

SEXUAL AND REPRODUCTIVE HEALTH STATUS OF ADOLESCENTS AND YOUTH IN NEPAL

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Sexual and reproductive health of adolescents and youth is a common concern for policy makers, service providers, academicians and development practitioners. This article sheds light on current sexual and reproductive health status of young people in Nepal. Using data from Nepal Demographic and Health Survey 2011 and Nepal Adolescents and Youth Survey 2010/11, this article illustrates number of important sexual and reproductive health issues. Nepali youth are at turmoil of demographic, cultural and social shifts. They have begun to challenge the conventional values without social and family acceptance. At the time service mechanisms are not sufficiently institutionalized to address the need of young people, it is urgent to scale up the youth friendly services. Despite improvements in lives of young people, their vulnerability is also increasing. At the time, age at marriage and first birth have increased; knowledge of family planning is universal; exposure to means of communication has improved; the recent surveys show increasing sexual and reproductive health vulnerability of young people. Therefore, a service delivery mechanism addressing the dynamics of young people is required to safeguard sexual and reproductive health and rights of young people.

INTRODUCTION

Sexual and reproductive health (SRH) status and behaviors of adolescents and youth in Nepal are drawing attention to academicians, policy makers, development partners and public health service providers. Two reasons largely appear for this. First, SRH behaviors of young people are significantly changing. Such changes have implications in socioeconomic and demographic outcomes. Second, adolescence and youth period is full of turmoil. Unless addressed and guided by young people friendly social systems, public policies and service delivery systems, the risk of health disadvantage multiplies because changing SRH behaviors have inherent risks. Young people's attempts to adjust with sexually maturing body, learning to deal with sexual desires, confronting with sexual attitudes, values, norms and practices, experimenting with sexual behaviors and developing an image of self (Crockett, Raffaelli & Moilanen, 2003) put them at a crossroad of risks where individual coping abilities and family supports are essential strategies to help them practice healthy behaviors.

The International Conference on Population and Development (ICPD) 1994 has been successful to bring SRH concerns as an agenda of development, policy response and academic discourse. The ICPD has stressed on access to adolescents friendly health services because the existing services, as it argues, are unable to cater reproductive health services (UNFPA, 2004). Nepal, as a co-signatory in 1994 to the Plan of Action of the ICPD has committed itself to improving the reproductive health status of the people throughout the kingdom. As recognized by ICPD, adolescents (and youth) have particular health needs that differ in important ways from those of adults. Their SRH status is quite important because it lays the foundation for our demographic future (Pathak, 2006).

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Adolescence and youth is a period defined by certain biological and physiological changes (Khan & Mishra, 2008; The World Bank, 2004) followed by experimental behaviors and imaging self. Such an image of self largely depends on the existing socio-cultural and family norms and generally, produces different images between male and female. Understanding the complexity of defining adolescence in differential socio-cultural, religious and gender practices, the ICPD has reiterated vulnerabilities and risks associated with such practices. Imaging self is an output of age and gender-related risks and opportunities available in families, communities and societies leading to create conditions for both negative and positive health outcomes (WHO, 2011).

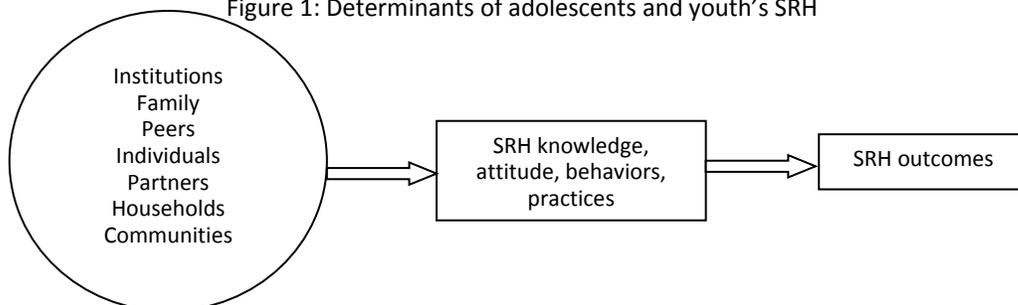
Contextualizing SRH of Young People

SRH outcome of young people is a product of a complex phenomenon with a comprehensive interaction with the existing socio-cultural and institutional structures and practices. This is simply because an individual is a biological entity surviving and positioning in a complicated socio-cultural and institutional setting. Among several obvious in one's life, passing from adolescence and youth period is also an obvious which witnesses the age-related changes in physiology, understanding and activities. Such changes involve the attempts to define own sexuality and sexual behaviors. This period often faces challenges to deal in a positive and responsible way with their sexuality (WHO, 2011).

