP services, engaging them in raising awareness at community level, strengthening service delivery through advocacy and capacity development, and delivering FP services to adolescents in and out of schools through mobile camps.

Data collection for the endline survey was completed November to December 2020. In the endline, 3,680 participants, 1,840 each from both the intervention and control districts completed the quantitative survey. Alongside the survey, qualitative assessments were conducted to assess the perceived effectiveness and potential areas of improvement in the intervention. A total of 117 qualitative interviews were conducted among different categories of beneficiaries (65 interviews), the programme implementors (44 interviews) and local leaders (8 interviews) during the process.

Results

By the time of the endline survey, 24.8% of the participants in intervention districts had been reached by the *Sakshyam Kishor Kishori* intervention. Respondents' knowledge score (total: 28 points) increased by 1.27 points in control districts and 4.65 points in intervention districts from baseline to endline

survey. Intervention districts gained additional 3.38 points in knowledge score during the intervention period which was statistically significant at $p< 0.05$ indicating that intervention was effective in improving knowledge of FP in the study. Similarly, perception of risk score (total: 40 points) decreased by 1.19 points in control districts, but it remained stable in intervention districts. Despite this, the difference in change of perception of risk score from baseline to endline survey, in intervention and control districts was statistically significant. Intervention was also found to be effective in improving perception about the benefit of using FP services and self-efficacy in use of FP services. The perception of benefit score (total: 35 points) and self-efficacy score (total: 30 points) improved by additional 1.08 points and 1.15 points respectively in intervention districts. However, intervention did not have statistically significant improvement in the use of contraceptives. As COVID-19 pandemic prevailed for most of the implementation period, the effect of the pandemic over the effectiveness of the intervention was adjusted and the analysis was re-run. After adjustment for impact of COVID-19, the intervention was found effective in overcoming barriers to FP services as well.

Although reluctance was seen in early stage of the intervention, the programme gradually gained confidence of the participants and was well accepted in later stages of the intervention, as revealed by qualitative component of the study. Participants shared that it was relatively easy to comprehend and receive the message, ask questions, contact, or visit tutors for information at flexible time when both participants and tutors are of same age. Lack of knowledge, poverty, distance to health facilities, feeling of shame, pressure from family members and their attitude, fear of side effects and the fear that they may have to compromise with their privacy were the major concerns from participants relating to FP service use, which were addressed by five key strategies of *Sakshyam Kishor Kishori* intervention. Participants shared that, after the intervention, they were able to talk confidently about FP services with their family members and health workers. Parents of the adolescent participants also noticed changes in their children and shared that they are now more informed about health issues like menstruation and able to talk about it with their parents and family. Apart from benefiting direct beneficiaries, the intervention also benefitted a wider segment of the community, increasing understanding about FP services, child spacing and the appropriate age for marriage. Participants shared that engaging girls below the age of adolescence too could help them prepare for the transition to adolescence, with the accompanying bodily changes. According to participants, more engagement of adolescent boys could further improve the effectiveness of intervention.

Conclusion

The intervention was found effective in improving knowledge of FP, perception of the risk and benefits of using/not using FP services, overcoming barriers to FP services and self-efficacy in use of FP services. However, the effect of intervention may take slightly longer period to influence indicators like contraceptive prevalence rate.

1. Introduction

1.1 Background

Adolescence, in general terms, is considered a time of transition from childhood to adulthood that occurs between the ages of 10-19 years, during which young people experience changes following puberty, but are not yet fully matured into the roles, privileges, and responsibilities of adulthood. This period is subdivided into early (10-13 years), middle (14-15 years) and older (16-19 years) adolescence.[1,2] Early adolescence is characterised by initial physical changes and rapid brain development during which adolescents may be physically, emotionally, cognitively and behaviourally closer to children than adults. Middle adolescence is the period when sexual orientation develops progressively, and friends become an important source of influence. The older adolescents may physically resemble adults, but may not have reached cognitive, emotional and behavioural maturity. [3,4]

Sexual and reproductive health (SRH) needs of adolescents differ significantly from those of adults something often not fully understood.[5] Many adolescents often face family pressure to marry and bear children early which can impact on their educational and employment prospects alongside its direct impact on health. With transition from childhood to adulthood occurring faster than intellectual maturity, some adolescents do not know how to avoid a pregnancy, while others are unable to use contraceptives to prevent pregnancies.[6] In addition, early marriage has also been the leading cause of school dropout thereby limiting the educational potentials that enable adolescents to make appropriate choices regarding timing and spacing of children.[7]

Around 12 million adolescent girls (age 15 to 19 years) give birth each year in developing countries[8,9] with risk of pregnancy death being almost double for girls aged 15-19 compared to women aged 20-29.[10] Around 11% of total babies born globally are from adolescent mothers with 95% of these births occurring in developing countries.[6] Approximately 3.9 million girls of this age group undergo unsafe abortions[11], whilst complications during pregnancy and childbirth are the leading cause of death for 15 to 19 year-old girls globally.[9] Evidence suggests that adolescent mothers are at higher risk of puerperal endometritis, eclampsia, and systemic infections compared to women aged 20 to 24 years.[11] The health consequences of adolescent childbearing are also extended to their infants and children. Stillbirths and new-born deaths are 50% higher among infants of adolescent mothers than among infants of women aged 20-29 years. New-borns of adolescent mothers are also more likely to have a low birth weight, with the risk of long term effects.[3, 5,12]

FP empowers couples to anticipate and attain their desired number of children, facilitating the appropriate timing and spacing of their births.[2] Contraceptive use is known to prevent approximately 20-35% of maternal deaths in most lower and middle-income countries. However, adolescents often tend to have limited access to and use of contraceptive services.[10,13]

In Nepal, adolescents constitute 24% (6.4 million) of the population according to the census of 2011.[14] The practice of early marriage and childbearing is very common in Nepal.[15,16]. After declining between 2001 (21%) and 2011 (17%), teenage childbearing has remained constant over the past 5 years (17%)[16] which indicates the need for appropriate FP interventions targeting the adolescent segment of the population. On average, one-third of births or pregnancies among

married adolescent mothers are either mistimed or unwanted in Nepal.[17] Access to FP services is critical among adolescents as delaying first birth and ensuring appropriate birth intervals has remained the main strategy for promoting adolescent health. Delaying childbearing can prevent premature maternal and neonatal deaths and also provides opportunities for adolescents to gain education and seek employment opportunities.[17]

Despite efforts from governmental and non-governmental sectors in improving adolescents' SRH, adolescents' low uptake of contraception is a persistent and serious problem in Nepal. Use of modern contraceptives among adolescents has remained at 14% without remarkable change since 2006.[18]

1.2 Rationale of the study

Studies suggest that around 10% of maternal deaths each year were accounted for by adolescents aged 15–19 years. Adolescents contribute approximately 12% of total births. Distribution of adolescent maternal deaths is largely skewed with 20 countries including Nepal accounting for almost 82% of the world's total adolescent maternal deaths. High adolescent fertility rates have contributed to high maternal mortality rates in countries across the world.[19]

Despite the legal age of marriage being 20 years in Nepal, both the median age at first marriage and median age at first sexual intercourse stand at 17.9 years as revealed by Nepal Demographic Health Survey (NDHS) 2016. Among adolescent girls aged 15-19 years, in 2016 approximately 17% had begun childbearing and the proportion was same in 2011 as shown by NDHS. Despite the fact that almost half of the women are married during adolescence stage, contraceptive prevalence rate(CPR) among married adolescents is only 14.5%.[16] The Government of Nepal has been prioritising FP programmes, and have attempted to cater to the needs of adolescents. However, despite continuous efforts, the adolescent fertility rate in Nepal stands at 88 per 1000 women in 2018, which is an increase from 81 per 1000 women in 2011.[16,20]

Making investments to delay first pregnancy, reduce maternal mortality, improve health outcomes for mother and child are of public health priority and can contribute to a reduction in adolescent and overall maternal mortality and also contribute to the achievement of development goals and reduction of poverty.[3,12] However, the utilisation of services such as FP that would have helped to achieve these outcomes appears to be still lagging, especially among adolescents. Amidst this, there is also a dearth of evidence on effectiveness of interventions that could prevent early marriage and delay the first birth. In this context, this study is designed to meet the evidence gap.

1.3 Research questions and objectives of the study

1.3.1 Research question

- Does the *Sakshyam Kishor Kishori* intervention improve knowledge, attitude, self-efficacy and use of FP services among married adolescent girls?

1.3.2 Objectives of the study

General Objective:

- To assess the effectiveness of *Sakshyam Kishor Kishori* intervention on improving knowledge, attitude, self-efficacy and use of FP services among married adolescent girls.

Specific objectives:

- To assess the change in knowledge about FP and attitude towards FP among married adolescent girls before and after *Sakshyam Kishor Kishori* intervention
- To assess the effect of *Sakshyam Kishor Kishori* intervention on self-efficacy on use FP services among married adolescent girls
- To measure the change in the uptake of FP services among married adolescent girls before and after *Sakshyam Kishor Kishori* intervention
- To assess the perceived effectiveness of FP intervention and potential areas of improvement of intervention from perspective of beneficiaries, programme implementers and local leaders

2. Methods

2.1 Study design

This operational research study used quasi-experimental design to test the effectiveness of *Sakshyam Kishor Kishori* intervention that comprehensively attempted to address the determinants of adolescent pregnancy, thereby increasing FP uptake among adolescents. The baseline survey was conducted in both control and the intervention sites. Following the baseline survey, *Sakshyam Kishor Kishori* intervention was rolled-out in the intervention sites. At the end of 11 months of implementation, an endline survey was conducted in all the study sites to assess the changes in key outcome variables of the study. Qualitative interviews with different groups of beneficiaries of the intervention and the implementers were conducted alongside to explore the perception about the intervention in the intervention sites.

2.2 Study site and population

The study includes Sarlahi and Arghakhanchi as intervention districts and Pyuthan and Sunsari as control districts. The study population consisted of married adolescent girls of 15-19 years of age at quantitative baseline and endline assessments. However, in addition to married adolescent girls, the qualitative component of the study covered married adolescent boys and programme implementers (who could be of any age/sex) to assess the perceived effectiveness and potential areas of improvement in the intervention.

2.3 Sample size

The sample size for the quantitative survey was estimated assuming alpha error of 5% and statistical power of test as 80%. It was then subjected to finite population correction and then adjusted for non-response rate of 5%. This sample size was powered to detect 25% changes in prevalence of modern contraceptives among married adolescents from the baseline value of 14.5% (proportion of married adolescents as per 2016 NDHS). The calculated sample size was divided to palikas (municipalities) and then to wards. After rounding up the decimal places, a total of 3690 married adolescents of 15-19 years of age was decided to be the final sample size for the study. The response rate however was 98.5% in the baseline survey and 99.7% in the endline survey. Hence, the total number of samples collected during baseline reached 3,634 (1812 participants from the intervention districts and 1,822 from control district) and in the endline it reached to 3680 (1840 each from both the intervention districts and control districts). The participants were selected through multistage cluster sampling process for the survey.

In the case of the qualitative assessment, a total of 117 qualitative interviews were conducted which included 65 interviews from programme beneficiaries, 44 interviews from programme implementers and 8 interviews from local leaders. The number of interviews to be conducted was decided based on the theory of saturation, meaning that the interview process was continued till the information became saturated and no further new information was obtained on repeating the interviews. The diversity of the participants represented in qualitative component have been presented in **Annex I**.

2.4 Sampling process

Multistage cluster sampling was used in the study to select the adolescent girls for the quantitative component of the study. The calculated sample size was equally divided among four districts. In the first stage, four palikas from each of the intervention and control districts were randomly selected. The number of total samples required from the district was distributed proportionately among the four palikas based on the population of married adolescent girls in the palikas as reported in the National Census Report 2011. In the second stage, the number of wards required to meet the final sample size from each palika was calculated based on the average number of target population available in a ward which was followed by random selection of wards from the palika. The number of samples in the palika was further distributed proportionately among the selected wards. In the last stage, married adolescent girls aged 15-19 years were approached by visiting all the households starting from the North East corner of the ward until the required sample size from each ward was met.

Quota sampling method was adopted for selection of participants for qualitative interview. Sampling processes attempted to capture diversity among three categories of participants: programme beneficiaries, programme implementers and local leaders (elected local representatives).

2.5 Key study variables

FP behaviour that includes existing use and intention to use FP services and self-efficacy in use of FP services were used as primary outcome variables in the study. Apart from these variables, knowledge on FP, perceived risk, perceived benefits, and perceived barriers were considered as secondary outcome variables. Two broad categories of explanatory factors: socio-demographic (age, place of residence, ethnicity, religion, educational status, history of previous pregnancy, migration status) and exposure to different components of the intervention are considered as the explanatory variables. Operational definition of key variables (knowledge on FP, perceived risk, perceived benefits, perceived barriers, self-efficacy, and FP behaviour-use of or intention to use FP services) has been presented in **Annex III**.

2.6 Implementation of Sakshyam Kishor Kishori intervention

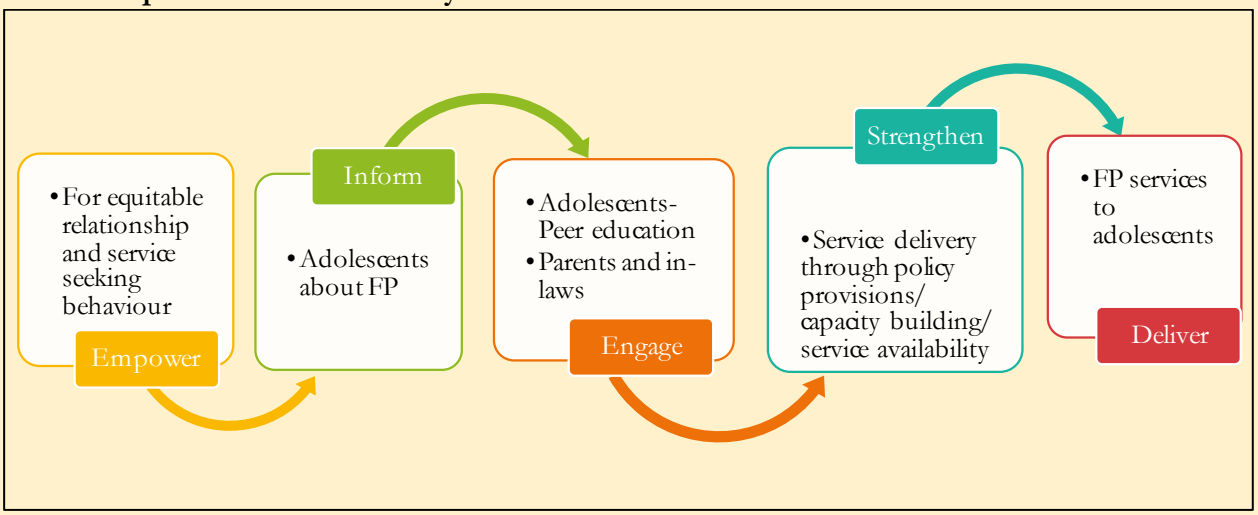


Figure 1: Five key strategies of Sakshyam Kishor Kishori intervention

Sakshyam Kishor Kishori, the intervention of the study, basically involved five key implementation strategies *Figure 1*. The first, empowering adolescents, included life skills training to the groups of adolescent girls using standardised package called *Rupantaran.* Besides reproductive health, nutrition, and gender equality the package covered a range of areas in its 15 modules, the details of which has been provided in the annex. The second, informing adolescents about SRH and FP involved home based counselling for newlywed couples by Social Mobilizers (SMs), animated video session, quizzes, and games. The third, engaged adolescents in the form of the Peer Educators (PEs) in awareness raising activities. The study trained SMs and PEs to conduct *Rupantaran* sessions, counselling sessions and awareness raising activities before implementing the above activities.

Next, the intervention aimed at strengthening Adolescent Sexual and Reproductive Health (ASRH) service delivery through training of service providers and certification of health facilities on Adolescent Friendly Services (AFS) and finally this also involved delivering FP services, specifically to reach out to those adolescents who could have been missed out from above four strategical approaches, through mobile camps. Details of the intervention alongside its strategies has been provided in ***Table 1***.

The *Sakshyam Kishor-Kishori* intervention was rolled out in four palikas of each intervention district. Two implementation teams were formed for rolling out the intervention: one each for Sarlahi and Arghakhanchi district. Although *Rupantaran* sessions were conducted among girls' circles formed in two of the wards of each palika, all other activities were implemented throughout the palika. SMs, adolescent members of the community, visited the households identifying and counselling adolescent couples on FP services. Being members of the local community, they were supposed to bridge the gap between the community and the intervention implementation team. A total of eight SMs (four in Sarlahi district and four Arghakhanchi district) were trained and mobilised in the community.

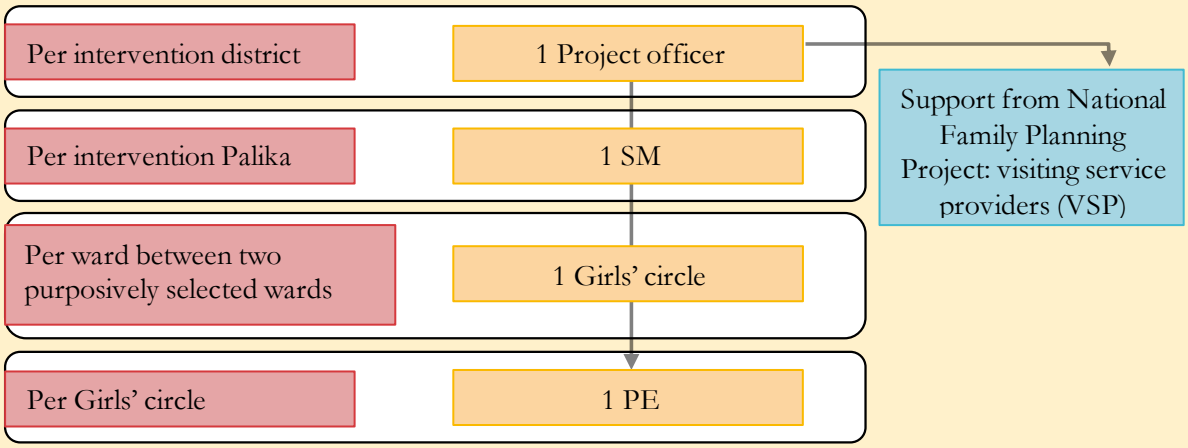


Figure 2: Organisation of field team in each intervention district

Table 1: Details of the Sakshyam Kishor Kishori intervention rolled out in intervention sites

Intervention		Target population	Objective	Details
Empower	Deliver life skills education (topics ranging from reproductive health, nutrition, and other health information to basic financial literacy and civic awareness)	Adolescent girls' circles	To empower adolescent girls and make them capable of independent decision making	A total of 16 girls' circles (two circles in each of 8 intervention palika) with a total of 452 adolescent girls (242 in Arghakhanchi and 210 in Sarlahi) directly benefitted from the *Rupantaran* package. The package consisted of 15 modules delivered in one-hour sessions twice a week for 36 weeks. Overall, 4.2% of all girls' circle members could not complete the final session of *Rupantaran*.
	Dedicated version of the life skills package aimed at parents	Parents of the adolescents attending the girls' circles	To help them understand what the girls are learning and to gain their trust and support for the programme	A total of 782 parents/in-laws (350 In Arghakhanchi and 432 in Sarlahi) of the adolescents attending *Rupantaran* sessions were reached.
Inform	Counselling sessions for newlywed adolescent couples (SM goes door to door to meet newlywed couple and counsel them to use FP method)	Adolescent couples	To make adolescent couples physically and emotionally ready for FP and childbearing	A total of 16 SMs (8 each in Arghakhanchi and Sarlahi) visited house to house, counselling adolescent couples on FP. During the intervention period, a total of 389 married adolescents (102 in Arghakhanchi and 287 in Sarlahi) were referred for FP services by SMs. Among those referred to health facility (HF), 266 (68.4%) adolescents reached HFs (62 in Arghakhanchi and 203 in Sarlahi) seeking for service.

Intervention		Target population	Objective	Details
	Production and distribution of educational materials including newsletter focused on ASRH and animated video on SRH and FP	Adolescent girls, stakeholders, elected members, local government staff	To inform the target population about the current scenario for adolescents	A total of three issues of a newsletter were published, of which 525 copies (225 copies in Arghakhanchi and 300 in Sarlahi) were distributed to intervention palikas. One animated video was produced and was shown in the girls' circle during *Rupantaran* sessions.
	Game based orientation and quizzes	School going adolescents	To raise awareness about FP services	School quizzes and games on SRH and FP were conducted in 20 schools during the intervention period. A total of 606 adolescents (270 in Arghakhanchi and 336 in Sarlahi) were reached through FP focused school quizzes and games.
Engage	Mobilise peer educators to conduct awareness raising activities in schools as well as out of school setting through various activities (e.g. exhibition, quiz etc.)	Adolescents	To raise awareness on ASRH and FP among adolescents	An adolescent from each of the girl's circles, based on ability to communicate, confidence and willingness to contribute was selected as PE. A total of 16 PEs were trained who in turn delivered Rupantaran package to adolescent girls with the support from SMs.
	Engaging mothers and in-laws	Mothers and in-laws	To maintain support to adolescents to attend Rupantaran session To secure support to adolescent on FP service use imparting knowledge	Apart from engaging parents and in-laws in life skill sessions, they were also counselled for FP during the household visit by SMs so as to raise awareness and gain trust and support for FP counseling to married adolescents.
Strengthe	Support ASRH training to FP service providers from health facilities in project localities	Health Service providers (HSPs)	To train the HSPs about ASRH and adolescent friendly services	A total of 12 health workers (4 from Arghakhanchi and 8 from Sarlahi) were trained on ASRH.

Intervention		Target population	Objective	Details
	Strengthening FP services in an adolescent friendly manner in health facilities through AFS certification	HFs	To build trust among adolescents towards HF and increase its utilisation	Three (2 in Arghakhanchi and one in Sarlahi), HFs of study area were certified as AFS sites. Additional four HFs were provided with half-day orientation (covered content of National ASRH programme, quality improvement of ARSH services) and logistics to facilitate certification process. All staffs of HFs, representatives from Health Facility Operation and Management Committee (HFOMC), teacher representatives, ward chairperson and health coordinators of respective municipality participated in the orientation.
Deliver	FP service delivery through mobile camps	Adolescents	To reach the unreached population, or to reach the adolescents who does not receive regular services from HF	A total of 17 health camps (8 in Arghakhanchi and 9 in Sarlahi) were conducted during the study period. All age group could utilize the service from the camps. A total of 22 adolescent girls (6 in Arghakhanchi and 16 in Sarlahi) utilized service from the camps.
	Supporting service delivery through AFS sites	Adolescents	To ensure access to service after demand generation activities	Altogether there were 16 AFS in intervention palikas. Total 18,719 adolescents (15,163 in Arghakhanchi and 3,556 adolescents in Sarlahi) had visited these sites (between July 2020-December 2020, after lockdown imposed to contain COVID-19 was relaxed), which was approximately an increase of 5.9% from the corresponding period in the previous year.

2.7 Data collection tools and technique

A quantitative community survey assessed knowledge of FP, incidence, the perceived risk, perceived benefit, barriers to FP services, self-efficacy, and the FP behaviour (constructs adopted from Health Belief Model). The approximate duration of the interview was 30 minutes. Structured questionnaire was used as data collection tool for quantitative survey. Questions for constructs adopted from health belief model were developed based on previous studies/literatures by King et al 2019[21], Ashley D Miller 2016[22], Marvin Eisen 1985[23] and Kelli Stidham Hall 2011[24].

In depth interviews were conducted for qualitative assessment using separate interview guidelines for different categories of beneficiaries, programme implementers and local leaders. The guidelines were developed through discussion amongst the central research team and subsequently refined as new information was brought up in interviews during data collection process. All the interviews were conducted in Nepali language except for 27 interviews which were conducted in Bachika, the local language in Sarlahi, considering the participants' command and preference to Nepali. All the qualitative interviews were audio recorded with the written consent from research participants.

