



Perspectives on adolescent girls' health-seeking behaviour in relation to sexual and reproductive health in Nepal

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ABSTRACT

Aim: To explore health care providers' perspectives on adolescent girls' health-seeking behaviour in Nepal in relation to their sexual and reproductive health and rights. Twenty health-care providers were included in this interview study. Ethical approval was obtained from the Nepal Health Research Council.

Findings: The main category 'Barriers affect adolescent girls' health-seeking behaviour in relation to their sexual and reproductive health' was divided into five categories: a conservative society with social stigma; lack of information, education and knowledge; lack of facilities and respectful care; insufficient confidentiality and privacy; and unmet needs of adolescent-friendly facilities.

Conclusions: Lack of knowledge among adolescent girls and unmet needs of adolescent-friendly facilities affect their access to sexual and reproductive health care in Nepal. Lack of knowledge could be seen as a barrier, and as a reason why adolescent girls do not seek sexual and reproductive health care.

Introduction

Good adolescent health outcomes globally are linked to adequate information and knowledge about sexual and reproductive health and rights (SRHR), in combination with not being fearful of social stigma, not being judged by health-care providers and having access to information and facilities to which adolescents can turn for help [1,2]. This is not however the case today. Of the 580 million adolescent girls in the world, 85% live in low- and middle-income countries [3]. Nepal is an example of a low-income country, where one-fourth of the population consists of adolescents [4]. Data show that adolescents from low- and middle-income countries are at heightened risk of experiencing gender inequality, child marriage and domestic violence, which makes them more vulnerable to unwanted pregnancies and sexually transmitted infections [1]. Similarly, they are also less likely to have the negotiation skills and power needed to refuse unwanted and/or unsafe sex [2,5]. This is also true of Nepal [6].

Around twenty-four per cent of Nepal's population of about 28 million people [7] live below the international poverty line. With adolescents making up twenty-five per cent of the population [4], adolescent girls are a particularly vulnerable group in the country [6]. The legal age of marriage is twenty years, or eighteen years with

parental consent, but both voluntary and involuntary adolescent marriages are common [6]. Despite the government's commitment to improve the sexual and reproductive health of adolescents [8], the status of women and girls remains low due to a deep patriarchal tradition, leading to economic, educational, social and political discrimination, and to there being no effective judicial safeguards to protect female rights [9,10].

Although sexual and reproductive health education is mandatory in schools in Nepal, SRHR is often not taught until grades 10 or 11 (when pupils are age 18 on average), after many girls have already dropped out of school [9]. Once they are married, as previous studies have shown, the husband often has the decision-making power regarding contraceptive use and family planning; the women are submissive and lack self-determination [10,11]. Sexual violence within marriage is common, particularly in rural areas [12], and the girls often lack the power to make decisions [9,13]. A few studies describe adolescent girls' access to sexual-reproductive health care in Nepal [9,14,15]. A few other studies describe their feelings when being treated by health-care providers [14,16]. Thus, with the aim of contributing complementary data and suggesting possible actions to make improvements in this important field, this study explores factors affecting adolescent girls' health-seeking behaviour in relation to their sexual and reproductive

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health, as described from the perspective of health-care providers.

Method

Study design

This study was based on individual interviews with health-care providers (medical doctors, nurses and nursing students) in Nepal. Interviews using open-ended questions were analysed with inductive content analysis. Ethical approval was obtained from the Nepal Health Research Council (Reg.no. 02/2016). The authors followed the ethical principles of the World Medical Association and the Swedish Research Council [17,18].

Setting and participants

Health-care facilities were selected based on convenience sampling [19]. The interviews were carried out at eight health-care facilities, two hospitals and six public-health facilities in Kathmandu and outside the city. The authors obtained permission from the manager(s) of each facility by sending an email with an outline of the study. Snowball sampling was used for recruitment of participants [19]. Inclusion criteria for the health-care providers were proficient English language skills and meeting adolescent girls at work regularly. Twenty health-care providers, four men and 16 women, aged 19–58, from different areas in the country (urban, mountain, hill and Terai areas) participated. The health-care providers either worked at various health-care facilities and had different levels of experience, from eight months to 36 years, or were nursing students (Table 1).