SRH has evolved from a concept of family planning in later half of 20th century. The concept of family planning, at its origin, was focused on birth control mechanism (Seltzer, 2002; Hulme, 2009). The demographic rationale of family planning was later extended to health and human rights rationale (Seltzer, 2002). However, it was still not sufficient to address the comprehensive need of women and men. Therefore, after the ICPD, concept of family planning was largely been addressed within the framework of reproductive health. However, the reproductive health was conceptualized from the narrow window of population and demography (Hulme, 2009) which could not address the non-demographic issues related to adolescents, youth, women and men. Followed by the ICPD 1994, the concept of reproductive health has taken wider space in development discourse which now has been integrated with right-based approach and non-demographic issues to form sexual and reproductive health and rights (SRHRs). SRHR is broader concept and incorporates rights into reproductive health needs and dynamics.

Adolescents and youth pass through a contested situation who often frame SRH knowledge, attitude, behavior and practice (KABP) within a complex social situation as discussed by (Adamchak et al., 2000) which is shown in Figure 1. The SRH status is outcome of complex socio-cultural, individual and institutional factors.

Figure 1: Determinants of adolescents and youth's SRH



Source: Adapted from Adamchak et al. (2000).

Each factor from the left circle plays role to influence KABP of adolescents and youth on sexual and reproductive behaviors and thus resulting the SRH outcomes. The institutions, for example, represent the government policies, practices and arrangement to address the SRH needs of the young people. In many instances reproductive health needs of adolescents and youth have been largely ignored in the existing health service delivery mechanism (UNFPA, 2004). Likewise, peer pressures have a tremendous impact on SRH behaviors because if youth believe that their friends have been engaged in some sexual practices, they are more likely to involve themselves in such activities.

DATA AND SOURCE

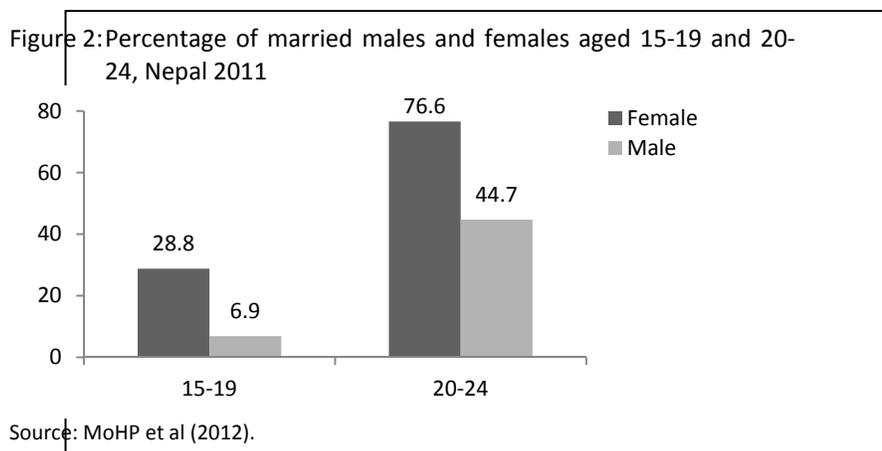
This article primarily focuses to elucidate the SRH status and behaviors of adolescents and youth in Nepal focusing on two main surveys accomplished recently - Nepal Demographic and Health Survey (NDHS) 2011 and Nepal Adolescents and Youth Survey (NAYS) 2010/11. The NDHS is newer version of earlier series while NAYS is the first of its kind. Both surveys have sufficiently disclosed the changing SRH issues of adolescents and youth. Although the aim of this article is to highlight the results from these two surveys, due comparisons are made with global practices, particularly with south Asian region. Data used in this article are from NDHS 2011 cited as Ministry of Health and Population (MoHP) [Nepal], New ERA & ICF International Inc. (2012), in short MoHP et al. (2012) and NAYS 2010/11 cited as Ministry of Health and Population (MoHP) [Nepal] (2012), in short MoHP (2012) unless stated otherwise.