2.8 Adjustments for COVID-19 in endline survey

Although the restrictive measures were lifted during the endline survey, Monitoring, Evaluation and Operational Research (MEOR) and the study implementing partner, Adventist Development and Relief Agency (ADRA) Nepal, reached the conclusion that there could be some risks of acquiring the disease and spreading it to the community, particularly during the quantitative household survey. The research team tried to mitigate these risks to the best possible level. In the endline survey, enumerators screened the participants for COVID-19 status (enumerators asked participants if they had tested positive or had symptoms of COVID-19) to minimize the risk of acquiring the disease from participants and spreading it to the wider community. Enumerators were instructed to use face mask and sanitizers, maintain social distance of 2 meters during the interview and avoid interviews in enclosed spaces to minimise the risk of spreading the disease. Supervisors were assigned the responsibility of making sure that these preventive measures were followed in field settings. Enumerators were instructed not to engage HSPs unless strictly necessary to make sure that service providers were not occupied with research related activities that could affect their availability for the COVID-19 response. Enumerators engaged other local leaders in preparation of social mapping and identifying potential participants, sparing health workers for the COVID-19 response and service delivery. Furthermore, enumerators were instructed to provide information on COVID-19 prevention measures to the local community and alleviate their concerns to the best possible level during household visit.

MEOR also sought an amendment from Ethical Review Board (ERB) of Nepal Health Research Council (NHRC) on the proposal originally submitted to include additional questions for screening participants on COVID-19 status and to identify the potential impact on service utilisation. The process of enrolling eligible participants after reaching a household is shown in **Annex V**.

2.9 Quality Assurance

The field research team (16 enumerators, 4 supervisors in baseline and 32 enumerators, 8 supervisors in the endline) were provided three days training on the study objective, design, sampling and data collection procedure, research ethics, interviewing etiquette, field data

management and data storage. Researchers from MEOR and ADRA, facilitated the training sessions.

The qualitative field team consisted of eight enumerators having previous experience in conducting qualitative interviews. Qualitative team were provided two days training on objectives and study design, intervention and its implementation modality and the data collection method and technique research ethics, data storage, recording, note keeping and transcription process.

The central research team, including MEOR, ADRA and United Nations Population Fund (UNFPA), monitored the baseline survey, roll out of the intervention and the endline survey. Feedback was provided on rapport building, way of asking questions, dealing with queries of research participants, dealing with problematic situations, checking completeness of data in field and ensuring cultural sensitivity during the baseline and endline survey. During the roll out of the intervention, the central research team provided feedback on increasing coverage, COVID-19 precautions during implementation of intervention, and recording of the programme data and skills for dealing with married adolescents/ parents/ in-laws.

For the qualitative field team, MEOR team regularly reviewed the transcripts and provided feedback. Through discussion using a virtual platform every alternate day, MEOR researchers took reflections from the field team, provided feedback on potential probing questions and rephrasing of questions and dealing with difficulties encountered during the interview.

Data quality checks were performed in two levels. In the first level, field supervisors checked the quality of data collected by field enumerators. Data were then submitted to the server digitally. In the second level, the quality of data was checked on daily basis by MEOR researchers. Quantitative data were checked for consistency and any errors were communicated to the field team who verified the data by revisiting the household or by contacting participants via telephone. To eliminate the risk of error in data entry at the point of data collection itself, skip logics and value labels were set in the digitized questionnaire in priori.

2.10 Ethical consideration

Ethical clearance was obtained from the Ethical Review Board- Nepal Health Research Council (ERB-NHRC). Research teams involved in the study were committed to respecting the ethical principles of the research, and the core research team were aware of the national ethical guidelines set by the NHRC. Field enumerators were also trained on research ethics as per the guidelines. As the COVID-19 pandemic was ongoing during the endline survey, amendments in the initial proposal was submitted to ERB-NHRC with addition of COVID-19 related question and approval was obtained.

Written informed consent was obtained from each participant before participation in the study. For participants aged 15-18 years, written informed consent was obtained from legal guardian and assent was obtained from participants. For participants above 18 years, written informed consent was obtained from the participants. Each consent form was written in Nepali, explaining the purpose of study, the participant's role in the study, voluntariness of participation, authority to withdraw at any point of the study without any justification to the research team, privacy, and maintenance of the confidentiality of the information provided. For participants who were not

able to read and write, the consent request form was read to them in the local language in presence of a witness. Participants were given an opportunity to ask any questions relating to the study. After participants fully understood the information provided, a signature or thumb print was taken as appropriate.

2.11 Data management and analysis

The quantitative and the qualitative data of the study were managed and analysed separately whilst data integration was done through narrative, only at the interpretation and reporting level. Details on data management and analysis process for each type of data has been provided in the paragraphs below.

2.11.1 Management of quantitative data

Quantitative data from community surveys were collected digitally through predesigned digital questionnaires in a mobile application. The central research team checked the completeness and consistency of data on a regular basis and provided instructions to field team in case of any discrepancies. The dependent variables: perceived risk, perceived benefits, barriers, cues to action and self-efficacy were scored by the participant which ranged from 1 to 5 where 1 refers to strongly disagree and 5 refers to strongly agree. The total score of each of the item measuring these constructs was 5. Total score of the construct was computed by summing the score of perceived risk, perceived benefit, barriers, self-efficacy, and cues to action making maximum possible total score of 40, 35, 50, 30 and 35 respectively (for details please refer to **Annex IV)**. Nine items in perceived barrier, four items in perceived risk and one item in self-efficacy were reverse scored so that higher score mean the favourable outcome (lower level of barrier faced, better perception of the risk and better self-efficacy) in use of FP services. An average knowledge score was calculated by marking one for every correct answer on a set of 28 questions making the total knowledge score equals to 28. Difference in differences (DID) analysis was performed to assess the effectiveness of intervention in improving perceived risk, perceived benefit, barriers, self-efficacy score and utilization of FP services. One of the advantage of DID analysis is that it allows comparison of groups which are at different levels of the outcome at the baseline as DID focuses on change rather than absolute levels of the outcomes in intervention and control groups.[25]

The pre- and post-intervention changes in outcome variables were estimated using DID model. DID estimates were derived from a linear regression model. As the data were collected from the two different cross-sectional samples of the same clusters at baseline and endline, the cases from the baseline and endline surveys were analysed using the following model.

$$y=\beta o+\beta 1.Time+\beta 2.Intervention+\beta 3\ (Time.\ Intervention)+\varepsilon,$$

where y is the outcome of interest; Time is the time dummy (1 = endline, 0 = baseline); Intervention is the intervention group dummy (1 = intervention group, 0 = control group); β3 is coefficient of the time and intervention interaction and is also the estimate of DID; and ε is the error term. In this model, β3 can be interpreted as the effect of treatment (change in mean score) by comparing the average change over time in the outcome variable for the treatment group, compared to the average change over time for the control group. In a separate model, we included the COVID-19 impact variable, which was generated based on the participants' responses on whether the FP services utilization was affected by COVID-19.

2.11.2 Management of qualitative data

Interviewers took the field notes of the interviews particularly focusing on key points of the interview and body language of participants while expressing their opinion. All the interviews were audio recorded with the permission from participants. With the help of field notes and the audio record, full transcripts of the interviews were produced in the subsequent stage.

Interviews were transcribed in language of interview (27 interviews in Bachika and the remaining in Nepali) from the notes and audio record. The transcripts in Bachika language were later translated into Nepali language. All the information including incomplete sentences, interrupted conversations, agreements, pause, facial expressions and gestures and non-verbal behaviours, etc. were transcribed as they appeared.

A three stage coding process was adopted. In the first stage, transcripts were assigned codes that most closely represent the meaning of the sentences (open coding). In second stage, similar codes were merged to develop slightly broader codes named as axial coding. In the third stage, axial codes were merged into more broader themes named as selective coding. The process continued till the codes were deduced into manageable number of themes. In the next stage, summary of each thematic areas was prepared carefully reviewing the codes under each theme and verbatim from the participants. The research team made best efforts to make sure that the ideas are not missed due to subjective judgement of researchers regarding the relative importance of the opinion and experience shared by research participants.

3. Results

Results on effectiveness of this study have been grounded on the changes in the key outcome variables of the study; the change being assessed through data obtained from baseline and endline surveys. Total 3,690 married adolescents of 15-19 years of age were approached for baseline survey out of which 3,634 participated in the survey, reflecting a 99.8% response rate. Among them, 1,812 participants were from the intervention districts and 1,822 were from the control districts. In the endline survey, total number of participants was 3,680 with 100% response rate. Out of 3,680 participants 1,840 participants were from the intervention districts and the same number were from the control districts.

3.1 Characteristics of Participants

Table 2 shows the background characteristics of the participants in both intervention and control districts. The mean age of participants in both the districts during baseline and the endline was 18 years. Most of the participants in intervention districts during baseline and endline were Dalit followed by Madhesi and Brahmin/Chhetri. In the case of control districts, majority of participants were Dalit in both baseline and endline followed by Janajatis, Brahmin/Chhetri and Muslim. The proportion of Janajatis and Muslim was higher in both intervention and control districts during endline survey. Likewise, most of the participants were Hindu (Baseline: intervention districts=91%, control districts=84%, Endline: intervention districts=81%, control districts=80% followed by Muslim in both the intervention and control districts. Almost two out of every ten participants in intervention districts (Baseline: 19%, endline: 22%) were illiterate however in control districts, one out of every ten participants (10%) in baseline and two out of every ten (22%) in endline were illiterate. Among participants, those attaining higher secondary level education was higher in intervention district (Baseline: 17%, Endline: 18%) compared to control districts (Baseline: 11%, Endline: 10%). More participants were engaged in domestic work as homemaker in control districts (Baseline: 94%, Endline: 88%) compared to intervention districts (Baseline: 91%, Endline: 79%).

The median age at marriage of the participants was 16 years (IQR, 15-17years) in all study sites. The proportion of participants not living with their husband decreased in control districts (Baseline: 45%, Endline: 34%) while it remained nearly constant in the intervention districts (Baseline: 46%; Endline: 45%). Among participants not living with their husband, more than 7 out of 10 had their husband involved in foreign employment. Less than 3% were separated while the rest had their husband travelling to other cities for various reasons.

Among participants in the control districts, 27% and 31% were planning to space childbirth for 1-2 years in the baseline and endline respectively. In the intervention districts, 20% participants were planning to space childbirth for 1-2 years in the baseline while 24% were planning to space childbirth for 1-2 years in the endline. From baseline to endline, the proportion of participants planning to limit childbirth varied in the control (Baseline: 14%, Endline: 10%) and intervention districts (Baseline: 12%, Endline: 15%).

Table 2: Characteristics of the survey participants

Characteristics	Control Districts				Intervention Districts			
	Baseline (n=1,822)		Endline (n=1,840)		Baseline (n=1,812)		Endline (n=1,840)	
	N	%	N	%	N	%	N	%
Age								
15 years	13	0.7	17	0.9	42	2.3	34	1.9
16 years	36	1.9	32	1.7	62	3.4	82	4.5
17 years	77	4.2	144	7.8	148	8.2	150	8.2
18 years	496	27.2	528	28.7	526	29.0	592	32.2
19 years	1,200	65.9	1,119	60.8	1,034	57.1	982	53.4
Mean age ± SD*	18.86 ± 0.82		18.59 ±0.78		18.57±0.94		18.51 ±0.91	
Ethnicity								
Dalit	632	34.7	505	27.5	490	27.0	519	28.2
Janajatis	332	18.2	433	23.5	325	17.9	306	16.6
Madhesi	206	11.3	200	10.9	465	25.7	349	18.9
Muslim	293	16.1	364	19.8	112	6.2	318	17.3
Brahmin/Chhetri	353	19.4	336	18.3	417	23.0	346	18.8
Others	6	0.3	2	0.1	3	0.2	1	0.0
Religion#								
Hindu	1,526	83.8	1,475	80.2	1,657	91.5	1,492	81.1
Buddhist	3	0.2	2	0.1	38	2.1	21	1.1
Muslim	293	16.1	362	19.7	112	6.2	323	17.6
Christian			1	0.0	4	0.2	4	0.2
Literacy^								
Illiterate	183	10.0	357	19.4	337	18.6	406	22.1
No formal schooling	131	7.2	99	5.4	71	3.9	98	5.3
Formal schooling	1,508	82.8	1,384	75.2	1,403	77.4	1,334	72.6
Highest level of education$ *(among those with formal schooling)*								
Primary or less	344	22.8	259	18.7	216	15.4	225	16.9
Secondary level of education	992	65.8	980	70.8	949	67.6	866	64.9
Higher secondary level and above	172	11.4	145	10.5	237	16.9	243	18.2
Work status								
Domestic work/ housemaker	1,706	93.6	1,625	88.4	1,641	90.6	1,454	79.3
Student	50	2.7	82	4.5	99	5.5	95	5.2
Enterprises with private ownership	31	1.7	40	2.2	39	2.2	52	2.8
Services	15	0.8	16	0.9	19	1.1	19	1.0
Labour	11	0.6	29	1.6	9	0.5	74	4.0

Characteristics		Control Districts				Intervention Districts			
		Baseline (n=1,822)		Endline (n=1,840)		Baseline (n=1,812)		Endline (n=1,840)	
		N	%	N	%	N	%	N	%
Agriculture		9	0.5	47	2.6	5	0.3	140	7.6
Annual income									
≤160000		469	25.7	292	15.9	417	23.0	292	15.9
160000-240000		745	40.9	629	34.2	681	37.6	574	31.2
240001-300000		231	12.7	358	19.5	189	10.4	198	10.8
>300000		361	19.8	527	28.6	450	24.8	462	25.1
Refused		16	0.9	34	1.9	75	4.1	314	17.1
Median income (IQR)**		216,000 (IQR, 156,000-300,000)		240,000 (IQR, 180,000-360,000)		240,000(IQR, 180,000-336,000)		240,000 (IQR, 120,000-312,000)	
Marital Life									
Currently living with husband		994	54.6	1,223	66.5	984	54.3	1,018	55.3
Currently not living with husband		828	45.4	617	33.5	828	45.7	822	44.7
Reason for living separately with husband *(among those not living together with husband)*									
Husband abroad for foreign employment		633	76.5	442	71.6	600	72.5	612	74.5
Husband often travel to other cities		180	21.7	160	25.9	207	25.0	199	24.2
Separated from husband		15	1.8	15	2.4	21	2.5	11	1.3
Duration of separation from husband $$ *(among those not living together with husband)*									
≤ 1 month		161	19.4	164	26.6	188	22.7	178	21.7
1-6 months		355	42.9	169	27.4	349	42.2	229	27.9
6-12 months		187	22.6	164	26.6	173	20.9	254	30.9
>12 months		125	15.1	120	19.5	118	14.3	160	19.5
Age at Marriage									
5 yrs and below						6	0.3	5	0.3
6-10 yrs		1	0.0	10	0.5	14	0.8	7	0.4
11 to 15 yrs		751	41.2	596	32.34	601	33.2	614	33.4
16 to 19 years		1,070	58.7	1,234	67.1	1,191	65.7	1,214	65.9
Median age at Marriage (IQR)**		16 (IQR, 15–17)		16 (IQR, 15–17)		16 (IQR, 15–17)		16 (IQR, 15–17)	
Pregnancy history									
Gravida	Zero	387	21.2	463	25.2	522	28.8	505	27.5
	1-3	1,424	78.2	1,371	74.5	1,272	70.2	1,323	71.9
	>3	11	0.6	6	0.3	18	0.9	12	0.7
Parity	Zero	599	32.9	619	33.6	702	38.7	692	37.6
	1-3	1,216	66.7	1,218	66.2	1,100	60.7	1,141	62.0

Characteristics	Control Districts				Intervention Districts			
	Baseline (n=1,822)		Endline (n=1,840)		Baseline (n=1,812)		Endline (n=1,840)	
	N	%	N	%	N	%	N	%
>3	7	0.4	3	0.2	10	0.6	7	0.4
Age of last Child								
1 to 45 days	67	5.5	76	6.2	93	8.4	73	6.4
46 days to 6 months	299	24.5	267	21.9	293	26.4	229	20.0
7 months to 2 years	718	58.7	723	59.2	622	56.0	709	62.0
above 2 years	139	11.4	155	12.7	102	9.2	132	11.6
Sexual Activity								
Sex in last month	786	43.1	1020	55.4	860	47.5	857	46.6
Family Plan								
Currently planning for a child	213	11.7	267	14.5	238	13.1	303	16.5
Planning to space childbirth for 1-2 years	485	26.6	575	31.3	364	20.1	433	23.5
Planning to space childbirth for >2 years	864	47.4	812	44.1	994	54.9	826	44.9
Planning to limit childbirth	260	14.3	186	10.1	216	11.9	278	15.1

**SD= Standard Deviation, **IQR= Inter-quartile range, # 1 refused to state religion, ^ 1 refused to state literacy. $ 1 refused to state level of education, $$ 1 refused to answer duration of separation from husband*

3.2 Reach of the intervention

Penetration of the intervention by the end of the study period, was determined by assessing the exposure status of the participants of the endline survey to the intervention. The participants were asked if they had been reached by or participated in certain components of *Sakshyam Kishor Kishori* intervention. Out of 1,840 married adolescents in the intervention districts, a quarter (24.8%) had been reached by *Sakshyam Kishor Kishori* intervention. However, there was a remarkable difference in penetration of the intervention between two study sites. Every two among five participants (around 41% out of 918 total participants) of the survey in Sarlahi had participated in an activity of

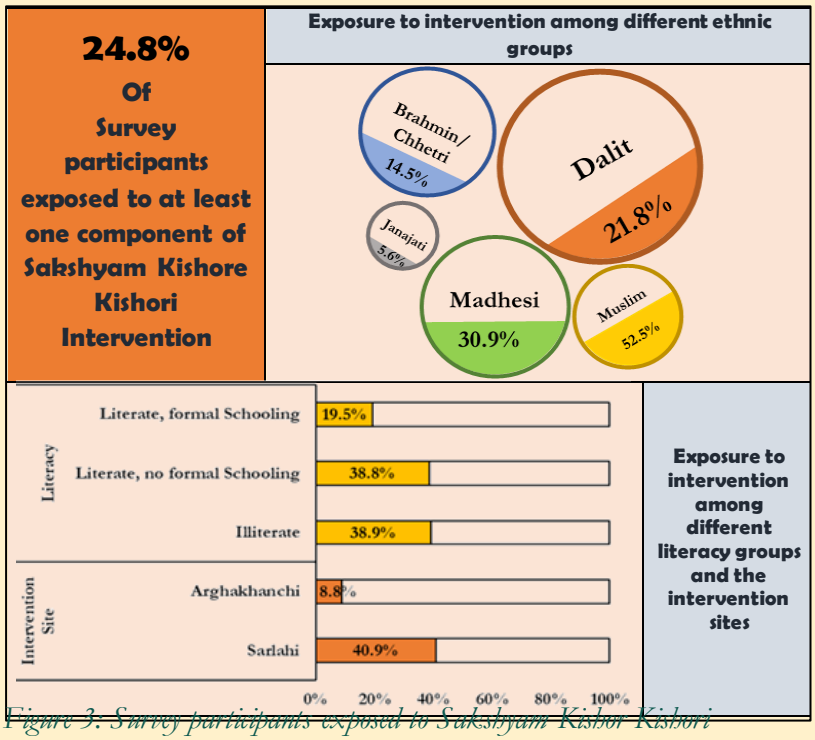


Figure 3: Survey participants exposed to Sakshyam Kishor Kishori intervention in intervention districts

the intervention while in case of Arghakhanchi district it was quite low and remained around 9% (out of 922 total participants). The two study sites greatly vary in their topographical situation; Sarlahi being the plain land supports easier mobility compared to Arghakhanchi which might have contributed to greater reach of the intervention in Sarlahi.

Nonetheless, the intervention had reached out to almost 39% (out of 406) of the survey respondents who were illiterate and to the similar proportion of the respondents who were literate but had no formal schooling (out of 98). Likewise, more than half (out of 318) of Muslim respondents who constituted around 17% of total respondents had been reached by the intervention. Similarly, 22% (out of 519) of Dalit respondents who constituted around 28% of total survey respondents had their involvement in at least one activity of the intervention. Interestingly, nearly one third of Madhesi (out of 349), constituting around 19% of total survey participants were reached by the intervention while the proportion for Janajatis and Brahmin/Chhetri (constituting about 17% and 19% respectively of total surveyed married adolescent girls) with intervention reach was only around 5% (out of 306) and 14% (out of 346) respectively (*Figure 3).*

3.3 Changes in Outcome Variables after Intervention

Table 3 and *Table 4* shows the changes in outcome variables of the study from baseline to endline. An increment in average knowledge score was observed in both intervention and the control districts; however, intervention districts had steep increases in mean knowledge score from 11.99 in baseline to 16.64 in endline. This indicates a positive change in knowledge of married adolescent population about FP in study sites over the study period, with the change being more pronounced in intervention districts compared to control districts. The increase was seen in almost all the aspects of knowledge regarding family planning; the details of which has been provided in **Annex VII**. Likewise, positive changes were observed in perception of risk of not using FP services, perception about benefits of FP services, perception about barriers to FP services and self-efficacy in using FP services as their mean scores increased over time but the raise was not considerably high compared to knowledge score.

Table 3: Knowledge and the attitude variables in intervention and control districts before and after the intervention

Variables	Control districts				Intervention district			
	Baseline		Endline		Baseline		Endline	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Knowledge score	14.02	6.35	15.29	6.08	11.99	6.05	16.64	6.37
Score for perception of the risk of not using FP services	28.52	3.99	27.33	4.59	27.89	3.71	28.09	4.01
Score for perception about the benefits of FP services	25.74	3.46	27.15	3.93	25.14	3.72	27.63	4.68
Score for perception about the barriers to FP services	34.76	4.01	36.32	5.17	33.49	4.05	35.45	5.63
Score for self-efficacy in use of FP services	21.59	3.99	22.37	4.53	20.9	4.26	22.83	4.27

During the baseline survey, the proportion of married adolescents using any contraceptive methods (modern or traditional) was 22.2% in intervention district which increased to 28.6% in the endline. In control district, the proportion was 22.8% and this increased to 30.4% in the endline. There was a notable increase in use of modern contraceptives in control districts (increased from

20.9% to 28.3%) while it remained relatively stable in intervention district (20.9% in baseline and 22.4% in endline). On contrary, use of traditional contraceptives methods steeply raised in intervention districts from 1.3% in baseline to 6.2% in endline. On contrary, this increased by almost 1% (from 1.9% to 2.1%) only in the control districts. However, these findings should be understood in context that there has been differential impact of COVID-19 in intervention and control districts (dealt in later section in this report).

Like the use of modern contraceptive methods, HF visits for FP services has increased by higher proportion in control district than the intervention district. In baseline survey, 12.7% of the participants had reported that they visited HF for FP counselling; the proportion increased to 27.4% in the endline survey. The proportion of married adolescent visiting the HF for FP counselling in intervention districts was 13.5% in baseline which increased to 18.5% during the endline. A steep rise in proportion of study participants intending to use FP services was observed in intervention districts with 12% in baseline to 22% in endline. Control districts did have an increase in proportion of such participants however, the rise was minimal compared to intervention districts (9.9% in baseline to 11% in endline).

Table 4: Family Planning service utilization in Intervention and Control districts before and after the intervention

Service utilization	Control districts				Intervention district			
	Baseline (1,822)		Endline (1,840)		Baseline (1,812)		Endline (1,840)	
	N	%	N	%	N	%	N	%
Contraceptive use (modern or traditional)	415	22.8	559	30.4	402	22.2	526	28.6
Utilization of modern contraceptive methods	381	20.9	520	28.3	379	20.9	412	22.4
Utilization of traditional contraceptive methods	34	1.9	39	2.1	23	1.3	114	6.2
HF visit for FP counselling	231	12.7	504	27.4	245	13.5	340	18.5
Planning use of FP services	145	9.9γ	150	11.09γγ	179	12.1τ	305	21.9ττ

Note: γ = calculated out of 1,461 samples, γγ = calculated out of 1,353 samples, τ = calculated out of 1,485 samples, ττ = calculated out of 1,390 samples.

3.4 Graphical Analysis of Changes in outcome Variables

The distribution of numerical outcome variables was analysed and has been shown in *Figure 5* . In the curve, the peak for the variables like perceived benefit score, perceived barrier score, efficacy and knowledge score have shifted right in both the intervention and control district meaning that there could have been some positive changes in these variables irrespective of the intervention. The curve for risk score on contrary shows a minimal shift in intervention districts but left shift in control districts indicating that perception of risks of not using FP decreased in control districts.