Interview guide and data collection

A semi-structured interview guide was developed and piloted with health-care providers. The questions in the interview guide focused on health-care providers’ perspectives on adolescent girls’ health-seeking behaviour in relation to sexual and reproductive health care. Data were collected by the principal investigators NB and AD after ethical permission was obtained in January 2016. The 20 individual interviews provided rich descriptions, and the pilot interviews were included in the study. All interviews were conducted in English, were audio recorded, and lasted 20–60 min. The interviews were conducted as per the participants’ choice, such as in a café, private home, or workplace. Prior to the interviews, the participants were informed about the aim of

Table 1
Personal characteristics of the informants (n = 20).

Interview no.	Origin	Age	Religion	Gender	Occupation
1	Kathmandu	27	Hindu	Male	Doctor-4 years
2	Kathmandu	28	Hindu	Female	Doctor-6 years
3	Chitwan	27	Hindu	Male	Doctor-4 years
4	Kathmandu	27	Hindu	Male	Doctor-3 years
5	Small village in the south western part of Nepal	58	Hindu	Female	Nurse midwife-36 years
6	Small village in the southern part of Nepal	30	Hindu	Female	Doctor-8 months
7	Terai	40	Hindu	Male	Doctor-11 years
8	Patan	52	Hindu	Female	Nurse-30 years
9	Dulikhel	55	Hindu	Female	Nurse-28 years
10	Small village in the northern part of Nepal	45	Does not believe in religion	Female	Nurse midwife-25 years
11	Small village in the centre of Nepal	48	Hindu	Female	Nurse midwife-30 years
12	Small village in the western part of Nepal	21	Hindu	Female	Nursing student
13	Small village in the southern part of Nepal	21	Hindu	Female	Nursing student
14	Khumbu	22	Hindu	Female	Nursing student
15	Chapa Bhanjyang	20	Hindu	Female	Nursing student
16	Small village in the eastern part of Nepal	20	Hindu	Female	Nursing student
17	Narayanghat	20	Does not want to answer	Female	Nursing student
18	Kalanki	21	Hindu	Female	Nursing student
19	Kathmandu	21	Hindu	Female	Nursing student
20	Small village in the south western part of Nepal	19	Hindu	Female	Nursing student

the study, confidentiality and the possibility to withdraw from the study at any time; moreover, consent forms were signed.

Data analysis

Content analysis, inspired by Elo and Kyngäs, was used to analyse the data [20]. A stepwise guide was followed [20]. In the first step, the authors read the collected data repeatedly to become familiar with the text. During the second step, a total of 551 meaning units were identified. These units were statements corresponding to the aim. The next step was to condense the text. Only the essential parts of longer answers remained. The fourth step was to group and code the condensed meaning units with similar and different content, which means the meaning units were abstracted and labelled. The coding was the bridge between the meaning units and further analysis. In the fifth step, the codes and the meaning units with similar content formed the categories. During this process, a main category describing the health care providers’ perspective on adolescent girls’ health-seeking behaviour in Nepal was formed from abstracted content from the sub-categories and generic categories.

The analysis was a repeated in a back-and-forth process between the original text, the condensed meaning units, the categories and the main category. The authors applied a self-critical approach throughout the analysis process, which allowed for alternative descriptions and/or interpretations. In the final step of the analysis, quotations from the interviews were used to illustrate verbal descriptions in the sub-categories. At the end of the analysis process, five categories and one main category, combining the categories, emerged.