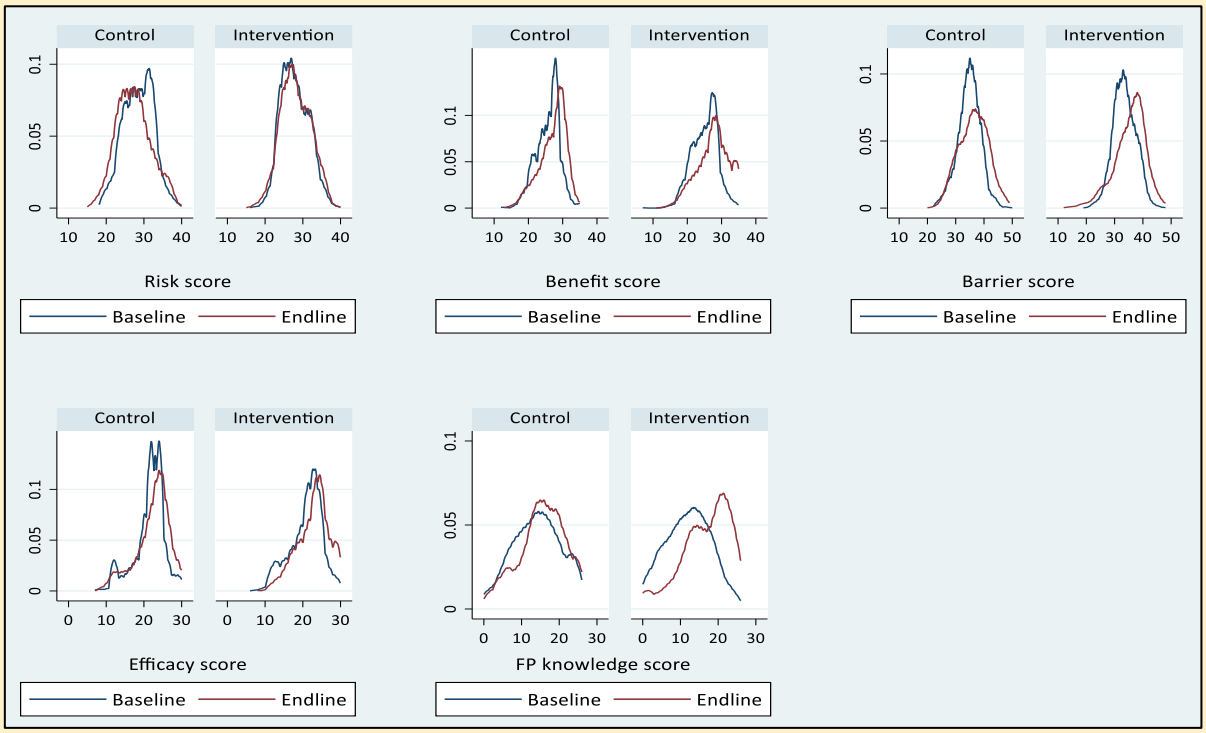


Figure 5: Distribution of outcome variables

Further, numerical outcome variables before and after the intervention, in both the intervention and control districts were plotted in Box and whisker plot. The result has been shown in *Figure 4*. The plot shows an increase in mean score for perceived benefits of the contraceptives, barriers to contraceptive services, and FP knowledge. The score for perception of risk of not using contraceptive services has decreased from baseline to endline in control districts while there is marginal improvement in intervention districts. Notable shift has been seen in score for FP

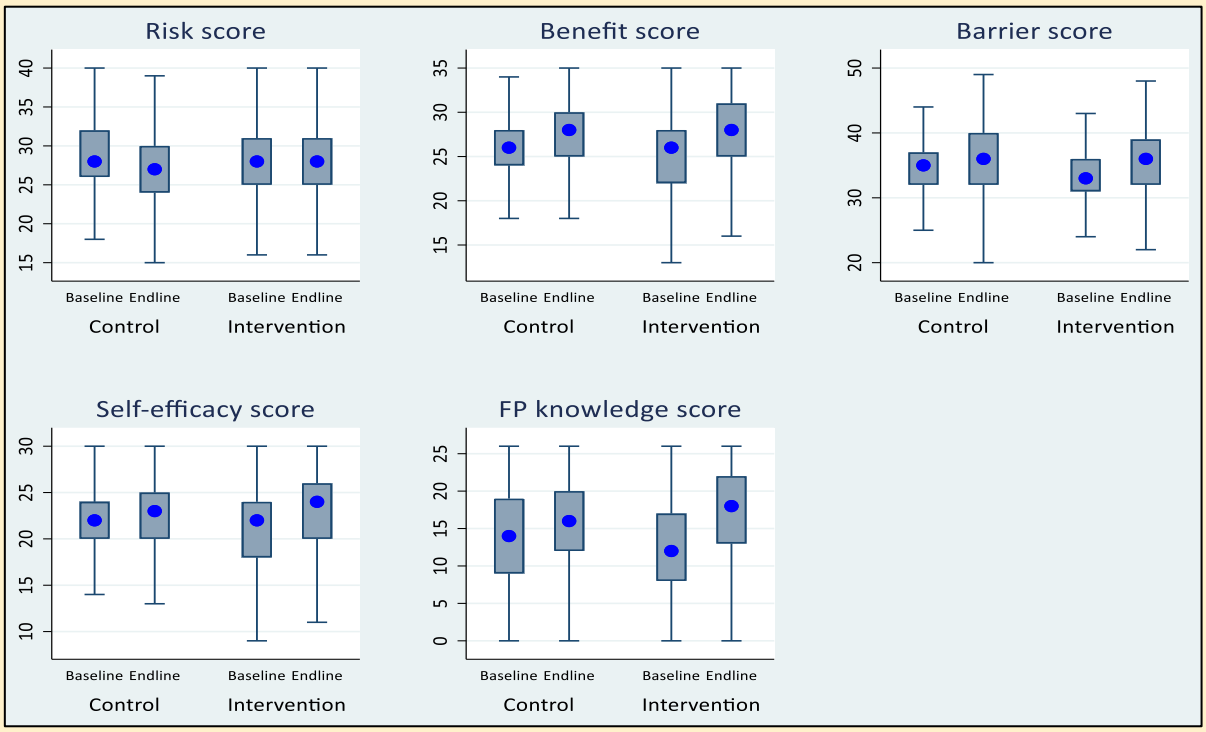


Figure 4: Box plot for outcome variables by intervention and control group at baseline and endline

knowledge in intervention districts. Exact numerical figure of these variables before and after intervention in both the intervention and control districts have been presented in Table 5.

3.5 Difference in Differences analysis for the impact of intervention

Intervention was found effective in improving the knowledge of participants of FP services, perception of the risk of not using FP services, perception on benefit of FP and self-efficacy to use FP services. The change in knowledge score, perceived risk, perceived benefit, perceived barrier, self-efficacy, and contraceptive utilization is shown in Figure 6 graphically.

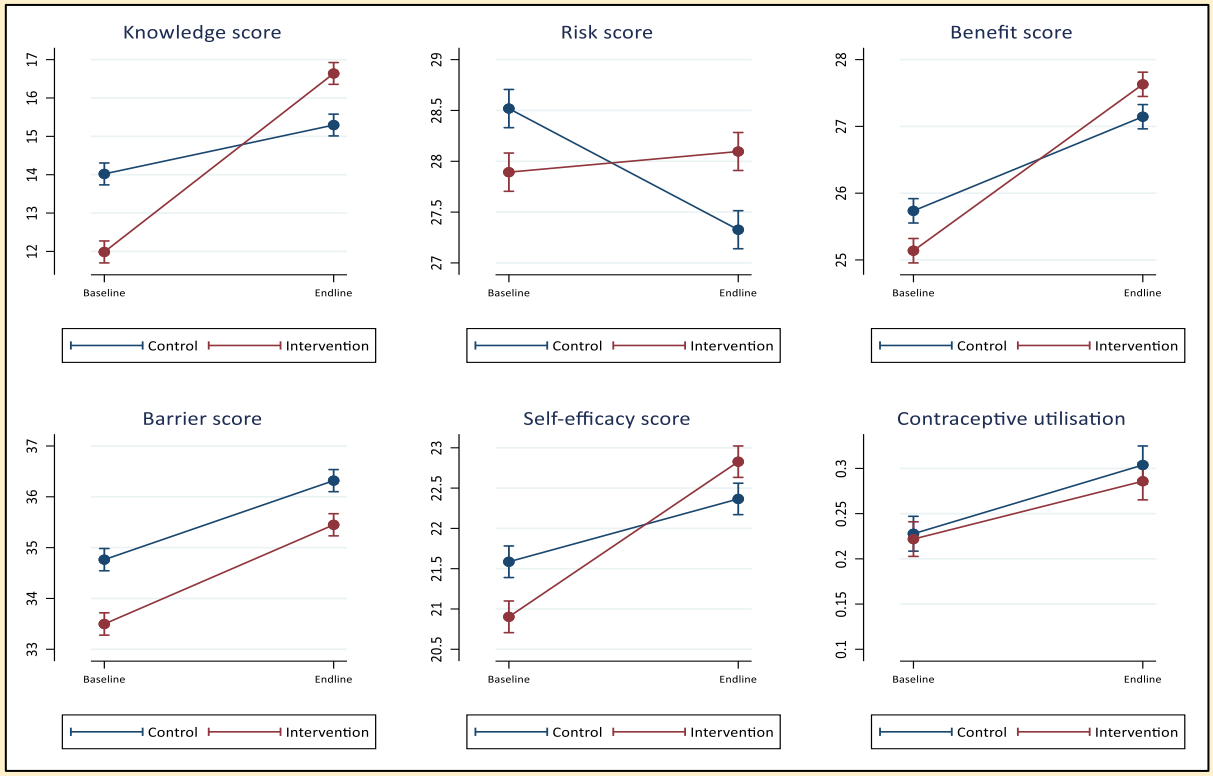


Figure 6: Effect of intervention on various outcomes

Table 5 shows the results of DID analysis showing point difference in control and the intervention districts over the study period and additional gain on points due to the intervention. Knowledge score increased by 1.27 points in control districts and 4.65 points in intervention districts from baseline to endline. Intervention districts gained additional 3.38 points in knowledge score and this gain was statistically significant indicating that intervention has been effective in improving knowledge of FP in the study although the knowledge also improved in control districts over the period of intervention.

During the baseline survey, participants in control districts had slightly better perception of the risk of not using FP services (risk score of 28.52 in control districts and 27.89 in intervention). However, the perception of risk score decreased in control district by 1.19 points during period of intervention while it did not change significantly in intervention. Although the gain in intervention district from baseline to endline survey itself was not statistically significant, additional gain in intervention districts over control district was found statistically significant.

Table 5: Difference in difference analysis for effectiveness of intervention in improving different outcome variables

Variables	Control districts				Intervention districts				Difference in difference	
	Baseline		Difference		Baseline		Difference		Coefficient	SE
	Mean	SE	Coef.	SE	Mean	SE	Coef.	SE	Coef.	SE
Knowledge and Attitude										
Knowledge score	14.02	0.15	1.27**	0.21	11.99	0.14	4.65**	0.21	3.38**	0.29
Perception of the risk	28.52	0.09	-1.19**	0.14	27.89	0.09	0.20	0.13	1.40**	0.19
Perception of the benefit	25.74	0.08	1.41**	0.12	25.14	0.09	2.49**	0.14	1.08**	0.19
Barrier	34.76	0.09	1.55**	0.15	33.50	0.10	1.95**	0.16	0.40	0.22
Self-efficacy	21.59	0.09	0.78**	0.14	20.90	0.10	1.92**	0.14	1.15**	0.20
Service utilisation (expressed in proportion)										
Contraceptive service utilization	0.23	0.01	0.08**	0.01	0.22	0.01	0.06**	0.01	-0.01	0.02
Utilization of modern contraceptives	0.21	0.01	0.07**	0.01	0.21	0.01	0.01	0.01	-0.06**	0.02
Utilization of traditional methods	0.02	0.00	0.00	0.00	0.01	0.00	0.05**	0.01	0.05**	0.01
Planning to use FP	0.10	0.01	0.01	0.01	0.12	0.01	0.10**	0.01	0.09**	0.02
Visited HF for FP counseling	0.13	0.01	0.15**	0.01	0.14	0.01	0.05**	0.01	-0.10**	0.02

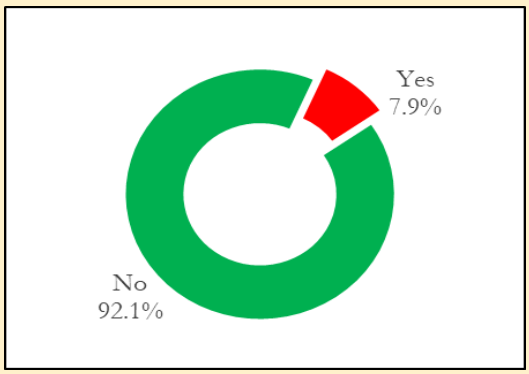
Note: means the result is significant at p value 0.05, **means that the result is significant at p value 0.001*

Intervention was not found effective in increasing the use of contraceptive services. The use of traditional contraceptive methods increased by 1.5 percentage points in control districts and seven percentage points in intervention districts. Although contraceptive use did not change over the study period, the proportion of participants intending to use FP services changed significantly in intervention districts. Moreover, the additional gain in percentage point in this indicator in intervention districts was statistically significant. Likewise, the proportion of participants visiting health facility for FP counselling significantly increased over the study period in both control and intervention districts but the additional gain in percentage point was statistically significant for control district.

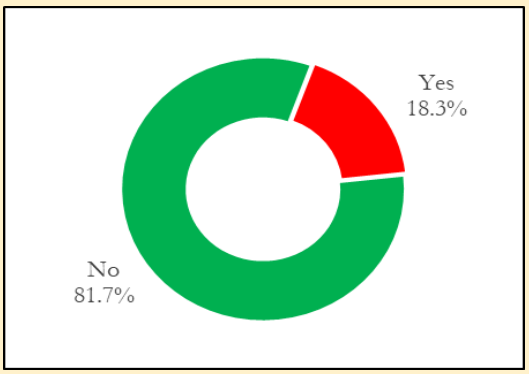
Noting that the impact of any FP related intervention could be different based on the ethnicity of the participants, their literacy, average family income, spousal separation, parity and sexual activity in past one month from the day of survey, we performed stratified analysis based on these variables. The analysis showed a significant improvement in knowledge score amongst different strata of these variables except for literacy where, knowledge score decreased significantly among literate participants without formal education. Risk score, benefit score and self-efficacy score shared a similar change pattern across different strata. Their scores changed positively although no impact was observed in some ethnic groups. Overall barrier score did not differ over time, however, the intervention was found to be effective in increasing it among Dalit communities, illiterate participants and the participants currently living with the husband. Similarly, contraceptive use remained static across all the strata over study period and so did the modern contraceptive use. The later indeed decreased irrespective of the parity of the participants. Use of traditional methods on other hand, was frequently pronounced except for Madhesi, Muslim, literates, those with at least a child and those with no sexual activity in past one month. Despite the intervention had no significant impact on contraceptive use among study participants in overall, participants from most of the strata including Muslim and Madhesi ethnic groups, illiterate group of participants, those with at least a child and those with or without sexual activity during the past one month intended to use FP. The result of this stratified analysis has been provided in the tables in **Annex VII.**

3.6 Impact of COVID-19 on FP service utilization

Approximately 8% of the participants in control district and 18% of the participants in intervention districts respectively had faced difficulty in utilising FP services because of COVID-19 and policy measures adopted thereafter *Figure 7*.



1. Impact of COVID-19 in FP service use in control districts



2. Impact of COVID-19 in FP service use in intervention districts

Figure 7: Impact of COVID-19 in use of FP services

In control district, 5.3% adolescents had reached HF but had to return without utilising the FP services because service was not available due to COVID-19 situation during their visit while this number was 3.5% in intervention district. Approximately, 15.3% participants in intervention district and 3.5% participants in control districts shared that they were unable to reach HF for FP services because of COVID-19 and policy measures adopted thereafter. Of the total adolescents interviewed, 6 of them reported of having unintended pregnancy in control districts and 37 in intervention districts and 2 and 11 adolescents opted abortions in control and intervention districts, respectively. Similarly, approximately 0.7% (13 adolescents) in control district and 1.6% (30 adolescents) in intervention districts shared that they faced difficulty in obtaining FP information amidst COVID-19 situation in the field *(Table 6)*.

Table 6: Details of the impact of COVID-19 in FP service utilisation

Impact	Control districts (1840)		Intervention districts (1840)		p value
	N	%	N	%	
Had to return from HF without FP services	98	5.3	64	3.5	0.006
Unable to reach HF for FP services	65	3.5	282	15.3	<0.001
Had unintended pregnancy	6	0.3	37	2.0	<0.001
Had to opt for abortion	2	0.1	11	0.6	0.012
Had difficulty in obtaining FP related information	13	0.7	30	1.6	0.009

After adjusting the impact of COVID-19, the intervention was also found effective in helping adolescents improve FP knowledge and some of their perceptions including around overcoming the barriers to FP service (the score increased by 1.63 points in control and 2.64 points in intervention districts). However, the results of the DID analysis did not change notably for contraceptive utilization even after adjusting for impact of COVID-19 *(Table 7)*.

Table 7: Intervention effect after adjusting the impact of COVID-19 pandemic on different outcome variables

Variables	Control				Intervention				Difference-in-difference	
	Baseline		Difference		Baseline		Difference			
	Mean	SE	Coef.	SE	Mean	SE	Coef.	SE	Coef.	SE
Knowledge and Attitude										
Knowledge Score	14.02	0.15	1.28**	0.21	11.99	0.14	5.36**	0.21	3.65**	0.29
Perception of risk	28.52	0.09	-1.14**	0.15	27.89	0.09	0.60**	0.13	1.57**	0.19
Perception of benefit	25.74	0.08	1.43**	0.13	25.14	0.09	2.46**	0.15	1.08**	0.19
Barrier	34.76	0.09	1.63**	0.16	33.50	0.10	2.64**	0.17	0.70**	0.22
Self-efficacy	21.59	0.09	0.92**	0.14	20.90	0.10	2.13**	0.15	1.29**	0.20
Service utilisation (expressed in proportion)										
Contraceptive service utilization	0.23	0.01	0.07**	0.01	0.22	0.01	0.08**	0.02	-0.01	0.02
Utilization of modern contraceptive methods	0.21	0.01	0.07**	0.01	0.21	0.01	0.01	0.01	-0.06**	0.02
Utilization of traditional methods	0.02	0	0	0	0.01	0	0.06**	0.01	0.05**	0.01
Planning to use FP	0.1	0.01	0.01	0.01	0.12	0.01	0.05**	0.01	0.06**	0.02
Visited HF for FP counselling	0.13	0.01	0.14**	0.01	0.14	0.01	0.03*	0.01	-0.11**	0.02

Note: ** means the result is significant at p value 0.05, ** means that the result is significant at p value 0.001*

3.7 Qualitative assessment of the intervention

This section deals with the findings from qualitative interviews of the beneficiaries of *Sakshyam Kishor Kishori* intervention and the programme implementers relating to their opinion and experience about the intervention. The perspective of the service users or beneficiaries has been presented under six thematic areas: opinion about the intervention, barriers in service utilisation, changes after the intervention and health benefits, diffusion of learnings at household and community and effect of COVID-19 on the intervention and suggestion for improvement of the programme. The perspectives of the programme implementers have been organized under eight thematic areas: role of service providers and implementers, coverage of the programme, acceptance of programme from beneficiaries and community, focus on disadvantaged groups, changes after the intervention or achievement of programme, challenges, impact of COVID-19 in the intervention and suggestions for further improvement of the programme.

3.7.1 Service user's perspective

Service users are different categories of participants who have benefited from the program. This includes adolescents receiving services from SMs, Adolescent Friendly Information Corner (AFIC), camp, receiving life skills education and their parents who have taken life skill education. Findings of the intervention programme in perspective of service users were also based on the major six broad thematic areas.

a. Opinion about Sakshyam Kishor Kishori intervention

While sharing about their opinion on *Sakshyam Kishor Kishori* intervention, participants discussed about acceptance of the intervention in early stages, approach adopted in delivery of information and services, issues covered by the intervention, effectiveness of the peer education approach, usefulness of AFICs, their trust about maintenance of the confidentiality of information and diffusion of the information to the household and at the community level.

Overall, the programme was well perceived by the participants. Although participants were relatively reluctant towards the programme at the early stage, they were later found convinced of the usefulness of the intervention and felt that the programme was much needed.

> *"At first, I was afraid of how the class would go, whether I may waste my time, will I learn anything or not. But later, after participating in the classes, I know that it was not a waste of time"*- Adolescent girl from *Rupantaran* session

> *"Our parents wouldn't allow to go for classes, they said it was just for time pass. Later when miss (tutor) counselled them they allowed us to go for classes."* Adolescent girl from *Rupantaran* session

Participants of *Rupantaran* session explained that the programme covered wide array of topics ranging from skills that could help them become independent to specific topics on FP which could help them make appropriate decision for their health and wellbeing. According to participants, programme covered topics on agriculture, child marriage, concept of sexual and reproductive health, health concerns during adolescent phase, need and availability of FP services and the contraceptive methods that could match the need of participants. Pad making programme, topics on menstruation and FP services were of special interest to the participants.

"The sessions included menstruation, FP methods, making pads…. I liked the (sessions on) pad making and FP methods"-Adolescent girl from *Rupantaran* session

Sharing about the peer education approach adopted in the programme, participants shared that it was relatively easy to receive message from the tutor of similar age. Participants opined that the discussion can move ahead in a comfortable manner where issues can be discussed freely, can be discussed in flexible time as per need and can even visit house of the tutor in case any information is needed which is practically not possible with tutor of relatively older age group. Participants also shared that they do not feel shy while asking questions to their tutor when they are of their own age. Furthermore, peer education approach facilitated the learning process as tutor could understand the concerns of the adolescents better and could clarify their concerns and queries.

"the sister (tutor) shared information more clearly...and in an easy way and we were able to understand....health workers used to inform briefly whereas sister (tutor) used to provide explanation as well"-Adolescent girl from *Rupantaran* Session

"...learning from a tutor of similar age really helped us to understand more in a comfortable setting. Sometimes I visited her home and sometimes she visited my home which even made the learning process easy ..."- Adolescent girl from *Rupantaran* session

"While receiving services from my own friend, I could tell everything freely. When I ask similar things to people of older age, I fear that they might say that I talk too much. With friends of my age, I can ask anytime, if not today then tomorrow..... Also, when asking with elders, we feel shy"- Adolescent girl from *Rupantaran* session

Emphasizing the specialties of AFICs, participants shared that the Information, Education and Communication (IEC) materials are easily available, can get the information more freely and in flexible timing.

"materials on menstruation and contraception are available, besides that other materials are needed to provide further information for adolescents. last time when we went on a tour there were enough materials, separate materials on maintaining confidentiality for adolescents were available but it is not available here, so need to add other materials". Female service user, AFIC

Participants also shared that as separate room was available for discussion in issues related to FP services, they could discuss their problems in comfortable environment that could ensure their privacy. They also shared their trust that the service providers maintain confidentiality of the information.

"....we were taken into separate room alone and discussed our queries and problems in a confidential manner.."- Adolescent girl from *Rupantaran* session

"...maintained confidentiality... because they only talked to the person receiving the service"-Adolescent girl from *Rupantaran* session

Elaborating about the setting of FP camps, participants shared that different compartments were arranged in the FP camps which could help them discuss the issues freely.

"Yes, there were three rooms arranged, one for female adolescents, another for women and another room for counselling" Female service user, FP camp

As a part of intervention, under *Rupantaran* package, parents of the adolescents were also delivered special package to make sure that adolescents have a comfortable family environment to ensure the adolescents continuous participation in the intervention and help them make FP decision in a supportive environment. Parents also shared their experience of participating in the *Sakshyam Kishor Kishori* intervention. Participants particularly appreciated that the training and services were available at their doorsteps and benefitted them without having to travel elsewhere.

"All these facilities come closer to the community so that people don't have to go far walking…isn't it? ....made the easy access and availability"- Parents from life skill education(Female)

"...but now with the training being provided at your doorstep you get to know about many benefits in regard to health. What to do, what not to do, what benefits you, I say you get to know everything"-Parents from life skill education (Female)

b. Barriers in FP service utilization

Regarding the perceived barriers, participants reported lack of knowledge, poverty, distance to health facilities, feeling of shame, pressure from family members and their attitude, fear of side effects and the fear that they may have to compromise with their privacy as the major barriers in the utilization of FP services.