Example of content analysis

Interview no.	Meaning unit	Condensed meaning unit	Code	Category
No. 17	Well it can be awkward or maybe they feel scared or ashamed.	Avoid seeking care because feelings of shame or fear.	Shame	A conservative society with social stigma

Findings

The data collected and analysed formed five categories describing factors that affected adolescent girls’ health-seeking behaviour in Nepal. The categories were: a conservative society with social stigma;

lack of information, education and knowledge; lack of facilities and respectful care; insufficient confidentiality and privacy; and unmet needs of adolescent-friendly facilities.

A conservative society with social stigma

The health care providers described a conservative society, of which they are a part, where social stigma affects health-seeking behaviour. This was explained as:

The health care providers are part of the conservative society and have that kind of understanding that if a girl comes to seek family planning, like contraceptives or abortion, it could mean that she is a bad girl. The girls are fearful of that (interview no. 10 health-care providers)

Adolescent girls felt shy talking about sexual and reproductive health, because it was considered something you should not talk about, or discuss. Another factor relating to social stigma was sex before marriage. Becoming pregnant was not even thinkable. *‘Young people do have sex before marriage, it’s not bad to do that but the cultural values don’t allow it. Young people are impacted by their culture’* (interview no. 12). The health-care providers perceived that most girls will only tell their closest friends or boyfriend about their sexual and reproductive health-related problems and/or questions because they were afraid of being judged by family members and excluded by the community.

According to the health-care providers, it was more acceptable for a married girl to seek sexual and reproductive health care. Thus, based on their experience, some girls lied about their marital status and identity when seeking care. *‘The adolescent girls are afraid that society will think they are bad girls if they are single, unmarried and seeking sexual and reproductive health care’* (interview no. 10). The health-care providers believed that health-seeking behaviour was a big issue among adolescent girls in Nepal, and was related to weak sexual and reproductive health and rights. *‘The girls don’t seek help; they marry early, don’t go to school and get pregnant at a young age’* (interview no. 4).

Depending on how the girls grow up, their health-seeking behaviour may differ. The health-care providers stated that many parents from conservative families taught their children from a young age not to talk about sex. *‘From childhood, we are taught by the conservative society not to talk about sex’* (interview no. 20). This was why many girls did not seek health care: they were too ashamed, and afraid of what members of society would think if their problems were disclosed. *‘The families need to broaden their conservative mind set so that it won’t be considered a big deal to seek sexual and reproductive care’* (interview no. 16). Because of the conservative society, where social stigma was prevalent, health-care providers perceived that adolescent girls sometimes contemplated suicide before telling anyone or seeking help.

Lack of information, education and knowledge

The health-care providers identified lack of information, education and knowledge as factors affecting adolescent girls’ health-seeking behaviour. They were viewed as not having enough knowledge about physical changes during adolescence, and not knowing when or where to seek help for their sexual and reproductive health-related problems. According to the health-care providers, this topic was included in the school curriculum, but was not usually taught, as many teachers did not feel comfortable teaching the subject. *‘In the curriculum, they have to have education about sexual and reproductive health and rights, but some teachers don’t like that; they hate it’* (interview no. 14). Consequently, adolescents received accurate information about the menstrual cycle, but topics such as contraception, sexually transmitted infections and safe sex were left out. Another factor affecting health-seeking behaviour was lack of information about rights concerning free abortion, free testing for sexually transmitted infections, and treatment. *‘If the adolescent girls don’t get knowledge, they can’t make the right decisions’* (interview no. 19).

According to the health care providers, it is easy to buy emergency contraceptive pills without a prescription in Nepal. Therefore, they perceived that adolescent girls went to the pharmacy instead of seeking care at a health facility. This, in turn, can lead to unsafe abortions. The health care providers had observed that girls sought treatment from traditional healers with septic abortions and death as a consequence. *‘In the remote areas, the girls do not know about health-care facilities so they go to the traditional healers. Because of that we have many cases of septic abortions and some girls die’* (interview no. 1).