Participants shared that adolescents are not able to share their need of FP to family, are often unable to convince their husband and obtain family permission for the use of FP services. This prevented them from using FP services despite their willingness to use it.

"Some may (find it difficult to use FP) due to husband's pressure, some may be due to the fear that it may cause health problems…. some may be due to shyness"- Adolescent girl from *Rupantaran* session

"Yes, I think due to pressure from family members such as in laws, married couples are not able to use FP methods. Or the attitude of earlier people saying there is no harm in bearing children, no need to use FP methods, these things have pressure on married couples"- Female service user, AFIC

Use of FP service was also impacted by some broader issues like economic status of the family and distance to HFs.

"I feel because of poverty most people are not using the service. Due to poverty they do not have money, so they are not using the service"- Married adolescent male counselled by SM

"ahh.. if the distance is long it would be difficult. If unmarried it would not be feasible to tell others and many people ask questions on why they are visiting the health facility....they ask if they are not feeling good"- Female service user, AFIC

Sharing about how the adverse effect serves as barrier to use of FP services, one of the participants shared how she had adverse effect from one of the contraceptive methods that led her to switching of the method.

"once I used depo, when injected I didn't have period exactly for one year, when menstruation stopped for one year, ...nothing happened when I tested my urine for 3/4 times, had video x-ray for 2/3 times, nothing

was diagnosed. My menstruation started with one pill, this type of side effects can happen with depo, now my menstruation is regular" Female service user, FP camp

One of the participants shared that she was scared about compromising with her privacy while using the service as a barrier to service utilization.

"...now...what to say....I am feeling scared that our confidentiality will be compromised.." Female service user, AFIC

c. Changes after of the intervention and health benefits

Participants shared that the programme has helped them broaden their understanding in different dimensions of daily life covering issues like nutrition, child marriage, reproductive health and rights and FP services. Participants also shared that they are now interested in FP related issues which was not of their interest before the intervention. Participants shared that they have been capable of making more informed decision about the FP services and are now more confident in talking about the FP services within their family and with health workers.

"I didn't know about the FP methods and didn't show interest as well, later after when maam (tutor) taught us on this module I got to know about the methods of FP, the purpose of FP services such as when to keep birth spacing, where we can get FP methods, how to access the services and how to use them"- Adolescent girl from *Rupantaran* session

"This programme has had a great impact, at first I didn't know anything about FP service. I know a lot now and I can talk openly within my family"- Adolescent girl from *Rupantaran* session

Previously, FP services were considered to be important for only couples, the intervention has broadened the understanding, clarifying that it is important to know about FP services, develop capability of using services and actually using service irrespective of marital status.

"yes...since we are adolescents (unmarried), we thought it would be important only for those who are married, but now we think it is important for us as well." – Female service user, AFIC

Parents had also noticed some changes in the adolescents after the intervention. They shared that adolescents are now more informed about health issues like menstruation and are now able to talk about it with their parents and family.

"boys and girls, they didn't have any knowledge about menstruation, were not able to talk openly, felt embarrassed when talking to their parents, after your programme they do not feel embarrassed, they are able to talk and share information with their parents"-Parents from life skill education (Female)

Sharing about the impact of intervention in wider community, one of the service users from camp shared that women are now more informed about the FP services, its need and have easy access to it.

".....before people (females) did not understand, and they would have children, many women would want to use it, but service was not available, now all women in each house are informed. They do not need to ask anyone if they want to use the method, they can use service maintaining privacy"- Female service user, FP camp

Participants also shared the changes seen in their family and community after intervention. They shared that, before the intervention, girls used to get married at early ages and were not aware of the appropriate age for marriage. However, after the intervention, adolescents and parents of the adolescents have understood that their children should be married after the age of 20 years. Although it was previously not considered as an acceptable behaviour for daughter/ daughter in law to use FP services, it is now well accepted in the community. Participants shared that before the intervention, their family often questioned them why the FP services are needed and child spacing is needed and now most of them seem well informed about its importance.

> *"...ummm....before girls would get married at 15/16 if there were good proposals coming, there was this kind of problem. Now many have understood that parents should get their children married only at 21/22 years"*- Parents from life skills education (Female)

> *"Before it was not acceptable for daughter in law to use family planning. …. But now they are suggested to use family planning and motivated to go to the health facilities"*-Adolescent girl from *Rupantaran* session

> *"They used to ask why you need to keep birth spacing at first, now everyone is informed about birth spacing and its effects on the children and lead to problems in their life"*-Adolescent girl from *Rupantaran* session

In line with the opinion from adolescents, parents of the adolescent participants shared that they previously confined the concept of FP to the use of contraceptive services, particularly relating to operation in hospital (sterilization) and have realized that FP is much broader in scope than what they previously presumed.

> *".....at the beginning what I felt about family planning was....let's say about doing operation in the hospital I felt so about the family planning. Now I feel family planning is....making plans for family.....what we need to do...what we need to do for our children and for ourselves (regarding our own health)....what benefits us....I feel so."*-Parents from life skill education (Female)

> *"It had a lot of impact, provided education to the children who didn't know anything at the beginning, provided uneducated parents with the information on how to deal with the situation, and the need to send children to the school. We also got to know during menstruation...um....need to give more liquids and nutritious food....umm… get their children married at right age, we were provided information in all these things"*- Parents from life skill education (Female)

Adolescent girls from Rupantaran sessions, without formal schooling, also shared that the programme has empowered them making them able to read and write, introduce themselves to other and decide appropriate age at marriage. Intervention has enabled them to express their thoughts and ideas.

> *"before when this class was not conducted, we did not know when to get married, how to write our names and how to give introduction and how to talk properly. Now after this class, we can write our names, give our introduction and learnt we should not get married at early age"*- Adolescent girl (without formal schooling) from *Rupantaran* session

> *"ah...before we were not able to talk openly and not able to give our own introduction now.....wherever we go and anytime we are able to introduce ourselves...ummmm...we don't feel shy, we don't feel shy in*

anything...ah..before we were not able to talk to male teachers and also our father. Nowadays we are in a position to talk with them"- Adolescent girl from *Rupantaran* session

"many adolescents who have dropped out of school have learned to be independent, have learnt a lot from the classes.....adolescents are able to share their problems" – Adolescent girl from *Rupantaran* session and service user of FP camp

Apart from broadening understanding of the participants about different SRH issues and developing self-efficacy in use of health services including FP, participants also shared that they have noticed some changes in the way services are delivered in HFs and availability of services.

"before these (FP) methods were not available now they are available in the hospital. Methods for preventing birth were not available now all methods are available in our village"- Parents from life skill education (Female)

Participants shared that organization of SRH/FP camps in the community, they have been able to resolve their health concerns that were bothering them for relatively longer period of time.

"There were a lot of problems seen in my daughters like white discharge, problems during menstruation, they had them all checked up. And the problems I had, they were solved, and service was provided to my satisfaction level, I liked it very much." Female service user, FP camp

"I have been able to avoid pregnancy with the 5 years injection (implant). There was a lot of tension if my husband would return and I would be pregnant. Before I was tense a lot usually but now, I am not after I have used this 5-year injection. Now I am relieved that I will not be pregnant. There is no problem now". Female service user, FP camp

d. Diffusion of learnings at household and community level

Some of the participants shared that the benefits of the intervention are not confined to them who directly participated in the programme but have diffused to the wider community. Beneficiaries of the intervention reported sharing the information they gained in the classes to their parents and their parents in turn shared the information to their friends which helped to propagate the information to wider community.

"I used to share what I learnt in classes....my parents used to ask what I learnt in the class and I shared with them what I learnt, Yes...My mom shares whatever I have shared with her to her friends when she is out for work"- Adolescent girl from *Rupantaran* session

Apart from sharing information to their family members, participants also shared that they have tried to inform other people in the community about the need for FP services, child spacing and have been able to bring about some changes at the community level.

"yes...I have an aunt in my society who has given birth to 2-3 sons and daughters...because of this programme from ADRA Nepal, I was able to convince her that she already has enough children....and made her use ..what is that.....implant .."- Married female counselled by SM on FP

e. Effect of COVID-19 on the intervention

Like other sectors, this programme was also affected by COVID-19 pandemic. Participants shared that the programme was halted in early days as the result of nationwide lockdown imposed by the government as an initiative to prevent and tackle further spread of the disease. However, after the government eased-up the criteria of lockdown, classes were reopened following the preventive measures such as social distancing, use of masks, sanitizers, and proper handwashing. Participants also shared that the programme has also been effective and has played a notable role in improving social awareness regarding the COVID-19.

> "*....of course, COVID impacted our programme as well…....and we couldn't take classes for a long time."*- Adolescent girl *Rupantaran* session

> *"It was difficult. We used to learn every Friday. The situation of Corona did not allow us to gather so we did not get a chance to learn. Later when the situation turned to normal, we started learning again"*- Adolescent girl (without formal education) from *Rupantaran* session

The participants further added,

> *"In between due to corona there was a gap for 2-3 weeks. Later sessions were completed by making it regular"* Adolescent girl (without formal education) from *Rupantaran* session

f. Suggestions for improvement

Most of the participants appreciated the approach adopted in the programme and shared that the programme is very well received by adolescents, parents, and the whole society. They viewed this programme as a complete package and were confident about its usefulness to an individual, family and the community.

However, some participants shared some modifications that could further improve the outcome of the intervention. Some of the participants shared that involving girls of age group below adolescent would help them prepare to face the challenges that follow with adolescence age; could help them better understand and prepare for the sexual changes that occur during adolescence. Participants also suggested that the programme should engage adolescents of both sexes and focus on women of any age rather than focusing on adolescents only to further improve the efficacy as well as programme beneficiaries and overall outcome. Some participants stressed the need to expand the scope dealing with other health issues like uterine prolapse and other reproductive health issues.

> *"....girls of age below than ours should be able to get even more useful information and knowledge regarding these services."*- Adolescent girl from *Rupantaran* session

> *"only provided to girls, boys were not given. Also, focus was mainly for adolescents. We women were provided with implant and IUCD service but we also have problems related to uterine prolapse, white discharge. If we could also get such services it would have been better. These problems are for everyone and everyone should get service"*- Female Service user, FP camp

3.7.2 Perspective of service providers and programme implementers

Service providers and programme implementers including SMs, PEs, service providers at HFs, VSPs, teachers in schools with AFIC, local leader and programme officer were interviewed in the

study. Findings of the intervention from the perspective of service providers were based on the major thematic areas as follows.

a Role of service provider and implementer

Service providers were set to play various roles based upon the responsibility they bear from management and as needed for smooth operation of this programme leading to efficient delivery of the intervention and its uptake by service users. The roles of service providers can be summarized as facilitation in creating adolescent friendly environments, enriching their knowledge and welcome openness in discussion on such critical issues within family and society.

> *"in this program my role was planning on how to move forward with our door to door family planning services and ...hmm..going to the society and meeting people making them aware about the importance of the program ..."*-Service provider, health facility

> *"aah...I played a role as a service provider then after providing education to the participants co-ordinating with peer educators....aah...specially home to home; door to door service rather than focusing on health facility and community."*-Visiting Service Provider

b Coverage of the programme

Service providers stated that variety of activities were conducted under the programme focusing mainly on FP, SRH, gender violence, child marriage, life skills education and nutrition. School going and out of school adolescents were equally given a chance and were encouraged to take active participation in this program.

> "*... activities regarding rights and duties of the adolescents... changes during this (adolescent) phase, things to do when such changes takes place, and ... information regarding diet to eat during daily life ...and sexual and reproductive health...gender violence were also included (in the Rupantaran session)...*"-Peer educator

c Acceptance of the programme from beneficiaries and community

Service providers shared that initially adolescents were very shy and hesitant to even say their names and talk about FP. Some adolescents initially thought that FP was of importance to only couples and later admitted that it was of importance to all. Programme implementers shared that not only the adolescents and their family members but even the local leaders were reluctant about the programme in initial phases because of the prevailing misbeliefs about FP services in the community which changed later with repeated counselling and discussion in different settings.

> *"What my daughter have been taught? Heard of family planning? Is it even a good thing?...people had concerns like this. Even ward chairperson of a community had these concerns. But later, after we counselled them in a separate environment and settings, explained them about the things we teach, villagers started to support us."* Programme officer

d Focus on the disadvantaged groups

Participants shared that in line with the objective of the intervention to increase the understanding about FP services and increase access to the services particularly focusing on disadvantaged segment of population, adolescents of such groups have benefitted from the programme.

> *"...things have changed because in Muslim community due to their religion they were not using any FP methods now after classes they are using it"*-Peer educator

Participants added the programme was most beneficial to the disadvantaged groups including Muslims and non-school going adolescents who had not been able to utilize the services due to different barriers and were not able to obtain information they needed. Out of school adolescents who were not able to understand their sexual and reproductive rights, the need of child spacing and FP services and other life skills that could help them lead independent because of not being able to attend school education were benefitted from the programme.

> *"..we have gathered 25 non-school going adolescents and have provided them with training on all of family planning issues coordinating with our social mobilizer and peer educator.."* -Visiting Service Provider

> *"A lot has been changed....if we were to look at the record, more service users are adolescents from muslin community and that is the group most benefited from the program"*-Social mobilizer

e Changes after intervention or achievement of the programme

After the intervention which particularly included counselling sessions, adolescents were able to freely talk about their problems. Service providers shared that participants are now willing to consider birth spacing, have started sharing the information they have regarding FP methods and are also willing to share about the need for preventing early marriage with their friends and relatives.

> "*...in our parents training one of the participants shared that her daughter was always hesitant and shy in talking FP devices and services but after taking class she talks openly with her, shares her knowledge and ask her queries as well…*"-Peer educator

> '*... the programme has developed confidence to discuss in detail among the participants regarding the knowledge of FP devices and services, has positive impact and even helped disadvantaged families to improve their living standard.*"- Local leader

> *"aah... there's a difference. For example, adolescents are easy to convince and are ready to accept however on the other hand people of other age group resist to accept the fact and are time consuming during counselling..."*- Visiting Service Provider

> *"Yes. There was not anyone before. In fact, FP methods were not available and there were not any adolescents using it. There were few using FP methods in higher age groups. But not among adolescents now there are many"*-Social mobilizer

Participants also expressed that there has been an increase in the number of service users particularly those utilizing FP services following intervention. Programme implementers shared that this progress has been achieved in a piecemeal manner gradually increasing the understanding about FP services, increasing its acceptability, and increasing the number of service users.

> *" ....there isn't any instantaneous increase in number of service users however 1-2 cases, 3-4 cases of service users have increased pre and post implementation of the program."* Programme officer

f Challenges

Programme implementers shared that existing social and cultural values relating to FP services prevailing in the community can still serve as challenge in utilizing FP services particularly Dalit and disadvantaged community. Difficult geographical terrain and scattered settlement cluster could

be other challenges that could slow the pace of programme implementation or hinder some segment of community from harnessing the benefits of the programme. The emergence of COVID-19 pandemic and the restrictive measures following it also hindered the smooth roll out of the intervention (has been dealt as separate theme).

> *"Now, when we run the program, the same thing happens to the girls and teenagers. Some of them have to walk 2-3 hours, 3-4 hours."*-Social mobilizer

> *"...some barriers still prevail in our Muslim community which prevent them in using family planning devices.."*- Local leader

g Impact of COVID-19 in the intervention

Similar to service users, service providers shared that COVID-19 impacted the implementation of the intervention in the community. However, as the situation eased, classes were reopened following the preventive measures like social distancing, mask use, and sanitization. Programme also focused on sharing additional information on COVID-19 to raise awareness about the disease in the community and even prevent its further spread.

> "*...nowadays COVID has impacted every sector...not just a single sector...it has impacted every sector.....we are advising them to be cautious…take necessary precaution against COVID before conducting the program..*"- Local leader

> *"..like every other sector, our classes were completely disrupted however resumed after some time with necessary precautions and safety measures.....*"- Peer Educator

Even after the programme resumed, hindrance due to unavailability of safety as well as precautionary measures/equipment on smooth operation was experienced by some of the service providers.

> *"Sir we faced many challenges during COVID. Health posts were closed. There were many having desire for services. They were not able to receive services even after saying they did not have an infection. That time it was very difficult. With the availability of PPE and thermometer gun through the programme we were able to provide service during that condition.*"-Visiting Service Provider

Further the service providers added participants dropout rate was high resulting in the decreased participation in the study activities particularly in *Rupantaran* sessions.

> *"...after lockdown was eased up by government number of participants decreased...at first there were many participants later on 20-24 participants dropped out"*-Peer educator

The service providers also mentioned about the change in preference of FP methods during the time of COVID-19 stating,

> *"during COVID...as injecting depo would involve close contact people preferred pills over depo. It was like even after counselling for implants they preferred not using now. Those who used depo took pills"*-Service provider, health facility

h Suggestions for improvement

Service providers pointed out the need to focus more on disadvantaged groups with a multicentric approach securing coverage of a wide geographical area. Participants also shared the need of imparting practical skills to FP service providers on delivery of FP services.

> *"....here is some problem regarding IUCD insertion....for that reason it would be better if proper training was provided to one of our healthcare workers…"*-Local leader

> *"...bringing the essential book and relevant materials, continuity of the program...direct involvement of authorized personnel would definitely make this programme even more fruitful."*- School teacher, AFIC

> "*...Of course, there is a difference, there is a difference between socially disadvantaged adolescents and those who are advantaged and near us. They do not have an idea about FP and do not know much about the free service and other things. Differences also exist in terms of religion and culture*."- Service provider, Health Facility

Last but not the least, participants were found quite vocal and were not hesitant to point out the fact regarding the involvement criteria to this program. Service providers really do believe that involvement of male adolescents to the programme will result in better programme outcomes.

> *"..It would be more fruitful if we could take this programme to rural village communities and also involvement of male adolescents would be even more beneficial"*-Programme officer

3.7.3 Inductive picture of qualitative assessment

Narrowing down the findings of qualitative assessment, a comprehensive picture of implementation context, that could have affected the intervention in either way, was visualized along with the achievements made over the outcomes of the study (***Figure 8)***.

Married adolescent girls face different barriers to reach and utilize FP services. Most of the barriers for FP service utilisation that pre-existed in the study sites and reported by the participants were lack of knowledge, poverty, distance to health facilities, feeling of shame, pressure from family members and their attitude and fear of side effects. *Sakshyam Kishor Kishori* intervention seemed to have addressed these barriers well through its five key strategies although the intervention itself had to face implementation challenges over the study period.

FP being a stigmatized topic in the community, gaining trust and having married adolescent girls and their parents participate in the study was a challenge to overcome. Reluctance over the participation was observed in the early phase of implementation which later changed as efforts were laid in building rapport and gaining trust of the community. Empowering adolescents through life skills session, carefully addressing their concerns particularly on privacy and confidentiality, overcoming shyness in assessing information and seeking services, ensuring credibility through deployment of trained SM and PE and making educational materials available through information corners, engaging adolescents from the local community who are aware of the local cultural context seem to have aided acceptance of intervention. On-boarding gate keepers such as local leaders and most importantly the guardians in various activities of the intervention such as engaging parents/in-laws/husbands in FP counselling and in life skill sessions further aided in increasing the acceptability of the intervention. The high rates of retention of the beneficiaries in Rupantaran sessions, could be an example of the relevance of the contents delivered and the

trust that beneficiaries had towards the intervention. To summarize, the robust design of the intervention itself played a huge role in its successful implementation.

Similarly, the implementation modality seemed to have an impact not only on the achievement of the intervention but also on effective roll-out of the intervention, by determining its penetration into the community. As mentioned by the participants, a targeted approach with involvement of disadvantaged groups such as ethnic minorities and out of school married adolescents increased their accessibility to FP information and FP services in the broader scale. A considerable level of intervention penetration was reflected in quantitative findings of the study, which demonstrates that intervention has been able to reach hard-to-reach segment of population which could also be useful in improving equity in subsequent stages. Participants opined that the community could have benefitted more if intervention had engaged more of adolescent boys as well as the early adolescents. Through diffusion of intervention, it could have impacted slightly larger community than direct beneficiaries.

Nonetheless, the intervention was able to achieve changes in FP knowledge and behaviour related to primary and the secondary outcomes of the study. Participants reported that the intervention broadened the horizon of their understanding about family planning and increased their interest on the topic. Most importantly, the knowledge acquired by the direct beneficiaries of the intervention was diffused to wider community. Adolescent girls shared their learnings from counselling sessions and *Rupantaran* sessions to their families and immediate neighbourhood marking the propagation of awareness on FP in the community. Participants also reported changed perception towards health facilities in terms of FP service utilization as the service had become more user friendly (lack of privacy was mentioned as one of the barriers) with strengthening of AFS in HFs. Similarly, conduction of FP camps helped in making the services more accessible thereby overcoming geographical barriers to the services; distance to HF was reported as one of the barriers for FP service utilization. Among other achievements of the intervention was increased interpersonal and communication skill amongst participants. Peer education approach for delivery of life skill sessions addressed the participants' concern on privacy and confidentiality and feeling of shame regarding FP and its use and thereby facilitated in building up more comfortable environment for the participants to learn and understand their potential to express their FP/SRH needs. This could help them obtain information on FP services in future.

These changes brought by Sakshyam Kishor Kishori intervention could have been more wide and vivid, had there been no emerging barriers for implementation. There was some unanticipated change in context like emergence of COVID-19 pandemic that was followed by stringent mobility restrictive measures during the intervention period which impacted the intervention, its coverage and outcome. As the intervention itself was halted for few months and operated in a restricted manner even after resuming, this posed a challenge for implementers to reach-out to the target population. Participants of the intervention too refrained from engagement due to fear of COVID-19 transmission. Drop-out of participants from Rupantaran session was noted during this period. Despite all the challenges, the intervention notably brought some changes in the study sites as changes related to both primary and secondary outcomes of the study was pointed out by the intervention beneficiaries and the implementers.

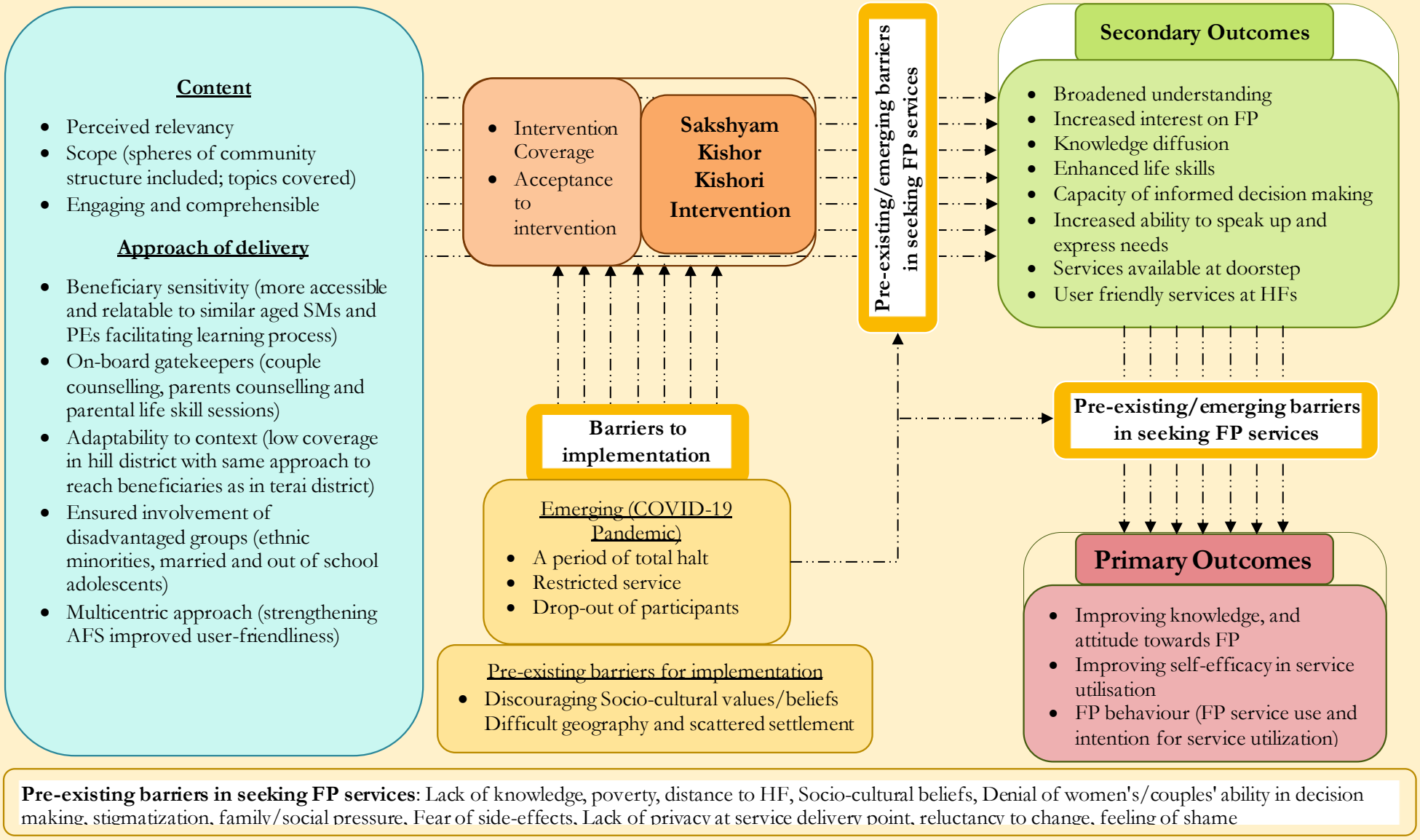


Figure 8: Description of implementation context and the achievement of Sakshyam Kishor Kishori intervention

4. Conclusions and recommendations

4.1 Conclusions

One out of every four participants in intervention districts were reached by the *Sakshyam Kishor Kishori* intervention. Four out of ten adolescents were reached by the intervention in Sarlahi, the Terai district in the study while only one out of every ten adolescents were reached in Arghakhanchi, the hilly district in the study indicating that same strategies may not be effective in reaching adolescents in hilly and Terai region of the country.