Lack of facilities and respectful care

Other factors affecting whether adolescents seek care were lack of facilities and respectful care. The health-care providers stated that it could be difficult for adolescent girls to seek health care at a facility level, especially in remote areas where some girls had to travel long distances, maybe walking for days, to seek sexual and reproductive health care. This was described as follows:

In urban areas, all girls know they can get sexual and reproductive care, like abortions, in the hospitals. But in rural areas, some girls have to walk 6–7 days to reach a district hospital. And the people living far away, they don’t know that they can get sexual and reproductive care in a district hospital (interview no. 3).

In the cities, where both private and public health-care facilities are available, the health care providers perceived that adolescent girls turned to private facilities, where there was better care and confidentiality was kept, but this option was often too expensive for most of the girls. Another factor affecting adolescents’ willingness to seek care was the health-care providers’ ability to treat the individual girl respectfully. The ability to make the girl feel comfortable and secure, rather than uncomfortable and excluded, was exemplified in following quote:

We have to change our attitudes, and it has to be good. If you have a child, an adolescent, a woman. You need to be good and warm and listen. It has to be the same; not being bad but we have to be nice. We need to help; we need to listen; we need to counsel (interview no. 9).

Insufficient confidentiality and privacy

According to the health-care providers, another factor affecting health-seeking behaviour was that many adolescent girls did not fully trust that the health-care providers at health facilities would maintain confidentiality and privacy, which in turn reduced their trust in the health-care providers. The health-care providers acknowledged that neither privacy nor confidentiality could be fully ensured at the health-care facilities, because they usually came from the village where they worked. As described by one health-care provider:

One reason why adolescent girls don’t trust health-care providers is lack of privacy. In rural areas, the health-care providers are from the same villages, so the girls might be shy and concerned that her information will be leaked and circulate around the village (interview no. 20).

Another factor affecting health-seeking behaviour was that if the girls had to be examined by a male doctor, they felt out of place, scared and uncomfortable. Another factor raised was lack of privacy at the health-care facility, which did not have separate rooms, and where a doctor cared for and talked to many patients and other family members in the same room at the same time. This meant that all patients and their relatives could hear each other. *‘Adolescent girls are afraid of seeking help because the health-care provider cannot ensure their confidentiality. Not even a separate room can be provided’* (interview no. 7).

Unmet needs of adolescent-friendly facilities

The health-care providers expressed concern about unmet needs of adolescent-friendly facilities, even though it was easier to maintain confidentiality and privacy in an adolescent-friendly facility where the health-care providers did not know the adolescent girl seeking care. The health-care providers at the adolescent-friendly facility had extensive experience of and knowledge about the importance of adolescent girls being counselled in a calm and private area. The health-care providers trusted the adolescent-friendly facilities and believed that every hospital should have a separate clinic for adolescents, where the youth could receive adolescent-friendly care. This would make it easier for young girls to have access to and talk about sexual and reproductive health matters. *‘There should be a separate clinic for adolescents so that it is easy for them to come. And so that more time can be given to the patient. Counselling is especially important for adolescents’* (interview no. 2). The health-care providers also stressed that the accessibility and acceptability for young girls of adolescent-friendly facilities for health care and counselling were continuously improving in Nepal. *‘The situation is improving. A kind of environment, where girls do not feel hesitant to visit any doctor should be created’* (interview no. 12).

Discussion

This paper identified factors across the health system affecting adolescent girls’ health-seeking behaviour in Nepal. Being aware of factors that affect health-seeking behaviour among adolescent girls can help with setting future priorities that can feed into an equitable health and education system in Nepal, to protect the health, well-being and dignity of the young people. The main findings in this study are descriptions of factors affecting adolescent girls’ health-seeking behaviour. These factors can be seen as results of a complex conservative society with a lack of information, education and knowledge among adolescent girls regarding sexual and reproductive health care and rights, and insufficient confidentiality and privacy, in combination with unmet needs of adolescent-friendly facilities. These factors thus negatively impact adolescent girls’ health-seeking behaviour in Nepal. Although the Government of Nepal has been implementing adolescent-friendly services, barriers remain. With this study we hope to promote adolescent- and youth-friendly services within and outside the health facilities (8, 28), even though our study confirms that the situation for youth in Nepal is continuously improving.