The intervention was found effective in improving knowledge of FP and improving perception of the risk of not using contraceptive services among participants. The intervention was able to improve the knowledge on FP services among married adolescents, perception about risk, benefits and barriers and the self-efficacy to use FP even though only one fourth of the total adolescent population were reached by the intervention. This means that the adolescents are more capable of utilizing the FP services after the intervention.

However, the use of modern contraceptive services did not improve significantly during the intervention period. Although higher proportion of adolescents have knowledge and can use contraceptive services or prevent births if they wish to stop or delay childbearing, it could take slightly longer period to get reflected in the indicators like mCPR.

4.2 Recommendations

Programme recommendations

- As the intervention has been effective in improving knowledge of FP services and attitude towards FP services (perception of risk, benefit, and barrier) among married adolescents, the programme can be scaled up in other districts. However, as the resources are limited and tend to have alternate use, the cost per output yield should be carefully weighted before scaling up the intervention.
- Drawing on the findings (qualitative) that participants felt more comfortable in receiving FP service information and messages from tutors of their age group. Peer education approach could be a useful approach whenever designing FP interventions specifically targeted to adolescent population.
- While rolling out similar interventions in future, more focus is needed in ensuring wider coverage of intervention. It could involve increasing the number of social mobilizers or adopting slightly different modality for diffusion of intervention at community level.
- As noted in the findings (qualitative), additional focus is needed in increasing the involvement of male adolescents in the intervention as use of FP services is a joint decision of the couple.
- Notably lower reach of the intervention in hilly intervention district compared to that of Terai indicates the need for consideration of geographical context while rolling out the intervention. Difficult geographical terrain and scattered residence clusters could be the reason for relatively lower level of penetration of intervention in hilly district. Intervention roll out strategy should take into consideration the geographical terrain, population density, distance to health facility and local cultural context while scaling up the intervention.

Research recommendations

- Policy decisions involve trade-off of the resource among different programme alternatives. Cost effectiveness analysis, thereby, comparing the cost per output yielded through this intervention should be compared with other similar alternatives intended to improve uptake of FP services among adolescents.
- Despite similar efforts from intervention implementors side, the intervention had notably lower coverage in hilly district (low in Arghakhanchi district and high in Sarlahi district). Qualitative research on how the intervention reach could be increased in hilly district could help future programme to have higher level of intervention coverage. Furthermore, qualitative studies exploring if different intervention modality are required in district with high and low population density could be useful in designing future programme.
- Despite improvement in knowledge of FP services, perception about risk of not using FP services, benefits of and barriers to FP services and the self-efficacy in use of FP services, there was no statistically significant improvement in CPR. This could be because of short intervention duration, during which, improvement in other variables could not get reflected on CPR. Future studies of similar nature should have longer duration of intervention that allows sufficient time for improvement in other variables like knowledge, perception and self-efficacy to get reflected in CPR.

5. Limitations of the study

The selection of district in the study was not random but was done from among the districts with presence of implementing partner ADRA Nepal as the research itself is a part of broader programme being implemented as a part of FP programme. Intervention districts were selected from among the districts ADRA Nepal had the plan for implementation of adolescent FP programme and control districts were selected from among the districts with presence of ADRA Nepal but not planned for adolescent FP program. So, selection of district for the study and assignment of intervention among the districts was not completely random.

The intervention of the study was rolled out from January 2020 till November 2020. However, with the beginning of COVID-19 pandemic, restrictive measures were imposed by government of Nepal in March 2020. As a result, all the activities of the intervention were halted and resumed only with easing in the situation in June 2020. At that time, a set of programme activities were further identified for scaling-up to compensate the time lost due to restrictive measures. However, these activities, along with the regular activities, were not as rigorously conducted as it would have been without the pandemic. However, continuous efforts in reinstating the study activities were made using alternative measures such as mobile based FP counselling by SMs. The intervention suffered a second round of lockdown when COVID-19 cases dramatically increased throughout the country. As a result, the research activities had few months of smooth operation while they were completely halted or had restricted implementation for the rest. Although study has attempted to quantify the impact of COVID-19 in FP service utilization and adjusted the impact in data analysis, there could be multiple ways the pandemic and the measures used to contain it, could have impacted the intervention which could have undermined the effectiveness of the intervention.

6. Dissemination and utilization of findings

6.1 Dissemination of study findings

The results have been shared with the relevant stakeholders of health sector including DoHS, MoHP and health external development partners at national level.

6.2 Utilisation of research findings

This is a complete report summarising the findings from the operational research assessing the effectiveness of *Sakshyam Kishor Kishori* intervention aimed at improving knowledge, attitude, and uptake of FP services among married adolescents. This report can be useful for policy makers in designing different targeted interventions related to FP services among adolescents.

6.3 Research open and enhanced access policy

This study strictly adhered to the then legacy DFID research open and enhanced access policy. The raw data used in this study will be made available in a publicly accessible repository.

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8. Annexure

Annex I : Categories of the participants interviewed for process evaluation

Category of Participants		Number Study participants Interviewed
Service Users		
Beneficiaries from SM	Male	2
	Female	10
	Total	**12**
Service user of FP camp	Male	3
	Female	6
	Total	**9**
Beneficiaries *of Rupantaran* session	Formal Schooling	11
	No Formal Schooling	5
	Total	**16**
Parents who attended life skill session	Male	7
	Female	10
	Total	**17**
Service user of AFICs	Male	4
	Female	7
	Total	**11**
Service Providers		
Service provider of health facility		8
Camp service provider		7
Programme officer		2
Peer educator		7
Social mobilizer		8
Visiting service provider		6
School teacher in AFICs		6
Local leader		**8**
Total Participants		**117**

Annex II : Study variables

Primary outcome variables	
FP behaviour	Utilisation of counselling services
	Modern contraceptive use among married adolescents
	Intention to use contraceptives in future
	Health facilities visit for contraceptive services
Self-efficacy	Ability to discuss with partner about contraceptive use
	Capability to use contraceptive services when needed
	Confidence in going to HF and discussing with service providers
	Knowledge about FP services and capability of making choices of appropriate method
Secondary outcome variables	
Knowledge on FP	Knowledge on FP based on a set of 28 questions
Perceived risk	Susceptibility to pregnancy
	Seriousness of the outcome of pregnancy during adolescence (consequences)
Perceived benefits	Benefits due to prevention of pregnancy
	Benefits related to prevention of STIs due to FP service use
Barriers to FP	Understanding/perception/experience of side effects
	Service availability
	Social/cultural/religious norms
	Geographical and financial barriers
Independent variables	
Socio-demographic variables	Age
	Place of residence (urban/rural)
	Ethnicity
	Religion
	Educational status
	History of previous pregnancy
	Educational status of husband
	Migration status of husband
	Future parenthood desire
Intervention related variables	Exposure to intervention that involves exposure to ➢ Life skills sessions ➢ Peer education ➢ Counselling service through Social mobilisers (SM) ➢ Animated video sessions

Annex III : Definition of Key variables and operationalization

Knowledge on FP: Knowledge on FP was assessed through a set of 28 questions that required participants to identify if the given methods are permanent or temporary, are intended for male or female and the duration of protection offered.

Perceived Risk: Participants' perceived risk of an unintended pregnancy and subsequent medical, social and professional consequences including birth, abortion, parenting associated problems, quitting school, losing job etc provides the incentive for the use of contraception. [26] In this study, perceived risk has been assessed under two domains: susceptibility to pregnancy and seriousness of the consequences of being pregnant in adolescent age. Theoretically, perceived susceptibility refers to cognitive assessment of how likely a participant believes that she would become pregnant if no preventive action is taken. There were two questions to assess the susceptibility to pregnancy that assess participants' understanding about likelihood of getting pregnant without any protection and likelihood that pregnancy can be prevented by using alternative methods other than modern contraceptives. Seriousness of the consequence was assessed in terms of the problems associated with getting pregnant at adolescent age, easiness of the alternative ways of dealing with pregnancy (abortion), health and medical problems associated with pregnancy, impact on personal and professional development and impact of early pregnancy on health of infant and children. Participants were asked to rate their perception on a five-point Likert scale ranging from strongly agree to strongly disagree. Thus, perceived risk was assessed through a set of 8 questions.

Perceived benefits: There were a total of 7 question to assess this construct. Potential benefits of the contraceptive use in this study are considered under two domains: benefits related to pregnancies prevented and those related to sexually transmitted infections (STIs). Participants were asked to rate their perception regarding the role of contraception in responsible sexual behaviour, personal and professional benefits, impact on relationship with partner, preventing anxiety related to pregnancy, and impact on social image of looking smart on a five-point Likert scale ranging from strongly agree to strongly disagree. There was also one question on the potential role of condoms in preventing STIs.

Barriers for FP: Perceived barriers include perceived side effects, social, cultural, and religious norms, availability, accessibility, and quality of FP services that hinder the use FP services. The survey tool consisted a total of 1 question related to norms, 3 questions related to perceived side effects, 3 questions related to availability and accessibility and 3 questions related to perceived quality of FP services. Theoretically, everyone is supposed to carefully weigh the potential benefits and risks. Individuals tend to conduct cost benefit analysis in an implicit manner weighing potential benefits against the cost in terms of travelling time, embarrassing situation, inconvenience etc. In this study, perceived side effects were assessed in terms of the effect of contraceptive use on ability to have children in later stages, undesirable health consequences, and impact it has on sexual drive. Social, cultural, and religious norms associated with the contraceptive use and its availability in the nearest HF were also assessed on a five-point Likert scale where participants rated the availability of service. Accessibility was measured in terms of travelling time and ability to pay for services. Perceived quality of services was assessed in terms of quality of FP commodity, skill/competency

of service providers and importance of quality services in case of FP service. All of these potential barriers to FP have been found to inhibit contraceptive use.[26]

Self-efficacy: Theoretically, self-efficacy is defined as the belief that one can execute a behaviour required to produce a desired outcome successfully. In this study, self-efficacy in use of FP were measured through two constructs: confidence and capability. Confidence was measured in terms of individuals' understanding about their ability to talk to service providers about their needs, ability to talk with the partner and ability to decide to use FP services irrespective of partner's will. Capability was measured based on participants' ability to visit HFs independently, making choices according to their needs and ability to convince their partner. A set of 6 questions were used to assess the self-efficacy of the participants.

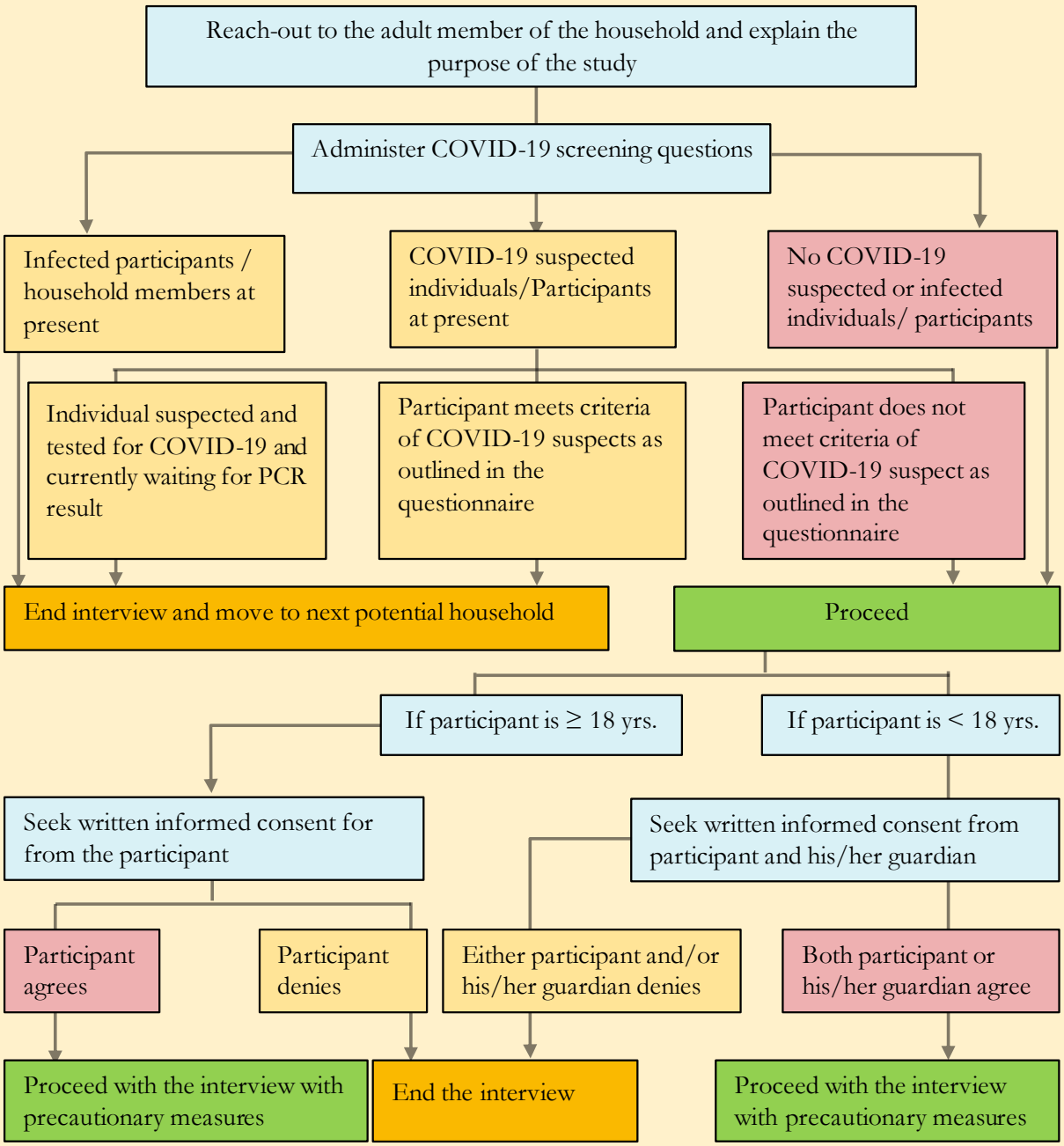
Cue to action: Cues to action are stimuli that trigger a consciousness of the perceived pregnancy threat and facilitate consideration of using FP services to prevent the threat. [26] In our study, cue to action were measured as the exposure to different contextual factors like role of teachers, social/cultural/religious norms, parents, siblings and other relatives, friends, media in shaping adolescents' opinions about FP services.

FP behaviour: FP behaviour were measured through existing use and intention to use the counselling for FP services or the use of contraceptives. Three questions relating to existing use of services, any preparation for using services in near future and likelihood of using services in future were asked to participants separately for both contraceptive services and counselling in order to measure the FP behaviour of the adolescents.

Annex IV: Scoring key for outcome variables

A		B	C	D	E	F
Construct measured		Question numbers (code)	Score of each item*	Items requiring reverse scoring	Total numbers of questions	Total score (F=C*E)
Knowledge	KT: Which of the following family planning methods are temporary and which permanent?	KT1, KT2, KT3, KT4, KT5, KT6, KT7, KT9, KT10 KT11	1		28	28
		Recoded as ZT1 ZT2 ZT3 ZT4 ZT5 ZT6 ZT7 ZT9 ZT10 ZT11				
	KT11: Which between given contraceptives provides a longer duration of protection?	KT11.1, KT11.4				
		Recorded as ZT121, ZT124				
	KM: Which of the following are modern method of contraception?	KM1, KM2, KM3, KM4, KM5, KM6, KM8, KM9, KM10, KM11				
		Recoded as ZM1 ZM2 ZM3 ZM4 ZM5 ZM6 ZM8 ZM9new ZM10 ZM11				
	KG: Which of the following FP methods are for female and for male?	KG1, KG3, KG4, KG5, KG6, KG7				
		Recorded as ZG1 ZG3 ZG4 ZG5 ZG6 ZG7				
Perceived risk	Susceptibility to pregnancy	R1, R2	5	R2 R3 R4 R5	8	40
	Seriousness of consequences	R3, R4, R5, R6, R7, B1,				
Perceived benefits		B2, B3, B4, B5, B6, B7, B8	5		7	35
Barriers for FP	Norms	N1	5	N1, S1, S2, S3, A1, A2, A3, Q1, Q3	10	50
	Perceived side effects	S1, S2, S3				
	Availability and accessibility	A1, A2, A3				
	Perceived quality of services	Q1, Q2, Q3				
Self-efficacy		E1, E2, E3, E4, E5, E6	5	E2	6	30

Annex V: COVID-19 consideration during the endline survey



Annex VI: Progress Monitoring

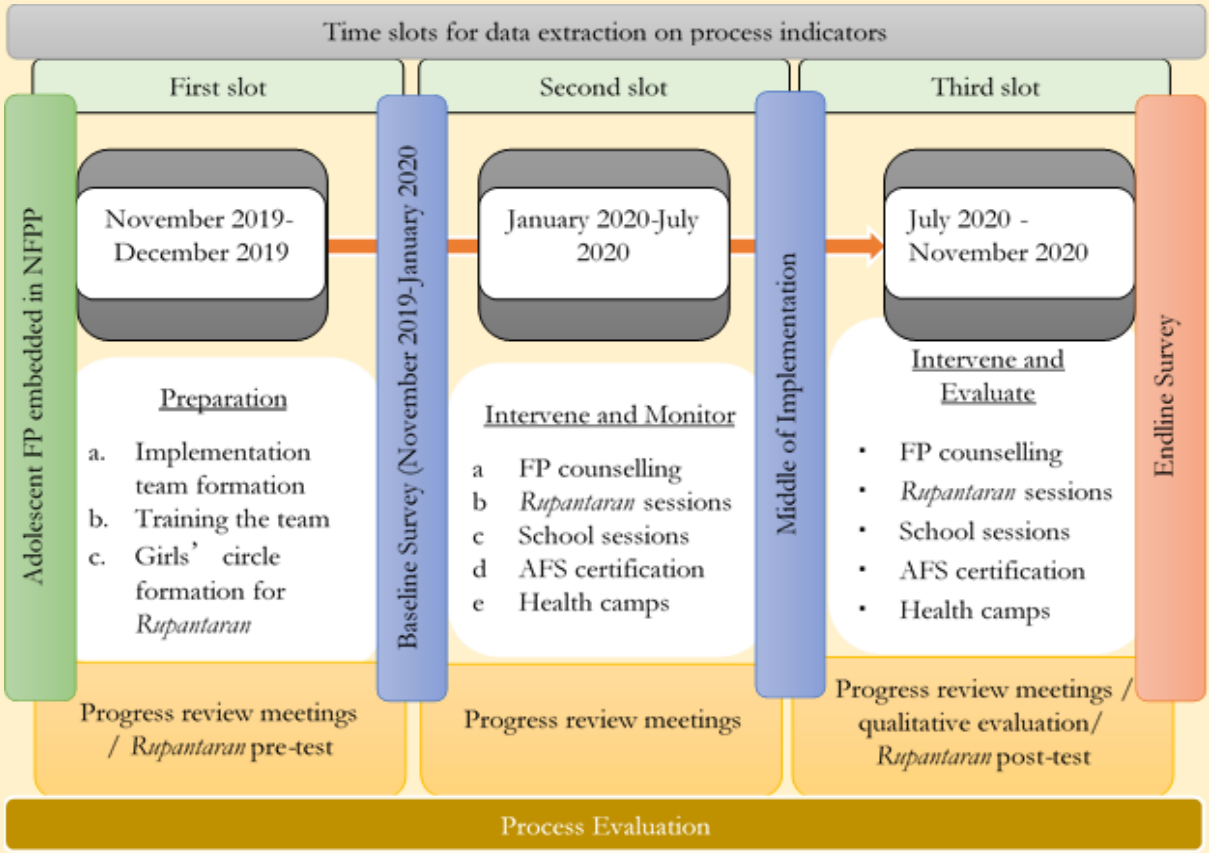


Figure A: Study Process and process evaluation

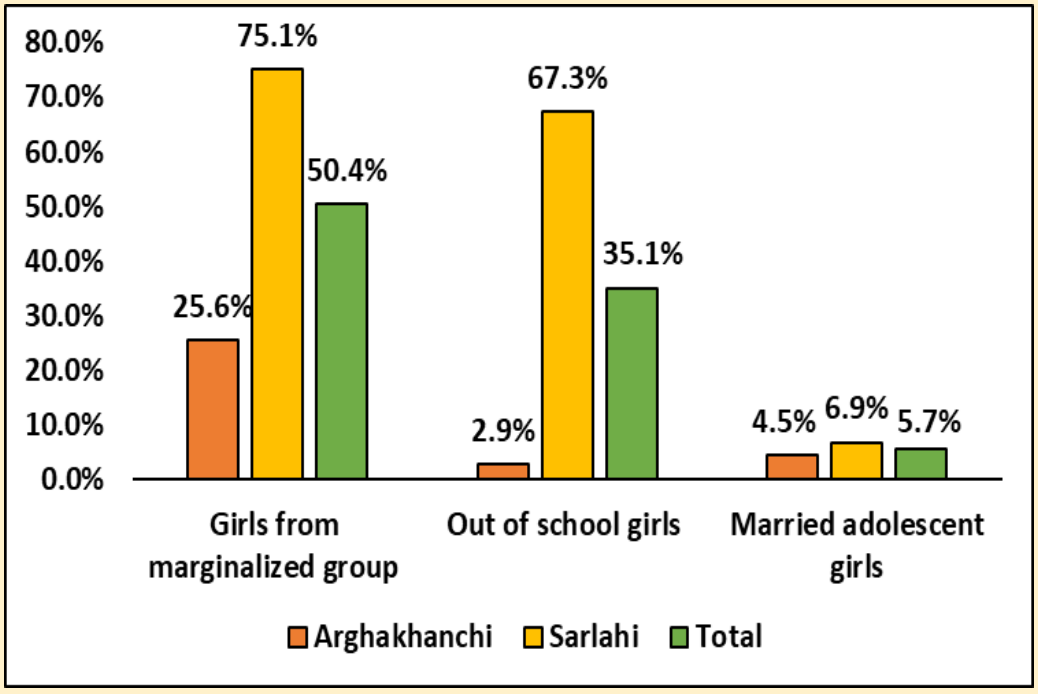


Figure B: Representation of marginalized community in Rupantaran session

Table A: Service utilization from AFS sites before and after intervention (data from HMIS)

	Arghakhanchi				Sarlahi				Total			
	Before *	After**	Increase		Before *	After**	Increase		Before *	After**	Increase	
			N	%			N	%			N	%
Sex												
Male	6,541	7,044	503	7.7	1,694	1,721	27	1.6	8,235	8,765	530	6.4
Female	7,627	8,119	492	6.5	1,820	1,835	15	0.8	9,447	9,954	507	5.4
Age												
10-14 yrs.	7,135	7,750	615	8.6	1,637	1,662	25	1.5	8,772	9,412	640	7.3
15-19 yrs.	7,033	7,413	380	5.4	1,877	1,894	17	0.9	8,910	9,307	397	4.5
Total	14,168	15,163	995	7.0	3,514	3,556	42	1.2	17,682	18,719	1,037	5.9

Note: ** = for six months before the intervention i.e. from July 2019 – December 2019, ** = six months after the intervention i.e. July 2020 – December 2020*

Annex VII : Additional findings

2.11.3Table A: Knowledge of participants on FP methods

		Baseline				Endline			
		Intervention districts (n=1,812)		Control districts (n=1,822)		Intervention districts (n=1,840)		Control districts (n=1,840)	
		N	%	N	%	N	%	N	%
Ever heard about following FP methods									
Condoms		1,568	86.53	1,661	91.16	1,686	91.63	1,627	88.42
Injectables (Depo-Provera)		1,550	85.54	1,704	93.52	1,713	93.10	1,700	92.39
Oral contraceptives/pills		1,424	78.59	1,626	89.24	1,669	90.71	1,564	85.00
Implant		1,266	69.87	1,466	80.46	1,522	82.72	1,311	71.25
Female sterilisation		1,103	60.87	1,254	68.83	1,483	80.60	1,550	84.24
IUCD (Loop)		936	51.66	909	49.89	1,308	71.09	863	46.90
Male sterilisation		802	44.26	918	50.38	1,248	67.83	954	51.85
Withdrawal (coitus interruption)		676	37.31	915	50.22	1,189	64.62	780	42.39
Rhythm method		492	27.15	762	41.82	806	43.80	747	40.60
Emergency hormonal contraceptives (I pill)		440	24.28	434	23.82	875	47.55	383	20.82
Lactational amenorrhea method (LAM)		350	19.32	424	23.27	622	33.80	385	20.92
Knowledge on duration of protection									
Temporary FP methods	IUCD	706	38.96	696	38.2	1,158	62.93	749	40.71
	Depo	1,369	75.55	1,505	82.6	1,616	87.83	1,598	86.85
	Implant	1,036	57.17	1,257	68.99	1,404	76.30	1,193	64.84
	Pills	1,259	69.48	1,450	79.58	1,607	87.34	1,509	82.01
	Condoms	1,417	78.20	1,498	82.22	1,634	88.80	1,574	85.54
	LAM	245	13.52	358	19.65	553	30.35	320	17.39
	Rhythm method	325	17.94	638	35.02	726	39.46	658	35.76
	Withdrawal	498	27.48	770	42.26	1,113	60.49	689	37.45
Depo acts longer than pills		1,003	55.35	1,262	69.26	1,416	76.96	1,349	73.32

		Baseline				Endline			
		Intervention districts (n=1,812)		Control districts (n=1,822)		Intervention districts (n=1,840)		Control districts (n=1,840)	
		N	%	N	%	N	%	N	%
Female sterilisation and male sterilisation both work for same period		451	24.89	539	29.58	1,007	54.73	827	44.95
Modern FP methods	Female sterilisation	520	28.7	706	38.75	1,067	57.99	1,182	64.24
	Male sterilisation	379	20.92	553	30.35	922	50.11	696	37.83
	IUCD	677	37.36	685	37.6	1,099	59.73	809	43.97
	Depo	1,170	64.57	1,249	68.55	1,450	78.80	1,617	87.88
	Implant	959	52.92	1,142	62.68	1,322	71.85	1,240	67.39
	Pills	1,050	57.95	1,189	65.26	1,370	74.46	1,498	81.41
	Condoms	1,045	57.67	1,096	60.15	1,357	73.75	1,531	83.21
	LAM	157	8.66	254	13.94	326	17.72	280	15.22
Traditional FP methods	Rhythm method	256	14.13	424	23.27	395	21.47	600	32.61
	Withdrawal	341	18.82	507	27.83	578	31.41	620	33.70
Sterilisation is for both male and female		702	38.74	835	45.83	1,182	64.24	930	50.54
Methods are for female	IUCD	876	48.34	872	47.86	1,258	68.37	844	45.87
	Depo	1,494	82.45	1,681	92.26	1,670	90.76	1,693	92.01
	Implant	1,201	66.28	1,438	78.92	1,493	81.14	1,286	69.89
	Pills	1,385	76.43	1,586	87.05	1,621	88.10	1,547	84.08
	LAM	309	17.05	379	20.80	570	30.98	372	20.22
	Rhythm method	374	20.64	648	35.57	675	36.68	666	36.20
Methods are for male	Condoms	1,340	73.95	1,487	81.61	1,354	73.59	1,548	84.13
	Withdrawal	621	34.27	865	47.48	1,066	57.93	761	41.36

Table B: Difference-in-difference analysis of knowledge and attitude variables across different strata of participants

Strata	N	Knowledge Score		Risk score		Benefit Score		Barrier Score		Self-efficacy	
		Coeff	SE	Coeff	SE	Coeff	SE	Coeff	SE	Coeff	SE
Ethnicity											
Dalit	2,146	4.00**	0.53	2.50**	0.36	2.64**	0.35	1.62**	0.41	1.91**	0.36
Janajatis	1,396	2.62**	0.64	1.76**	0.44	1.31**	0.38	-0.17	0.49	1.58**	0.43
Madhesi	1,220	1.49*	0.74	1.83**	0.46	-0.68	0.49	-0.09	0.55	1.22*	0.51
Muslim	1,087	9.72**	0.82	1.67**	0.46	2.26**	0.58	1.05	0.67	0.63	0.61
Brahmin/Chhetri	1,452	1.80**	0.62	-0.12	0.44	0.1	0.35	-0.25	0.47	0.58	0.37
Literacy											
Literate, formal education	5,629	3.62**	0.32	1.58**	0.22	0.97**	0.2	0.31	0.24	1.38**	0.22
Literate, no formal education	399	-2.47*	1.21	0.82	0.76	-1.03	0.82	-2.95**	0.98	-2.91**	0.87
Illiterate	1,283	4.01**	0.68	1.20**	0.42	2.35**	0.5	2.69**	0.58	1.40**	0.52
Income (annual)											
Less than or equal to 160000	1,470	3.89**	0.65	1.64**	0.41	1.03*	0.44	0.80	0.50	1.73**	0.46
160000-240000 income	2,629	3.57**	0.47	1.68**	0.31	0.63*	0.3	1.00**	0.35	1.32**	0.33
240001-300000 income	976	3.15**	0.8	2.26**	0.58	1.70**	0.5	1.08	0.64	1.19*	0.58
>300000 income	1,800	4.16**	0.6	1.35**	0.4	1.13**	0.38	-0.28	0.46	0.61	0.39
Spousal Separation											
Living with husband	4,219	3.25**	0.38	1.55**	0.25	1.33**	0.25	0.69*	0.3	1.34**	0.27
Separated with husband	3,095	3.34**	0.45	1.01**	0.29	0.62*	0.29	-0.1	0.33	0.82**	0.3
Parity											
Has at least a child	4,702	3.07**	0.35	1.23**	0.24	0.95**	0.23	0.23	0.28	0.84**	0.24
Does not have a child	2,612	3.74**	0.51	1.60**	0.32	1.24**	0.31	0.55	0.36	1.66**	0.34

Note: * means the result is significant at p value 0.05, ** means that the result is significant at p value 0.001

Table C: Difference-in-difference analysis of FP service utilization related variables across different strata of participants

Strata	N	Contraceptive Use (Any method)		Modern contraceptive (Any modern method)		Traditional methods (Any traditional method)	
		Coeff	SE	Coeff	SE	Coeff	SE
Ethnicity							
Dalit	2,146	-0.01	0.04	-0.06	0.04	0.04**	0.01
Janajatis	1,396	0.06	0.05	-0.06	0.05	0.12**	0.02
Madhesi	1,220	-0.01	0.05	-0.02	0.05	0.01	0.02
Muslim	1,087	-0.06	0.05	-0.06	0.05	-0.01	0.01
Brahmin/Chhetri	1,452	0.01	0.05	-0.06	0.05	0.07**	0.02
Literacy							
Literate, formal education	5,629	0	0.02	0.06**	0.01	-0.05*	0.02
Literate, no formal education	399	-0.18*	0.09	-0.16	0.08	-0.03	0.03
Illiterate	1,283	0.01	0.05	-0.01	0.05	0.03*	0.01
Income							
≤160000	1,470	-0.05	0.05	-0.08	0.04	0.03*	0.01
160000-240000 income	2,629	-0.01	0.03	-0.05	0.03	0.04**	0.01
240001-300000 income	976	0.01	0.06	-0.05	0.06	0.06**	0.02
>300000 income	1,800	-0.01	0.04	-0.05	-0.04	0.04*	0.02
Spousal Separation							
Living with husband	4,219	0.05	0.03	-0.03	0.03	0.08**	0.01
Separated with husband	3,095	-0.02	0.02	-0.03	0.02	0.01*	0.01
Parity							
Has at least a child	4,702	-0.05*	0.03	-0.07*	0.03	0.01	0.01
Does not have a child	2,612	0.04	0.03	-0.05*	0.02	0.10**	0.02
Sexual Activity							
Had sex in last one-month preceding the survey	3,523	0.11**	0.03	0.01	0.03	0.10**	0.02
Did not have sex in last one month preceding the survey	3,791	-0.06**	0.02	-0.06**	0.02	0	0

Note: * means the result is significant at p value 0.05, ** means that the result is significant at p value 0.001

Table D: Difference-in-difference analysis of FP service utilization related variables across different strata of participants

Strata	Visited Health Facilities for FP counseling			Intent to use contraceptives		
	N	Coef.	SE	N	Coef.	SE
Ethnicity						
Dalit	2,146	-0.05	0.03	1,669	0.07	0.04
Janajati	1,396	-0.14**	0.04	1,003	0.01	0.04
Madhesi	1,220	-0.02	0.04	1,004	0.17**	0.05
Muslim	1,087	0.01	0.05	919	0.17**	0.05
Brahmin/chhetri	1,452	-0.26**	0.04	1,084	0.01	0.04
Education						
Literate, formal education	5,629	-0.13**	0.02	4,315	0.07**	0.02
Literate, no formal education	399	-0.02	0.08	324	0.01	0.08
Illiterate	1,283	0.02	0.04	1,048	0.19**	0.05
Income						
≤1,60,000	1,470	-0.10*	0.04	1,180	0.10*	0.04
1,60,000-2,40,000	2,629	-0.13**	0.03	2,008	0.11**	0.03
2,40,001-3,00,000	976	-0.14*	0.05	738	0.08	0.05
>3,00,000	1,800	-0.02	0.04	1,409	0.11**	0.04
Spousal Separation						
Living with husband	4,219	-0.11**	0.03	2,824	0.09**	0.03
Separated with husband	3,095	-0.05*	0.02	2,865	0.10**	0.02
Parity						
Has at least a child	4,702	-0.11**	0.02	3,498	0.12**	0.03
Does not have a child	2,612	-0.08**	0.02	2,191	0.02	0.02
Sexual activity						
Had sex in last one month preceeding the survey	3,523	-0.08**	0.03	2,173	0.08*	0.03
Did not have sex in last one month preceeding the survey	3,791	-0.07**	0.02	3,516	0.10**	0.02

Note: * means the result is significant at p value 0.05, ** means that the result is significant at p value 0.001

Annex VIII : Data Collection Tools

A. Survey Questionnaire

सक्षम किशोर किशोरी कार्यक्रमको प्रभावकारिता अध्ययन

अनुसन्धानकर्तालाई सुझाव

- उपयुक्त उत्तर (विकल्पमा) मा गोलो चिन्ह O वा निर्देशन अनुसार टिक (√) चिन्ह लगाउनुहोस अथवा उपलब्ध गराइएको स्थानमा उत्तर लेख्नुहोस्
- सहभागीहरुले बुझ्ने गरी दिइएको प्रत्येक बिकल्पहरु स्पष्टसँग पढी उत्तरदाताले सो कुरा बुझेको सुनिश्चित गर्नुहोस

साधारण जानकारी			
कोड	जानकारी	प्रतिक्रिया र कोड	स्किप
I1	अनुसन्धानकर्ता कोड	☐☐	
I2	जिल्ला कोड	☐	
I3	नगरपलिका/गाउँपालिका कोड	☐☐	
I4	वार्ड नम्बर	☐☐	
I5	टोल/स्थान	……	
I6	घरधुरी कोड	☐☐☐	
P1	के तपाईं वा तपाईंको घरमा हाल संगै बसिरहनु भएको परिवारको सदस्य मध्य कसैलाई कोभिड-१९ संक्रमणको पुष्टी भएको छ / थियो ?	हाल सम्म परिक्षण नै गरेको छैन 0 पुष्टी भएको तर १४ दिन पछी पुन परिक्षण गर्दा नेगेटिभ देखियो 1 पुष्टी भएको र अझै संक्रमणकै अवस्थामा रहेको 2 परिक्षण गरेको तर नतिजा नै आएको छैन 77 भन्न नचाहेको 88	उत्तर 2 वा 77 आएमा सहभागीलाई धन्यवाद दिँदै अन्तरवार्ता टुङ्याउन अनुमती लिनुहोस्
I7	अन्तर्वार्ताको लागि प्रयास गरिएको पटक	पहिलो भ्रमण: …/ …/ …… दोस्रो भ्रमण: …/ …/ …… तेस्रो भ्रमण: …/ …/ ……	
I8	अन्तर्वाताका लागी यस घरमा सहभागिसँग तपाईंको भेट	भयो 1 भएन 0	
I9	घरमुलिको नाम	…… …… ……	
		पहिलो नाम / बिचको नाम / थर	
I10	घरमुलिको लिङग (अवलोकन गरी उपयुक्त विकल्पमा गोलो चिन्ह O लगाउनुहोस्)	पुरुष 1 महिला 2 अन्य 3	

साधारण जानकारी					
I11	सहभागीको नाम	....			
		पहिलो नाम	बिचको नाम	थर	
P2	के हाल तपाईंलाई तलका कुनै लक्षणहरु देखिएको छन् ? (मिल्ने सबै विकल्पमा टिक (√) लगाउनुहोस्)				कुनै एक वा बढी लक्षण देखिएमा सहभागिलाई कारण समेत बुझाई धन्यवाद दिँदै अन्तर्वार्ता अन्त्य गर्नुहोस्
			लक्षणहरु		
			ज्वरो आउने (१००.४ o F वा सो भन्दा बढी)		
			श्वास फेर्न गाह्रो / समस्या हुने		
			खोकी लाग्ने		
			कुनै पनि चिजको स्वाद वा गन्ध थाह नपाउने		
P3	के हाल तपाईंलाई निम्न बमोजिमका अन्य लक्षणहरु देखिएको छन् ? (मिल्ने सबै विकल्पमा टिक (√) लगाउनुहोस्)				कुनै दुई वा सो भन्दा बढी लक्षण देखिएमा सहभागिलाई कारण समेत बुझाई धन्यवाद दिँदै अन्तर्वार्ता अन्त्य गर्नुहोस्
			लक्षणहरु		
			थकाइ लाग्ने (अरु बेला भन्दा धेरै)		
			छाती दुख्ने		
			बोली लर्बराउने		
			घाँटी दुख्ने		
			पखाला लाग्ने		
			वाकवाकी लाग्ने		
			वान्ता हुने		
			नाक बन्द हुने वा सिंगान बगिरहने		
			ज्वरो आउने, काँप्ने वा काँम्प-ज्वरो आउने		
			मासंपेशी दुख्ने		
			ज्यादै टाउको दुख्ने		
D1	जन्म मिती		दिन/महिना/बर्ष		जन्म मिती थाहा नभएमा पुरा भएको उमेर सोध्नुहोस् ।
D2	तपाई अहिले कती वर्ष पुरा हुनुभयो?		बर्ष		
I12	सहभागी को कोड				
IC1	जानकारी पत्र पढेर सुनाई सकेपछी सहभागीबाट मन्जुरीनामा प्राप्त भए नभएको	प्राप्त भएको छ	1		सहभागी १८ वर्ष पुरा भएको भए *IC3* मा जानुहोस्
		प्राप्त भएको छैन	0		

साधारण जानकारी			
IC2	जानकारी पत्र पढेर सुनाई सकेपछी अभिभवकबाट मन्जुरीनामा प्राप्त भए नभएको	प्राप्त भएको छ 1 प्राप्त भएको छैन 0	
IC3	पूर्ण रूपमा मन्जुरीनामा प्रप्त भए नभएको	प्राप्त भएको छ 1 प्राप्त भएको छैन 0	
I13	सहभागीको घरमुलीसँगको नाता सम्बन्ध	आफै / घरमूलि 1 श्रीमान / श्रीमती 2 आमा / बुवा 3 सासु / ससुरा 4 अरु नातेदार 5 कुनै संबन्ध नभएको 6 भन्न नचाहेको 88	
I14	सहभागीको सम्पर्क नम्बर	☐☐☐☐☐☐☐☐☐☐	
I15	नजिकको आफन्त/छिमेकी को सम्पर्क नम्बर (सहभागी को आफ्नो सम्पर्क नम्बर नभएमा)	☐☐☐☐☐☐☐☐☐☐	
I16	कैफियत (केही भए)		

खण्ड (क): सहभागी सम्बन्धी जानकारी			
कोड	प्रश्न	प्रतिक्रिया र कोड	स्किप
D3	तपाईको जात/जातिय पहिचान के हो? [जाती समुह -उल्लेख गरेको थरको आधारमा *HMIS* कार्ड प्रयोग गरी वर्गिकरण गर्ने]	दलित 1 जनजाती 2 मधेशी 3 मुस्लिम 4 ब्राहमण्/क्षेत्री 5 अन्य 6 भन्न नचाहेको 88	
D5	तपाईं आफ्नो शैक्षिक अवस्थालाई कसरी परिभषित गर्न चाहनुहुन्छ ?	अशिक्षित 1 अनौपचारिक शिक्षा 2 औपचारिक शिक्षा 3 भन्न नचाहेको 88	यदी औपचरिक शिक्षा भन्दा अन्य भए D6 मा जानुहोस
D6	तपाईंले पुरा गर्नुभएको माथिल्लो शैक्षिक तह कुन हो ?	प्राथमिक तह वा सो भन्दा कम 1 माध्यमिक तह (कक्षा ६- १०) 2 उच्च माध्यमिक तह वा सो भन्दा माथि 3	

खण्ड (क): सहभागी सम्बन्धी जानकारी				
कोड	प्रश्न	प्रतिक्रिया र कोड		स्किप
		भन्न नचाहेको	88	
D7	बिगत १२ महिनामा तपाईंको मुख्य कामलाई तलका मध्ये कुन विकल्पले उपयुक्त रुपमा समेट्छ ?	सरकारी जागिर	1	
		गैरसरकारी जागिर/निजि	2	
		आफ्नै स्वामित्वको	3	
		बेतलबी/ सामाजिक कार्य	4	
		विद्यार्थी	5	
		घरायसी काम	6	
		वेरोजगार (काम गर्न सक्ने)	7	
		वेरोजगार (काम गर्न नसक्ने)	8	
		ज्यालादारी	9	
		कृषि	10	
		भन्न नचाहेको	88	
		अन्य (खुलाउनुहोस्)_____	96	
D8	तपाईंको परिवारको अनुमानित वार्षिक आय कती हो ? [उल्लेखित मध्य एक बिकल्पमा मात्रा आय उल्लेख गर्ने]	☐☐☐☐☐☐☐☐ रुपैँया प्रत्यक बर्ष	1	
		☐☐☐☐☐☐ रुपैँया प्रत्यक महिना	2	
		☐☐☐☐☐☐ रुपैँया प्रत्यक हप्ता	3	
		भन्न नचाहेको	88	

खण्ड (ख) : वैवहिक जिवन सम्बन्धी जानकारी				
कोड	प्रश्न	प्रतिक्रिया र कोड		स्किप
D9	के हाल तपाईं आफ्नो श्रीमान् सँग बसिरहनु भएको छ ?	छ	1	यदी छ भनेमा D12 मा जानुहोस
		छैन	0	
D10	तपाईं श्रीमान् सँगै नबस्नु को कारण के होला ?	रोजगारका लागी विदेश भएर	1	
		आवत-जावत गर्ने गरी कामको लागी अन्य शहर भएर (शिक्षा/जागिर/ब्यापार ब्यवसाय आदिको लागि)	2	
		सम्वन्ध विच्छेद गरि/नगरि अलग्गै बसेको भएर	3	

		अन्य 4 (खुलाउनुहोस्)_____	
D11	तपाईं र तपाईंको श्रीमान् सँगै नबस्नु भएको कती समय भयो	☐☐ वर्ष ☐☐ महिना ☐☐ दिन	
D12	तपाईं आफ्नो श्रीमानको शैक्षिक अवस्थालाई कसरी उल्लेख गर्नुहुन्छ ?	अशिक्षित 1 अनौपचारिक शिक्षा 2 औपचारिक शिक्षा 3 भन्न नचाहेको 88	यदी औपचरिक शिक्षा भन्दा अन्य भए O1 मा जानुहोस
D1	तपाईंको श्रीमानले पुरा गर्नुभएको माथिल्लो शैक्षिक तह कुन हो ?	प्राथमिक तह वा सो भन्दा कम 1 माध्यमिक तह (कक्षा ६- १०) 2 उच्च माध्यमिक तह वा सो भन्दा माथि 3 भन्न नचाहेको 88 थाहा भएन 98	

खण्ड (ग) : प्रजनन् तथा यौन व्यवहार सम्बन्धी जानकारी			
कोड	प्रश्न	प्रतिक्रिया र कोड	स्किप
O1	तपाईंको विवाह हुँदा तपाईं कति वर्ष पुरा हुनु भएको थियो ?	☐ बर्ष	
O2	विवाह पश्च्यात तपाईं कहिलै गर्भबती हुनुभएको छ ?	छ 1 छैन 0	यदी नभएमा O6 मा जानुहोस
O3	यदी थियो भने हाल सम्मभएको गर्भवती सङ्ख्या कति हो ?	☐ सङ्ख्या	
O4	हाल तपाईंका जिवित छोराछोरी कती जना छन् ?	☐ सङ्ख्या	यदी 0 आएमा O6 मा जानुहोस
O5	तपाईंको पछिल्लो बच्चाको पुरा भएको उमेर कति हो ?	☐☐ वर्ष ☐☐ महिना ☐☐ दिन	
O6	तपाईं र तपाईंको श्रीमान् को (थप) बच्चा जन्मउने योजना कहिले रहेको छ ?	हाल योजना गरिरहेको 1 (१-२ वर्ष) तत्काल नरहेको 2 (२ वर्ष भन्दा बढि) केहि समय नरहेको 3 थप बच्चा जन्माउने योजना नरहेको 4	

खण्ड (ग) : प्रजनन् तथा यौन व्यवहार सम्बन्धी जानकारी			
कोड	प्रश्न	प्रतिक्रिया र कोड	स्किप
O7	विगत एक महिनामा तपाईंले यौन सम्पर्क राख्नु भएको छ ?	छ छैन	यदी छैन भनेमा C10 मा जानुहोस
O8	यदी छ भने विगत एक महिना भित्र कति पटक सम्म यौन सम्पर्क राख्नु भयो ?	[ ] सङ्ख्या भन्न नचाहेको 88	