Our findings point to the fact that unmarried adolescent girls faced more barriers than married girls when it came to seeking sexual and reproductive health care. Factors such as teasing, bullying and harassment by community members and health-care providers, in combination with fewer opportunities to discuss their health concerns, had a negative impact on unmarried adolescent girls’ health-seeking behaviour. These findings are consistent with previous descriptions of women’s low decision-making power in a patriarchal cultural [21]. Being an adolescent girl, living in a conservative society with social stigma, implies major inequities in society, which must be addressed broadly by nurturing positive values of women’s reproductive health and decision-making power. According to Menger et al. 2014 [22], Nepali cultural scripts limit access to sexual relationships, education and information, and such matters should not be discussed openly.

Our findings confirmed the limited access to information, education and knowledge. Adolescent girls felt shy talking about sexual and reproductive health, even within the family, because it was considered something that you should not talk openly about or discuss. Findings in previous studies [14,16] revealed the same fact. Our findings highlight that to enhance girls’ health-seeking behaviour, knowledge regarding adolescent girls’ sexual and reproductive health and rights must increase in society. To this end, sexual education was added to the school curriculum, but not necessarily taught, as teachers are also part of the conservative society. This agrees with previous studies describing that

teachers sometimes were unwilling to talk about sexual and reproductive health and rights, and the topics made them uncomfortable [9,23]. Hence, a rights-based and gender-focused comprehensive sexuality education, including specific information and knowledge about human development, anatomy and reproductive health, as well as information about contraception, childbirth and sexually transmitted infections (STIs), including HIV is needed, both inside and outside school. This education should include discussions about family life, relationships, culture and gender roles, and should address human rights, gender equality, and threats such as discrimination and sexual abuse. Taken together, comprehensive sexual education inside and outside school will, over time, contribute to changing girls’ health-seeking behaviour due to a change in cultural norms. Interestingly, other studies found that Nepali adolescents’ main sources of information about sexual and reproductive health and rights found were friends and the Internet. However, the information they received was not always correct, and led to poor decision-making [14,16]. Clearly, these findings emphasise the need for capacity building among teachers to orient them in the curriculum content related to sexual and reproductive health and rights.

Because of the conservative society, fraught with social stigma, the health-care providers perceived that adolescent girls sometimes consider suicide before telling anyone or seeking help. According to Cousins (2016) and the United Nations (2013), suicide is the leading cause of death among women in Nepal, but neither of these studies has fully investigated the underlying causes of suicides [24,25]. Adolescent suicide is generally not the result of a deliberate choice; rather, these girls often have little say about their sexual and reproductive health and rights, and about decisions affecting their lives. Thus, these deaths further reinforce the importance of strengthening girls’ sexual and reproductive health and rights through comprehensive sexual education, information and protection, to enable them to reach their full potential.

This study indicates that girls living in remote areas often had to travel a long distance to reach a health-care facility. The relation between distance and cost was described in the so-called *three delays model* as a major problem for health-seeking behaviour. This model is used by the World Health Organization and other organisations when working to improve health outcomes worldwide [26] and is highly relevant when strategically planning for better service delivery to a population. Lack of respectful care was mentioned by all informants in this study as a factor affecting health-seeking behaviour. Thus, respectful care was clearly a main cause of whether adolescent girls sought care. Fear of being treated badly by health-care providers and the community has previously been described in studies conducted in Nepal [14,16,27]. Seen from a global perspective, a conservative society and fear of not being cared for with respect were described as factors affecting why adolescent girls in particular did not seek sexual and reproductive health care in developing countries [27]. This implies a level of failure within the healthcare system regarding its ability to provide quality service to adolescents in general, and girls in particular. It is therefore anticipated to promote policies for, and investments in accessible high quality youth-friendly health services.