खण्ड (घ) : परिवार नियोजन/ परिवार योजना सम्बन्धी कार्यक्रमको पहुच तथा प्रभावकारीता सम्बन्धी प्रश्नहरु			
कोड	प्रश्न	प्रतिक्रिया र कोड	स्किप
C1	बिगत एक वर्षमा कुनै “शिक्षक साथी” परिवार नियोजनको बारेमा जानकारी दिन तपाईं समक्ष आउनु भएको थियो ?	थियो 1 थिएन 0 थाहा भएन 98	यदी जवाफ 2 अथवा 98 आए C3 मा जानुहोस्
C2	तपाईं अथवा तपाईंको उमेर समुहका ब्यक्तिहरुलाई शिक्षक साथीबाट परिवार नियोजनका साधनहरु बारेमा जानकारी दिँदा कस्तो लाग्यो?	राम्रो लाग्यो/ उपयोगी लाग्यो 1 राम्रो लागेन/ उपयोगी लागेन 0	
C3	बिगत एक वर्षमा कुनै “समाजिक परिचालक” परिवार नियोजनको बारेमा जानकारी दिन तपाईं समक्ष आउनु भएको थियो ?	थियो 1 थिएन 0 थाहा भएन 98	यदी जवाफ 2 अथवा 98 आए C5 मा जानुहोस
C4	तपाईं अथवा तपाईंको उमेर समुहका ब्यक्तिहरुलाई “समाजिक परिचालक” बाट परिवार नियोजनका साधनहरु बारेमा जानकारी दिँदा कस्तो लाग्यो ?	राम्रो लाग्यो/ उपयोगी लाग्यो 1 राम्रो लागेन/ उपयोगी लागेन 0	
C5	बिगत एक वर्षमा तपाइले कुनै परिवार नियोजनको बारेमा जानकारी दिने “एनिमेटेड भिडियोहरु (श्रब्य दृश्य)” देख्नु भयो ?	थियो 1 थिएन 0 थाहा भएन 98	यदी जवाफ 2 अथवा 98 आए C7 मा जानुहोस्
C6	“एनिमेटेड भिडियोहरु (श्रब्य दृश्य)” को माध्यमबाट परिवार नियोजको बारेमा जानकारी दिँदा कस्तो लाग्यो?	राम्रो लाग्यो/ उपयोगी लाग्यो 1 राम्रो लागेन/ उपयोगी लागेन 0	

खण्ड (घ) : परिवार नियोजन/ परिवार योजना सम्बन्धी कार्यक्रमको पहुच तथा प्रभावकारीता सम्बन्धी प्रश्नहरु			
कोड	प्रश्न	प्रतिक्रिया र कोड	स्किप
C7	बिगत एक बर्षमा तपाईंले कुनै परिवार नियोजन सम्बन्धी क्विज/खेलकुद प्रतियोगता अथवा खेल भाग लिनु भएको थियो ?	थियो 1 थिएन 0 थाहा भएन 98	यदी जवाफ 2 अथवा 98 आए C9 मा जानुहोस्
C8	क्विज/खेलकुद प्रतियोगिताको माध्यम बाट परिवार नियोजनको जानकारी दिनु कतिको उपयुक्त लाग्यो?	राम्रो लाग्यो/ उपयोगी लाग्यो 1 राम्रो लागेन/ उपयोगी लागेन 0	
C9	बिगत एक वर्षमा तपाइले कुनै "किशोर किशोरीको समग्र बिकासका कार्यक्रम" (जस्तै pad बनाउने) मा सहभागीता जनाउनु भयो	थियो 1 थिएन 0 थाहा भएन 98	यदी जवाफ 2 अथवा 98 आए C10 मा जानुहोस्
C9a	"किशोर किशोरीको समग्र बिकासका कार्यक्रम"(जस्तै pad बनाउने) तपाईंलाई कतिको राम्रो/ उपयोगी लाग्यो?	राम्रो लाग्यो/ उपयोगी लाग्यो 1 राम्रो लागेन/ उपयोगी लागेन 0	
C11	बिगत १ बर्ष भित्र माथि उल्लेखित बाहेक कुनै परिवार नियोजन/परिवार योजना लक्षित कार्यक्रममा सहभागिता जनाउनु भएको थियो?	थियो 1 थिएन 0	

खण्ड (ङ) : परिवार नियोजनको जानकारी सम्बन्धी जानकारी			
K	के तपाईंले तलका परिवार नियोजनका साधनहरुका बारेमा सुन्नु भएको छ ?	प्रतिक्रिया	
		सुनेको छु	सुनेको छैन
K1	महिला बन्ध्याकरण (मिनिल्याप/ल्याप्यारोस्कोपी/अपरेशन/ Female Sterilization)	1	0
K2	पुरुष बन्ध्याकरण (भ्यासेक्टोमी/ पुरुषको अपरेशन/Male Sterilization)	1	0
K3	आइ यू सि डि (कपर टि/ IUCD)	1	0
K4	गर्व निरोधक सुई (डिपो प्रोभेरा/ सङ्गिनि/ तीन महिने सुई/ Depo Provera)	1	0
K5	गर्व निरोधक इम्प्लान्ट (नरप्लान्ट / Implant)	1	0
K6	पिल्स (खाने चक्की/ सुनौलो गुलाफ/ निलोकेन white/Pills)	1	0
K7	कन्डम (Condom)	1	0
K8	आकस्मिक गर्वनिरोध चक्की (आइ-पिल/ इ-कोन)	1	0
K9	परिवार नियोजनको स्तनपान बिधी (LAM)	1	0

खण्ड (ङ) : परिवार नियोजनको जानकारी सम्बन्धी जानकारी				
K10	माहिनावारीलाई आधार मानी सुरक्षित समयमा मात्र संपर्क गर्ने बिधी (Rhythm Method)		1	0
K11	विर्यलाई योनी बहिर स्खलन गराउने तरिका (Withdrawal)		1	0
KT	तलका परिवार नियोजनका साधन मध्य कुन कुन आस्थाइ र कुन कुन स्थाइ साधनाहरु हुन ?	प्रतिक्रिया		
		अस्थाइ	स्थाइ	थाहा छैन
KT1	बन्ध्याकरण (अपरेशन */sterilization)*	1	2	98
KT3	आइ यू सि डि (कपर टि/ IUCD)	1	2	98
KT4	गर्व निरोधक सुई (डिपो प्रोभेरा/ सङ्गिनि/ तीन महिने सुई/ Depo Provera)	1	2	98
KT5	गर्व निरोधक इम्प्लान्ट (नरप्लान्ट / Implant)	1	2	98
KT6	पिल्स (खाने चक्की/ सुनौलो गुलाफ/ निलोकेन white/Pills)	1	2	98
KT7	कन्डम (Condom)	1	2	98
KT9	परिवार नियोजन को स्तनपान बिधी (LAM)	1	2	98
KT10	माहिनावारिलाई आधार मानी सुरक्षित समयमा मात्र संपर्क गर्ने बिधी (Rhythm)	1	2	98
KT11	विर्यलाई योनी बहिर स्खलन गराउने तरिका (withdrawal)	1	2	98

खण्ड (ङ) : परिवार नियोजनको जानकारी सम्बन्धी जानकारी

KT12 अब तपाईंलाई दुई परिवार नियोजनका नाम भन्नेछु जस मध्ये कुन साधनले लामो अवधी सम्म गर्भधान रोक्न सुरक्षा प्रधान गर्छ बताइ दिनु होला

कोड	प्रश्न	प्रतिक्रिया र कोड	
KT11.1	गर्व निरोधक सुइ (डिपो प्रोभेरा) र पिल्स (खाने चक्की)	गर्व निरोधक सुइ (डिपो प्रोभेरा)	1
		पिल्स	2
		दुवैले एकै समयावधिको लागी	3
		थाहा भएन	4
KT11.2	आइ यू सि डि (कपर टि) र महिला बन्ध्याकरण (Female sterilization)	आइ यू सि डि (कपर टि)	1
		महिला बन्ध्याकरण	2
		दुवैले एकै समयावधिको लागी	3
		थाहा भएन	4
KT11.3	गर्व निरोधक इम्प्लान्ट (नरप्लान्ट /IMPLANT) र गर्व निरोधक सुइ (डिपो प्रोभेरा)	गर्व निरोधक इम्प्लान्ट	1
		गर्व निरोधक सुइ (डिपो प्रोभेरा)	2
		दुवैले एकै समयावधिको लागी	3
		थाहा भएन	4
KT11.4	महिला बन्ध्याकरण (Female sterilization) र पुरुष बन्ध्याकरण (भ्यासेक्टोमी /male sterilization)	महिला बन्ध्याकरण (Female sterilization)	1
		पुरुष बन्ध्याकरण (भ्यासेक्टोमी /male sterilization)	2
		दुवैले एकै समयावधिको लागी	3
		थाहा भएन	4

KM	तलका मध्ये कुन कुन परिवार नियोजनका साधान आधुनिक साधनहरु हुन ?	प्रतिक्रिया		
		हो	होइन	थाहा छैन
KM1	महिला बन्ध्याकरण (मिनिल्याप/ल्याप्यारोस्कोपी/अपरेशन/ Female Sterilization)	1	0	98
KM2	पुरुष बन्ध्याकरण (भ्यासेक्टोमी/अपरेशन/Male Sterilization)	1	0	98
KM3	आइ यू सि डि (कपर टि/ IUCD)	1	0	98
KM4	गर्व निरोधक सुई (डिपो प्रोभेरा/ सङ्गिनि/ तीन महिने सुई/Depo Provera)	1	0	98
KM5	गर्व निरोधक इम्प्लान्ट (नरप्लान्ट / Implant)	1	0	98

खण्ड (ङ) : परिवार नियोजनको जानकारी सम्बन्धी जानकारी				
KM6	पिल्स (खाने चक्की/ सुनौलो गुलाफ/ निलोकेन white/Pills)	1	0	98
KM7	कन्डम (Condom)	1	0	98
KM9	परिवार नियोजन को स्तनपान बिधी (LAM)	1	0	98
KM10	माहिनावारिलाई आधार मानी सुरक्षित समयमा मात्र संपर्क गर्ने बिधी (Rhythm)	1	0	98
KM11	विर्यलाई योनी बहिर स्खलन गराउने तरिका (withdrawal)	1	0	98

KG	प्रयोगको हिसाबले तलका परिवार नियोजनका साधनहरु महिला वा पुरुष कसको प्रयोग को लागि हुन ?	प्रतिक्रिया			
		पुरुष	महिला	दुबै	थाहा छैन
KG1	बन्ध्याकरण (अपरेशन / sterilization)	1	2	3	98
KG3	आइ यू सि डि (कपर टि/ IUCD)	1	2	3	98
KG4	गर्व निरोधक सुई (डिपो प्रोभेरा/ सङ्गिनि/ तीन महिने सुई/ Depo Provera)	1	2	3	98
KG5	गर्व निरोधक इम्प्लान्ट (नर्प्लान्ट/ Implant)	1	2	3	98
KG6	पिल्स (खाने चक्की/ सुनौलो गुलाफ/ निलोकेन white/Pills)	1	2	3	98
KG7	कन्डम (Condom)	1	2	3	98
KG9	परिवार नियोजन को स्तनपान बिधी (LAM)	1	2	3	98
KG10	माहिनावारिलाई आधार मानी सुरक्षित समयमा मात्र संपर्क गर्ने बिधी (Rhythm)	1	2	3	98
KG11	विर्यलाई योनी बहिर स्खलन गराउने तरिका (withdrawal)	1	2	3	98

KG12 परिवार नियोजन के - के उदेश्यका / कुरा का लागि प्रयोग हुन्छ **?**

(तल प्रदान गरिएका विकल्प नभनि सहभगि आफैलाई थाह भए सम्मका उपायोगहरु क्रमै सँग भन्न लगाउनुहोस र मिल्ने सबै विकल्पमा **गोलो** चिन्ह **O** लगाउनुहोस्।)

गर्वधान रोक्न	1
दुई बच्चा बिचको समयलाई पर्याप्त बनाउन	2
बच्चाहरुको सङ्ख्या सिमित गर्न	3
यौन तथा एड्स रोग बाट बच्न	4
थाहा छैन	98

खण्ड (ङ) : परिवार नियोजनको जानकारी सम्बन्धी जानकारी		
	अन्य (खुलाउनुहोस)	99
		5
		6
		7
		8

खण्ड (च) : परिवार नियोजनको उपयोगमा जोखिम, ब्यवधान, र सक्षमता						
अबका केहि प्रश्नहरुमा हामी तपाईंलाई परिवार नियोजनका सधान प्रयोग गर्दा अथवा नगर्दा का जोखिमहरु बारे सोध्ने छौं । प्रश्नको जवाफ अत्यन्त सहमत, सहमत, अणिर्नित, असहमत, अत्यन्त असहमत गरी ५ वटा विकल्पहरुमा दिनु हुन अनुरोध छ ।						
कोड	प्रश्नहरु	अत्यन्त सहमत	सहमत	अनिर्णित	असहमत	अत्यन्त असहमत
R1	परिवार नियोजन को साधनको प्रयोग बिना, बिबाहित महिलाहरु/किशोरीहरु गर्भवती हुने सम्भावना निकै धेरै हुन्छ ।	1	2	3	4	5
R2	गर्भाधारण रोक्नको लागि अन्य विकल्पहरु पनि अवलम्बन गर्न सकिन्छ जुन परिवार नियोजनका साधान जत्तिकै प्रभावकारी छन् ।	1	2	3	4	5
R3	किशोरी अवस्थामा गर्भवती भए पनि त्यो तेत्ति ठुलो समस्या होइन किन भने उनीहरु आमाको/अभिभावकको भूमिका जिम्मेवारीपूर्वक बहन गर्न सक्छन ।	1	2	3	4	5
R4	योजना नबनाई गर्भाधारण भए पनि अन्य विकल्पहरु जस्तै गर्भपतन बाट सजिलै ब्यवास्थापान गर्न सकिन्छ ।	1	2	3	4	5
R5	विवाहित किशोरीहरु गर्भवती भए पनि त्यो ठुलो समस्या होइन किन भने उनीहरु बिबाहित भइ सकेका हुन्छन ।	1	2	3	4	5
R6	गर्भवती अवस्थामा हुने स्वास्थ्य समस्याहरु लामो समयसम्म रहन सक्छन /असर गर्न सक्छन ।	1	2	3	4	5

खण्ड (च) : परिवार नियोजनको उपयोगमा जोखिम, ब्यवधान, र सक्षमता						
R7	कम उमेरमा गर्भवती हुदा व्यक्तिगत तथा व्यवसायिक जिवनको विकासमा पनि नकारात्मक असर गर्न सक्छ	1	2	3	4	5

अवका केही प्रश्नहरुमा हामी तपाईंलाई परिवार नियोजनका साधनहरुको फाईदाहरुका बारेमा तपाईंको बुझाई बारे सोध्ने छौ । प्रश्नको जवाफ अत्यन्त सहमत्, सहमत्, अणिर्नित, असहमत, अत्यन्त असहमत गरी ५ वटा बिकल्पहरुमा दिनु हुन अनुरोध छ।

कोड	प्रश्नहरु	अत्यन्त सहमत	सहमत	अनिर्णित	असहमत	अत्यन्त असहमत
B1	कम उमेरमा गर्भवती हुदा बच्चाको स्वास्थ्यमा पनि असर गर्न सक्छ	1	2	3	4	5
B2	सुरक्षित शारिरीक संबन्धको लागी परिवार नियोजन अवश्यक हुन्छ	1	2	3	4	5
B3	परिवार नियोजनका साधन प्रयोग गर्दा गर्भ रहदैन भन्ने कुरामा विश्वस्त छु	1	2	3	4	5
B4	परिवरनियोजनका साधन प्रयोग गरि योजना बनाएर गर्भाधारण गर्दा व्यक्तिगत तथा ब्यवासियिक जीवनको लागि पनि राम्रो हुन्छ	1	2	3	4	5
B5	परिवरनियोजनका साधन प्रयोग गर्दा श्रीमान /श्रीमती बिचको सम्बन्धमा पनि राम्रो असर गर्छ	1	2	3	4	5
B6	परिवरनियोजनका साधनको प्रयोगले मलाई विवेकी (Smart) देखाउँछ/देखिन सहयोग गर्छ	1	2	3	4	5
B7	परिवरनियोजनका साधनको प्रयोग गरे मैले गर्भ रहन्छ कि भनेर चिन्ता गर्नु पर्दैन	1	2	3	4	5
B8	कण्डमको प्रयोगले यौन रोगबाट पनि बचाउछ	1	2	3	4	5

अवका केही प्रश्नहरुमा हामी तपाईंलाई परिवार नियोजन साधन प्रयोग गर्दा हुने असरहरुको बारे तपाईंको बुझाई बारे सोध्ने छौ । प्रश्नको जवाफ अत्यन्त सहमत्, सहमत्, अणिर्नित, असहमत, अत्यन्त असहमत गरी ५ वटा बिकल्पहरुमा दिनु हुन अनुरोध छ।

कोड	प्रश्नहरु	अत्यन्त सहमत	सहमत	अनिर्णित	असहमत	अत्यन्त असहमत
S1	परिवार नियोजनको प्रयोग गरे पछि बच्चा जन्माउन सक्ने क्षमतामा नकरात्मक असर गर्छ	1	2	3	4	5

खण्ड (च) : परिवार नियोजनको उपयोगमा जोखिम, ब्यवधान, र सक्षमता						
S2	परिवार नियोजनको प्रयोग बाट स्वास्थ्यमा नकारात्मक असरहरु पनि देखिन सक्छन	1	2	3	4	5
S3	परिवार नियोजनका साधन प्रयोग गर्दा यौन संपर्कमा रुची घट्छ/ यौन संपर्क गर्न मन नलाग्ने हुन सक्छ	1	2	3	4	5
अवको प्रश्नमा हामी तपाईंलाई परिवार नियोजनको बारेमा सामाजिक मुल्य मन्यताको बारेमा सोध्ने छौ । प्रश्नको जवाफ अत्यन्त सहमत्, सहमत्, अणिर्नित, असहमत, अत्यन्त असहमत गरी ५ वटा बिकल्पहरुमा दिनु हुन अनुरोध छ।						
कोड	प्रश्नहरु	अत्यन्त सहमत	सहमत	अनिर्णित	असहमत	अत्यन्त असहमत
N1	सामाजिक सांस्कृतिक धार्मिक मूल्य मान्यताहरुले परिवार नियोजनका साधनको प्रयोगलाई स्वीकार गर्दैन	1	2	3	4	5
अवको प्रश्नमा हामी तपाईंलाई तपाईंको नजिकका स्वास्थ्य केन्द्रमा परिवार नियोजनका साधनहरुको उपलब्धता मन्यताको बारेमा सोध्ने छौ । प्रश्नको जवाफ अत्यन्त सहमत्, सहमत्, अणिर्नित, असहमत, अत्यन्त असहमत गरी ५ वटा बिकल्पहरुमा दिनु हुन अनुरोध छ।						
कोड	प्रश्नहरु	अत्यन्त सहमत	सहमत	अनिर्णित	असहमत	अत्यन्त असहमत
A1	मैले चाहेजस्तो परिवार नियोजनका साधनहरु नजिकको स्वास्थ्यकेन्द्र उपलब्ध छैनन्	1	2	3	4	5
A2	परिवार नियोजनका साधनको प्रयोगको लागि खर्च ब्यहोर्न सक्दिन	1	2	3	4	5
A3	परिवार नियोजनका साधन प्रयोग गर्न स्वास्थ्य केन्द्र सम्म पुग्नको लागि लामो दुरी पर्ने हुन्छ	1	2	3	4	5
अवको प्रश्नमा हामी तपाईंलाई परिवार नियोजनका साधनहरुको गुणस्तर बारेमा सोध्ने छौ । प्रश्नको जवाफ अत्यन्त सहमत्, सहमत्, अणिर्नित, असहमत, अत्यन्त असहमत गरी ५ वटा बिकल्पहरुमा दिनु हुन अनुरोध छ।						
कोड	प्रश्नहरु	अत्यन्त सहमत	सहमत	अनिर्णित	असहमत	अत्यन्त असहमत

खण्ड (च) : परिवार नियोजनको उपयोगमा जोखिम, ब्यवधान, र सक्षमता						
Q1	स्वास्थ्य केन्द्रमा उपलब्ध परिवार नियोजनका साधनहरु गुणस्तरीय छैनन्/ स्वीकार गर्न सकिने गुणस्तरका छैनन्	1	2	3	4	5
Q2	जुन सुकै परिवार नियोजन सेवा दिन पनि स्वास्थ्यकर्मीमा निकै उच्च दक्षता चाहिन्छ	1	2	3	4	5
Q3	स्वास्थ्य केन्द्रमा परिवार नियोजन को सेवा दिने स्वास्थ्यकर्मी दक्ष छैनन्	1	2	3	4	5
Q4	मेरो लागि सेवाको गुणस्तर परिवार नियोजन सेवा लिने कि नलिने भन्ने निर्णय गर्नको लागि एक महत्वपुर्ण पक्ष हो	1	2	3	4	5
अवका प्रश्नहरु आवश्यक परेको अवस्थामा परिवार नियोजनका साधना प्रयोग गर्ने तपाईंको क्षमता सँग सम्बन्धित छन। प्रश्नको जवाफ अत्यन्त सहमत्, सहमत्, अणिर्नित, असहमत, अत्यन्त असहमत गरी ५ वता बिकल्पहरुमा दिनु हुन अनुरोध छ।						
कोड	प्रश्नहरु	अत्यन्त सहमत	सहमत	अनिर्णित	असहमत	अत्यन्त असहमत
E1	परिवार नियोजन सम्बन्धि मेरो आवश्यकताबारे स्वास्थ्यकर्मी संग कुरा गर्न सक्छु भन्ने कुरामा विस्वस्त छु	1	2	3	4	5
E2	परिवार नियोजन बारे मेरो श्रीमान संग कुरा गर्न अप्ठारो हुन्छ	1	2	3	4	5
E3	मेरो श्रीमानले नचाहे पनि म परिवार नियोजनका साधनहरु प्रयोग गर्न सक्छु	1	2	3	4	5
E4	म आफै स्वास्थ्य केन्द्रमा परिवार नियोजन सेवाको लागि जान सक्षम छु	1	2	3	4	5
E5	म मेरो लागि उपयुक्त परिवार नियोजनका साधन छान्न सक्षम छु	1	2	3	4	5
E6	म आफ्नो श्रीमानलाई परिवार नियोजनका साधनको प्रयोगको लागि मनाउन सक्छु	1	2	3	4	5

खण्ड (च) : परिवार नियोजनको लागि उत्प्रेरणाका श्रोतहरु						
कोड	तपाईंको परिवार नियोजनको बुझाइलाई निम्न श्रोतहरुले प्रभाव पर्ने कुरामा कत्तिको सहमत हुनुहुन्छ	अत्यन्त सहमत	सहमत	अनिर्णित	असहमत	अत्यन्त असहमत
M1	School teachers (स्कुलका शिक्षक/ शिक्षिका))	1	2	3	4	5

खण्ड (च) : परिवार नियोजनको उपयोगमा जोखिम, ब्यवधान, र सक्षमता						
M2	social/religious/cultural norms (सामाजिक धार्मिक र सास्कृतिक मूल्य मान्यता)	1	2	3	4	5
M3	Guardians/ Parents (अभिभावक / बुवा आमा)	1	2	3	4	5
M4	Siblings (दाजुभाई दिदि बहिनि)	1	2	3	4	5
M5	Other relatives (अरु आफन्तहरु)	1	2	3	4	5
M6	Friends (साथीहरु)	1	2	3	4	5
M7	Medias (newspaper/radio/television) (संचार माध्यम हरु (पत्र पत्रिका/ रेडियो/ टिवी)	1	2	3	4	5
M8	…….	1	2	3	4	5
M9	…….	1	2	3	4	5
M10	…….	1	2	3	4	5

खण्ड (ज): परिवार नियोजनका बिभिन्न सेवा को प्रयोग				
कोड	प्रश्न	प्रतिक्रिया र कोड		स्किप
U1	तपाइले परिवार नियोजनाका कुनै साधनहरु प्रयोग गरि रहनु भएको छ?	छ 1 छैन 2		यदी छैन भने U6 मा जानुहोस
U5	यदी छ भने परिवार नियोजनका कुन कुन साधनहरु प्रयोग गरि रहनु भएको छ ? (तल प्रदान गरिएका विकल्प नभनि सहभगि आफैलाई भन्न लगाउनुहोस र सोही अनुसार मिल्ने सबै विकल्पमा **गोलो** चिन्ह **O** लगाउनुहोस् ।)	प्रयोग		यसपछी U8 मा जाने
		छ	छैन	
	U5.1 Temporary method (Provide List) अस्थाई साधनहरु			
	आइ यू सि डि (कपर टि/ IUCD)	1	0	
	गर्व निरोधक इम्प्लान्ट (नर्प्लान्ट/ Implant)	1	0	
	गर्व निरोधक सुई (डिपो प्रोभेरा/ सङ्गिनि/ तीन महिने सुई/ Depo Provera)	1	0	
	पिल्स (खाने चक्की/ सुनौलो गुलाफ/ निलोकेन white/Pills)	1	0	
	कन्डम (Condom)	1	0	
	Others (including परिवार नियोजनको स्तनपान बिधी (LAM))			
	U5.2 परम्परगत विधी			
	माहिनावारीलाई आधार मानी सुरक्षित समयमा मात्र संपर्क गर्ने बिधी (Rhythm Method)	1	0	
	विर्यलाई योनी बहिर स्खलन गराउने तरिका (Withdrawal)	1	0	

खण्ड **(ज):** परिवार नियोजनका बिभिन्न सेवा को प्रयोग				
कोड	प्रश्न	प्रतिक्रिया	र कोड	स्किप
	अन्य परम्परगत	1	0	
	अन्य परम्परगत (उल्लेख गर्नु होस्)	.....		
	U5.3 Permanent method (Provide list) स्थाई साधनहरु			
	महिला बन्ध्याकरण (मिनिल्याप/ल्याप्यारोस्कोपी/अपरेशन/ Female Sterilization)	1	0	
	पुरुष बन्ध्याकरण (भ्यासेक्टोमी/अपरेशन/Male Sterilization)	1	0	
U6	तपाइले परिवार नियोजनका कुनै साधन प्रयोग गर्ने तयारि गरि रहनु भएको छ ?	छ छैन	1 0	यदी छैन भने U8 मा जानुहोस
U8	तपाइले भविष्यमा (पनि) परिवार नियोजनका साधन प्रयोग गर्ने सम्भावना छ वा परिवार नियोजनको प्रयोगलाई निरन्तरता दिन चाहनु हुन्छ?	छ छैन	1 0	
CS1	बिगत एक वर्षमा तपाइले परिवार नियोजन सम्बन्धि सल्लाह सुझाव लिन कुनै स्वास्थ्य केन्द्रमा जानु भएको थियो ?	थियो थिएन	1 0	
CS2	तपाइँ परिवार नियोजन सेवाको बारे सल्लाह सुझाव लिनको लागि स्वास्थ्य केन्द्रमा जाने योजना बनाउनु भएको छ ?	छ छैन	1 0	
CS4	तपाइँ परिवार नियोजन सम्बन्धि सल्लाह सुझावको लागि भविष्यमा स्वास्थ्य केन्द्रमा जाने सम्भावना छ?	छ छैन	1 0	

खण्ड **(ज):** परिवार नियोजनका बिभिन्न सेवा को प्रयोग			
कोड	प्रश्न	प्रतिक्रिया र कोड	स्किप
U9	तपाईंले परिवार नियोजनका साधनहरु प्रयोग नगर्नुका कारणहरु के के हुन ? **(**मिल्ने सबै विकल्पमा **गोलो** चिन्ह **O** लगाउनुहोस् ।**)**		परिवार नियोजनका साधनहरु प्रयोग नगरेका सहभगिहरु लाई मात्र सोध्ने
	आबश्यक नलागेर	1	
	गर्भवती हुन चाहन्छु	2	
	श्रीमानले अनुमती दिनुभएन/श्रीमानले आबश्यक छैन भनेकोले	3	
	परिवारले आबश्यक छैन भनेकोले	4	
	स्वास्थ्य केन्द्र टाढा भएकोले	5	
	स्वास्थ्य केन्द्रमा सेवा उपलब्ध नभएकोले	6	
	नकरात्मक असर वा स्वास्थ्य संबन्धी चिन्ताले गर्दा	7	
	परिवार नियोजनको साधनसँग पहुँच नभएर / टाढा भएर	8	
	महँगो भएर	9	
	असजिलो भएर	10	
	नियमित रुपमा सेक्स हुँदैन	11	
	श्रीमान यहाँ हुनुहुन्न	12	
	बैबाहिक संबन्ध राम्रो नभएर /छुट्टेर बसेका छौं	13	
	हाल गर्भवती भएको	14	
	कोविड १९ को महामारी फैलिएकोले स्वास्थ्य सेवा लिन जान डर लागेर	15	
	कोविड १९ को महामारी फैलिएकोले स्वास्थ्य संस्थामा परिवार सेवा दिन बन्द गरिएकोले	16	
	कोविड १९ को महामारी फैलिएकोले समुदाय स्तरमा परिवार नियोजन सम्बन्धी क्याम्प नभएकोले	17	
	अन्य (खुलाउनुहोस्)	99	
	थाहा नभएर	98	

खण्ड **(झ): कोविड १९ को महामारीमा यौन तथा प्रजनन स्वास्थ्यको अवस्था**			
कोड	प्रश्न	प्रतिक्रिया र कोड	
P4	तपाईको विचारमा कोविड १९ महामारीका क्रममा स्वास्थ्य संस्थाबाट प्रदान गरिने तलका मध्य कुन कुन सेवा हरु अबरुद्द भए? **(**मिल्ने सबै विकल्पमा **गोलो** चिन्ह **O** लगाउनुहोस् ।**)**	यौन तथा प्रजानन स्वास्थ्य सेवा	1
		परिवार नियोजन सेवा	2
		दुबै	3
		कुनै पनि अवरुद्ध भएनन	4

खण्ड (झ): कोविड १९ को महामारीमा यौन तथा प्रजनन स्वास्थ्यको अवस्था

अवका प्रश्नहरु हाल भैइरहेको कोभिड-१९ को महामारिका कारण परिवार नियोजन र यौन तथा प्रजानन स्वास्थ्य सेवा लिन यहाँहरुलाई परेको अप्ठ्यारा र समस्या सँग सम्बन्धित रहेका छन । कृपया प्रश्नको जवाफ सहि/सहमत वा गलत/असहमत गरी २ वटा बिकल्पहरुमा दिनु हुन अनुरोध छ।

P5 कोविड १९ महामारिले तपाईंले प्रयोग गर्ने परिवार नियोजनसेवा कस्तो प्रभाव पऱ्यो ?

प्रभाव	सहि / सहमत	गलत / असहमत
स्वास्थ्य संस्थामा पुगेर परिवार नियोजन सेवा नपाई फर्किनु पऱ्यो	1	0
स्वास्थ्य संस्थामा जान सक्ने अवस्था भएन	1	0
परिवार नियोजन सेवा लिन नपाएकोले नचाहदा नचाहदै गर्व रहन गयो	1	0
गर्वपतन गर्नु पर्ने अवस्था आयो	1	0
असुरक्षित यौन संपर्क रहन गएकोले आपतकालिन परिवार नियोजन सेवा लिनु पर्ने अवस्था आयो	1	0
परिवार नियोजन सेवाबारे जानकारी लिन कठिनाई भयो	1	0
अन्य (उल्लेख गर्नु होस्)		

P6	के तपाईंले बिगत एक बर्षमा कोविड १९ ले गर्दा प्रयोग गरी रहेको परिवार नियजोन सेवा परिवर्तन गर्नु पर्ने अवस्था आयो ?	आयो आएन	1 0	यदी जवाफ आए 0 अन्तरवार्ता टुङ्याउनुहोस्

खण्ड (झ): कोविड १९ को महामारीमा यौन तथा प्रजनन स्वास्थ्यको अवस्था

P7 यदी परिवार नियोजन सेवा परिवर्तन गर्नु भएको हो भने पहिला प्रयोग गरी रहेको साधन के थियो उल्लेख गर्नु होस् *(तल प्रदान गरिएका विकल्प नभनि सहभगि आफैलाई भन्न लगाउनुहोस र सोही अनुसार मिल्ने सबै विकल्पमा **गोलो** चिन्ह **O** लगाउनुहोस् ।)*

बिधी/साधनहरु	प्रयोग	
	गर्थैं	गर्दिन थिएँ
अस्थाई साधनहरु		
आइ यू सि डि (कपर टि/ IUCD)	1	0
गर्व निरोधक इम्प्लान्ट (नर्प्लान्ट/ Implant)	1	0
गर्व निरोधक सुई (डिपो प्रोभेरा/ सड्गिनि/ तीन महिने सुई/ Depo Provera)	1	0
पिल्स (खाने चक्की/ सुनौलो गुलाफ/ निलोकेन white/Pills)	1	0
कन्डम (Condom)	1	0
अन्य	1	0
परम्परगत विधी		
परिवार नियोजनको स्तनपान बिधी (LAM)	1	0
माहिनावारीलाई आधार मानी सुरक्षित समयमा मात्र संपर्क गर्ने बिधी (Rhythm Method)	1	0
विर्यलाई योनी बहिर स्खलन गराउने तरिका (Withdrawal)	1	0
अन्य परम्परगत	1	0
अन्य परम्परगत (उल्लेख गर्नु होस्)		

सहभागिहरुलाई धन्यवाद दिएर बिदा हुने

B. Guideline for Indepth Interviews

1. बिवाहित कोशोरिहरुलाई सोधिने प्रश्नहरु

- परिवार योजना (नियोजन) बारेमा तपाईंको बुझाई के छ ?
    - कस्तो किसिमको सेवा हो ?
    - कसको लागि आवश्यक हुन्छ जस्तो लाग्छ ?
    - किन सेवा लिने/ लिनु पर्छ ?
- किशोर किशोरि कार्यक्रमाको बारेमा तपाईंको धारणा के छ?
    - कार्यक्रममा के कस्ता कुराहरु समेटिएका थिए?
    - ति कार्यक्रमहरुले तपाईलाई के कस्तो प्रभाव पारे?
    - परिवार नियोजन सेवाको बारेमा तपाईंको बुझाईलाई के कस्तो प्रभाव पऱ्यो ?
    - पहिला थाहा नभएका के कुराहरु सिक्नु भयो?
    - कार्यक्रम कत्तिको प्रभावकारी लाग्यो?
- परिवार नियोजन सेवा उपयोग गर्ने क्रममा के कस्ता ब्यवधानहरु हुन सक्छन ?
    - भौगोलिक ब्यवधानहरु
    - आर्थिक ब्यवधानहरु
    - सामाजिक ब्यवधानहरु (गलत धारणा, सामाजिक / पारिवारिक सहयोग)
    - ब्यक्तिगतहरु कुराहरु जस्तै (जानकारीको अभाव, आत्मबिश्वासको अभाव, लाज लाग्ने आदी)
    - तपाईंको अनुभव कस्तो छ?
- यि ब्यवधानहरुलाई/ समस्याहरुलाई सम्बोधन गर्न/ समाधान गर्न सक्षम किशोर किशोरि कार्यक्रम को भूमिका के रह्यो?
    - कुन कुन ब्यवधानहरु समाधान गऱ्यो ?
    - कसरी समाधान गऱ्यो ?
    - कुन कुन ब्यवधानहरु समाधान हुन सकेनन ?
- किशोर किशोरिहरुले परिवार नियोजन सेवा उपयोग गर्न जाने क्रममा स्वास्थ्यकर्मी को ब्यवहार सामान्यतया कस्तो हुने गर्दछ ?
    - सेवा ग्रहिप्रतिको सम्मान
    - गोपनियता / तपाईं र स्वास्थ्यकर्मी बिच भएको कुरा अरुले नसुनुन भन्नको लागि केही गर्नु हुन्छ कि स्वास्थ्यकर्मिले ?
    - सहयोग गर्ने तत्परता
- सक्षम किशोर किशोरि कार्यक्रम पछी कुनै परिवर्तन देख्नु भएको छ ?
    - स्वास्थ्यकर्मिको ब्यवहार
    - परिवार नियोजन सेवाको बारेमा जानकारी
    - सेवाको उपलब्धता तथा गुणस्तर
- किशोर किशोरी कार्यक्रमपछी तपाईंको समुदायमा परिवार नियोजन सेवा हेर्ने दृष्टिकोणमा के कस्ता परिवर्तनहरु देख्नु भयो ?
- तपाईंको परिवारमा परिवार नियोजनलाई हेर्ने दृष्टिकोणमा के कस्तो परिवर्तन पाउनु भयो ?
- किशोर किशोरी कार्यक्रममा के कस्ता विशेसताहरु देख्नु भयो ?
    - सकारात्मक पक्षहरु के के थिए

- के कुराहरु सुधार गर्नु पर्छ ?
- अरु कार्यक्रम भन्दा के सक्ष्यम किशोर किशोरि कार्यक्रममा के फरक पाउनु भयो ?

- हाल फैलिएको कोरोना रोगले परिवार नियोजन सेवामा के कस्तो प्रभाव परेको छ ? तपाईंको परिवार नियोजन सेवालिने क्रममा कोरोना महामारिले कुनै प्रभाव पर्‍यो कि पारेन ?

1a. शिक्षक साथी / सामाजिक परिचालकबाट सेवा लिएका किशोर किशोरिहरुका लागि थप प्रश्नहरु

- तपाईं जस्तै उमेरका शिक्षक साथीहरु (सहकर्मिहरु) परिवार नियोजन सेवाको जानकारी दिन आउँदा कस्तो महसुस गर्नु भयो?
  - आफु जस्तै साथीहरुबाट जानकारी लिदा कतिको सहज भयो ?
  - अरु बाट सेवा लिनु र सहकर्मिबाट सेवा जानकारी लिनु मा के फरक पाउनु भो ?
  - के कस्ता फाईदा हरु, के कस्ता बेफाईदाहरु?
- यसरी परिचालन हुने सहकर्मिहरुको दक्षता र ब्यवहाँर कस्तो पाउनु भयो? सुधार गर्नु पर्ने पक्षहरु के के होलान ?

  कतिको बुझाउन सक्नु भयो ?

- कोरोना माहामारिको कारण तपाईंको शिक्षक साथीसँगको अन्तर्कृया तथा जानकारी लिने काममा के कस्तो प्रभाव गर्‍यो ? महामारिको क्रममा उहाहरुसँग भेट भयो कि भएन ?

1b. क्याम्प बाट सेवा लिएका किशोर किशोरिहरुका लागि थप प्रश्नहरु

- क्याम्प बाट परिवार नियोजन सेवा लिदाको तपाईंको अनुभव कस्तो रह्यो ?
  - के कस्त सेवाहरु उपलब्ध थिए ?
  - अरु परिवार नियोजन क्याम्प र यसमा केही फरक पाउनु भयो कि ?
  - गोपनियताका लागि के कस्तो व्यावस्था गरेको पाउनु भयो ?
  - सेवा लिन तपाईंलाई कतिको सहज् भयो ?
- के कुराहरु राम्रो लाग्यो ? के कुराहरु सुधार गर्नु पर्ने देख्नु भयो ?

1c. जीवन उपयोगी शिक्षा लिएका किशोर किशोरिहरुलाई सोधिने प्रश्नहरु

- जीवन उपयोगी शिक्षाको प्रभाकारिता कस्तो लाग्यो ?
  - के कस्ता बिषयहरु समेटिएका थिए ?
  - कुन कुन कक्षाहरु राम्रो लाग्यो ?
  - तपाईंले उक्त कक्षाहरु लिएर के थप जानकारी हासिल गर्नु भयो ?
- यसले तपाईंको दैनिक जीवनमा केही परिवर्तन ल्याएको छ त ?
- सुधार गर्नु पर्ने पक्षहरु के के देख्नु भएको छ ?

1d. स्कुलमा परिवार नियोजन सम्बन्धी जानकारी दिने कर्नर् बारे

- जानकारी केन्द्रमा राखिएका सामाग्रीहरु कतिको प्रभाकारी छन ?
- ति जानकारी सामाग्रीहरुले तपाईंका चासोहरुलाई कतिको समेटेका छन ?
- जानकारी सामाग्रीहरुमा प्रयोग भएको भाषा कतिको सजिलो गरी बुझ्न सकिन्छ ?

- तपाईंको स्कुलमा आङ्रा नेपालबाट परिवार योजना सम्बन्धी कक्षा लिनको लागि कोही आउनु भएको थियो ? उहहाहरुले कक्षा लिदा कस्तो महसुस भयो ?
- थप् गर्नु पर्ने कुनै जानकारी सामाग्रीहरु छन कि ?
- यि केन्द्रहरुलाई थप् प्रभावकारी गराउन के गर्नु पर्ला ?

1e. जीवन उपयोगी शिक्षा लिएका किशोर किशोरिका परिवारलाई सोधिने प्रश्नहरु

- जीवन उपयोगी शिक्षाको प्रभावकारीता कस्तो पाउनु भयो ?
- तपाईंका छोरा छोरी बुहारीमा यो शिक्षा लिएपछी कस्तो परिवर्तन देख्नु भएको छ ?
- सुधार गर्नु पर्ने पक्षहरु के के हुन ?

2. सेवा प्रदायकलाई (including HF service provider) सोधिने प्रश्नहरु

- परिवार नियोजन सेवाको बारेमा जानकारी दिदा किशोर किशोरिहरुले मुख्यता कुन कुन कुरा हरुमा चासो राक्छन ?
    - सेवाग्राहिहरुको सामाजिक, अर्थिक, धार्मिक प्रिस्ठभुमी अनुसार उनिहरुले राख्ने चासोमा कुनै फरक महसुस गर्नु भएको छ ?

सक्षम किशोर किशोरि कार्यक्रम सन्चालन भए पछी किशोर किशोरिका परिवार नियोजन सम्बन्धी चासोहरुमा के कस्ता परिवर्तन पाउनु भयो ? कार्यक्रम सन्चालन भए पछी सेवा लिने किशोर किशोरीको संख्यामा कुनै परिवर्तन देख्नु भयो ?

- किशोर किशोरिहरुलाई जानकारी दिने क्रममा र अन्यलाई जानकारी दिने क्रममा के कस्ता फरक देख्नु भयो ? किशोर किशोरिलाई जानकारी दिदा कुनै विशेस कुराहरुलाई धेरै ख्याल गर्नु पर्ने?
- कोरोना महामारी ले तपाईंले समुदयमा किशोर किशोरिलाई लक्षित गरेर गर्ने परिवार नियोजन सम्बन्धी जानकारी दिने कामलाई कत्तिको प्रभावित गऱ्यो ? यो समयमा आफ्नो काम कसरी अगाडि बढाउनु भयो ?
- कोरोना महामारिको क्रममा परिवार नियोजन सेवा लिन आउने किशोर किशोरि को संख्यामा केही फरक पाउनु भयो ? उहाँहरुको परिवार नियोजनाका साधनको रोजाइमा कुनै परिवर्तन देख्नु भयो ?
- कोरोना*महामरिको क्रममा परिवार नियोजनको बारेमा जानकारी दिदा कत्तिको रुची दिएको पाउनु भयो ? अन्य समय र महामारिको बेला के फरक पाउनु भयो ?*

2a. काउनसिलरलाई (social mobilizer) सोधिने प्रश्नहरु

- उक्त कार्यक्रममा काउनसिलरको रुपमा तपाईंको भूमिका बारे जानकारी दिनुहोस्
    - कार्य क्रमको मुख्य उदेश्य ?
    - परिवार नियोजन सेवामा कार्यक्रमले कसरी सहयोग पुर्याउछ ?
    - सुरु सुरुमा के कस्ता चुनौतिहरु महसुस गर्नु भयो ? ति चुनौतिहरुलाई कसरी समाधान गर्नु भयो ?
    - अहिले कार्यक्रमम सन्चालन गर्न कत्तिको सहज् छ ?
- कुन कुन जानकारी सामाग्रीहरु को प्रयोग गर्नु हुन्छ ?
- उनिहरुलाई अध्ययन गर्नको लागि कुनै सामाग्री हरु दिनु हुन्छ ?
- किशोर किशोरिलाई जानकारी दिने क्रममा मुख्यतया कुन कुन पक्षहरुलाई समेट्नु हुन्छ ?
- परिवार नियोजन सेवाको बारेमा दिइने जानकारीलाई कत्तिको सजिलो गरी ग्रहण गरी रहेका हुन्छन ?
- कार्यक्रमको प्रभावकारीता तपाईंलाई कस्तो लाग्यो?
- कार्यक्रम पछी समाज तथा किशोर किशोरिहरुमा के कस्तो परिवर्तन भएको देख्नु भयो ?
- कार्यक्रमले किशोर किशोरीमा आएका परिवर्तनलाई कसरी अभिलेखिकरण (Record) गर्ने गर्नु भएको छ ?
- कार्यक्रमलाई सुधार गर्नको लागि के कस्ता परिवर्तन हरु गर्नु उपयुक्त होला

2b. क्याम्पबाट सेवा दिने सेवा प्रदायक लाई सोधिने प्रश्नहरु

- क्याम्पमा सेवा लिने किशोर किशोरि हरुले कत्तिको सहज् महसुस गर्छन् ?
- सेवा लिना आउने मध्य किशोर किशोरिहरु को सन्ख्या कती जती हुन्छ ?

- अझ धेरै किशोर किशोरि लाई सेवा मा समेट्न के कस्ता परिवर्तन हरु गर्नु पर्ला

2c. जीवन उपयोगी शिक्षा दिने सेवा प्रदायकहरुलाई सोधिने प्रश्नहरु

- जीवन उपयोगी शिक्षामा के कस्ता कुराहरु समेट्नु हुन्छ ?
- किशोर किशोरि को चासो मुख्या कुन कुन कुरा हरुमा हुने गर्दछ ?
- किशोर किशोरिका परिवारको चासो कुन कुन कुरा हरुमा हुने गर्दछ ?
- कार्यक्रममा सहभागि भएपछी किशोर किशोरिको जीवनमा कस्तो परिवर्तन पाउनु भयो ?

2d. परिवार नियोजन जानकारी केन्द्र भएका स्कुलका स्वास्थ्य शिक्षाका शिक्षकहरुलाई सोधिने प्रश्नहरु

- परिवार नियोजन केन्द्रमा किशोर किशोरिहरुले कत्तिको चासो राक्छन ?
- केन्द्रमा जानकारी सामाग्रीको उपयोग कत्तिको भएको छ ?
- तपाईं सँग कुनै प्रश्नहरु सोध्न पुग्छन कि ? के कस्ता प्रश्नहरु सोद्छन ?
- परिवार नियोजन सेवा उपयोग गर्ने क्रममा के कस्ता ब्यवधानहरु हुन सक्छन ?
- सुधार गर्न के के गर्नु पर्ला ?

2e. स्थानिय निर्वाचित जन प्रतिनिधि (वडा अध्यक्ष)

- किशोर किशोरिलाई लक्षित गरेर आड्रा नेपालले तपाईंको पालिका वडा मा के कस्ता कार्यहरु गरी रहेको छ
- उक्त कार्यक्रममा तपाईंको धारणा के छ ? अरु कार्यक्रमा भन्दा के फरक पाउनु भयो ?
- उक्त कार्यक्रममा समुदायको धारणा कस्तो पाउनु भएको छ
- कार्यक्रमलाई थप प्रभावकारी बनाउन के सुधार गर्नु पर्ने देख्नु हुन्छ ?

2f. कार्यक्रम अधिक्रित (Programme officer)

- तपाईंको जिल्लामा आड्रा नेपालबाट सन्चालित सक्ष्यम किशोर किशोरि कार्यक्रमको बारेमा वताउनुहोस् उक्त कार्यक्रममा समुदाय स्वास्थ्यकर्मिहरु, निर्वाचित जनप्रतिनिधिको प्रतिकृया कस्तो पाउनु भयो ? उक्त कार्यक्रममा किशोर किशोरिको प्रतिकृया कस्तो पाउनु भयो ? कार्यक्रमका मुख्य सफलताहरुलाई के के रहे ?
- सक्षम किशोर किशोरि कार्यक्रम संचलन गर्दा के कस्ता व्यवधानहरुको सामना गर्नु पऱ्यो (जस्तै सरोकारवालालाई कार्यक्रममा सन्लग्न गर्न, कार्यक्रमका सहजकर्ताहरुलाई परिचालन गर्न) ?
- उक्त कार्यक्रमवाट कती जती किशोर किशोरि लाभान्वित भए ? कसरी लाभावन्त भए ?
- भविष्यमा सक्षम किशोर-किशोरी कार्यक्रम जस्तै कार्यक्रम संचालन गर्नु परेमा उक्त कार्यक्रम प्रभावकारी रूपमा संचालन/कार्यान्वयन गर्न तपाईंका के कस्ता सुझावहरु रहेका छन ?

2g. Visiting Service Provider (VSP)

- कार्यक्रममा तपाईंको भूमिका के हुन्छ ? आफ्ना कार्यहरुलाई कसरी अगाडि बढाउनु हुन्छ ? कार्यक्रम सन्चालन गर्दाको तपाईंको अनुभव कस्तो रह्यो ?
- तपाईंले गर्ने कार्यमा समुदायको प्रतिकृया कस्तो पाउनु भयो ? कार्यक्रम सन्चालन गर्दाको तपाईंको अनुभव कस्तो रह्यो ?