Another factor that was raised was the lack of privacy at health-care facilities, which lacked separate rooms and where doctors cared for and talked to many patients and family members at the same time. Consistent with the findings from Regmi et al. (2010), adolescent girls feel shy and embarrassed talking about sexual and reproductive health, especially to health-care providers of the opposite sex [16]. Our findings also indicate unmet needs and the importance of introducing adolescent-friendly facilities in Nepal. However, this dialogue has been ongoing for a decade. The National Adolescent Sexual and Reproductive Implementation Guide indicated this need already in 2011 [28], when the Government of Nepal described a need for adolescent-friendly services being accessible and acceptable within the health system. This point to the importance of having a national strategy targeting quality service delivery, adolescent-friendly health personnel,

and sufficient funding, prioritising adolescents in general, and girls in particular. Such suggestions are supported by other researchers [14,29], who claim that more adolescent-friendly sexual and reproductive health education and adolescent-friendly facilities should be created, both in urban and rural areas in Nepal, to improve the situation for adolescent girls.

Strengths and limitations

When collecting and analysing qualitative data and writing a study with a qualitative approach, it is easy to misunderstand the informants and/or to misinterpret the collected data [19]; therefore, the authors tried to be humble, keeping their preconceptions and perspectives in check throughout the whole study. The health-care providers were all working in different health-care facilities both in Kathmandu and outside the city at the time of the data collection. This could be seen as a strength in terms of achieving diversity of data, and could hence add to the credibility and trustworthiness of the study [19]. Informants chosen through snowball sampling may provide similar feedback, however this was not the case in this study. We achieved diversity in data, which is considered a strength in qualitative studies, according to Polit and Beck (2012) [19]. With only 20 participants, there may still be more areas that need to be investigated, and saturation has most likely not been reached, however the authors had this in mind and tried to make sure the collected data were rich and widespread. This study is a modest contribution to the field of research addressing youth-friendly services in Nepal (8. 28) and can be transferred only with caution because of its limitations. It is recommended that a more in-depth analysis of different components of adolescent girls' health-seeking behaviour related to SRHR in future research should be from the point of view of the young people themselves, rather than that of the health-care providers. This is the main limitation of this study.

One of the inclusion criteria for participating in the study was *knowledge of English*. This was to avoid the need for translation from Nepali to English, which increases the credibility and transferability of the study, since no translation was necessary. This also gives the findings trustworthiness since the authors could work with the data collected on their own without being afraid that important information would be lost along the way, which might occur when using a translator [19]. On the other hand, it might be seen as a limitation, with greater risk of misunderstandings due to language barriers; however, this is not something that the authors experienced during the interviews.

Conclusion, clinical implications for practice and further research

This study shed light on the health-seeking behaviour of adolescent girls related to their sexual and reproductive health in Nepal. The results pointed to a set of factors affecting adolescent girls' health-seeking behaviour; however, they also reflected health-care providers' awareness of adolescent girls' vulnerabilities and needs. Thus, our findings can be considered a starting point for discussions aiming to contextualise global strategies, with a focus on comprehensive sexual education, appropriate sexual and reproductive health service delivery and the creation of initiatives that reach the most vulnerable adolescent girls. Future research can investigate the young people's perceptions of how barriers to utilization of youth-friendly services can be dealt with in Nepal.

Author contribution

All authors have made substantial contributions to the conception and design of the study, or to the acquisition, analysis and/or interpretation of data; have been involved in drafting the manuscript or revising it critically for important intellectual content; given final approval of the version to be published and sufficiently participated in the work to take public responsibility for appropriate portions of the

content; and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Conflicts of interests and funding

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