SEXUAL AND REPRODUCTIVE HEALTH STATUS OF ADOLESCENTS AND YOUTH

Demography of Young People

Nepal is predominantly a young population country with a large proportion of population below age 30. The NDHS 2011 shows that more than half of the population is below the age 24. Of the total population, young (10-24 years) people constitutes nearly one-third- 31.6 percent male and 32.7 percent female. The youth (15-24 years) people account 35 percent of total working age (15-64 years) population. This population has special needs because of having special characteristics.

Despite having improvements, Nepal still has early marriage practices. Figure 2 shows that as many as 29 percent of late adolescent (15-19 years) females are married while the percentage crosses three-



quarters for 20-24 years females. The corresponding figures for males are quite low - 7 and 45

percent in the age 15-19 and 20-24 respectively - implying that large proportion of females compared to males marry at younger age.

Figure 2 reiterates early marriage practice. The NDHS 2011 reinforces by median age at marriage. It reports the median age at first marriage for women (25-49 years) 17.5 years and for men (25-49 years) 21.6 years. Implied message is that more than 50 percent women in Nepal marry before 20 years of age. It also shows that, on an average, Nepalese men marry about four years later than women.

Median age	Male (25-49 years)	Female (25-49 years)
At first marriage	21.6	17.5
At first sexual intercourse	20.5	17.7

Source: MoHP et al. (2012).

Table 1 shows median age marriage and median age at first sexual intercourse. The median age at sexual intercourse of female is compatible with median age at first marriage

implying that sexual practices after marriage is common for females. Contrast to this, median age at sexual intercourse of male is lower than median age at first marriage implying that significantly large proportion of male enter into pre-marital sexual activities practices.

Perceptions on Marriage and Sexual Behaviors

Surveys indicate changing perceptions of Nepali young people towards marriage and sexual behaviors. Such findings have revealed several issues for policy and program response to ensure safer sexual and reproductive health and rights. The NAYS 2010/11 discloses that Nepali young people are contesting the traditional practices and thereby engaging in activities that Nepali society has reservation to accept. Table 2 shows a few examples of such behaviors.

Table 2: Percent distribution of young people age 10-24 by sex according to perceptions on marriage and sexual behaviors, Nepal, 2011

Perceptions on marriage and sexual behaviors	Male (%)			Female (%)		
	10-14	15-19	20-24	10-14	15-19	20-24
Love marriage appropriate	58	84	86	46	74	74
Living together before marriage acceptable	6	23	23	4	10	11
Premarital sexual intercourse acceptable	7	15	17	6	11	13

Source: MoHP (2012).

It is evident in Table 2 that Nepali young people are at a stage of behavioral and perceptual transition. They have conflicting opinion against the traditional Nepali society which needs to be safely managed. Sexual ideation and activity increase over this period (Halpern, Urdy, Chapbell & Suchindra, 1993). This transition has also put them at risk because they also have demonstrated several risky behaviors away from health scrutiny and family observations. As expected, males demonstrate flexible behavior compared to females. For example, male young people accept love marriage, living together before marriage and premarital sexual intercourse compared to female counterpart. This resembles the Nepali social and cultural settings which favors males. However, the proportion of females accepting these behaviors also indicate their changing preference out of the rigid traditional circle where virginity of female has cultural, religious and social values (Crockett et al., 2003).

Table 3 shows the involvement of young people in pre-marital sexual activities. The sexual practices of young people show that they are at risk of SRH. Surveys have shown that a significant number of young males and females are involved in pre-marital sexual activities with more male involvement.

Table 3: Percent distribution of young people age 10-24 by sex according to involvement in premarital sexual activities, Nepal 2011

Premarital sexual activities	Male (%)			Female (%)		
	10-14	15-19	20-24	10-14	15-19	20-24
Ever fallen in love affair	3	36	55	3	20	29
Involved in sexual activities at the time of visit	29	60	75	21	27	30
Having sexual intercourse with lover at the time of visit	5	36	57	4	9	11
Average number of lover by now	1.17	1.65	1.95	1.21	1.20	1.34

Source: MoHP (2012).

It is evident in Table 3 that age and involvement in the premarital sexual activities have an obvious positive relationship. More worrying is that large proportion of young people is engaged in premarital sexual intercourse which could be unsafe and unplanned. This may lead them to risky sexual behaviors because of inadequate knowledge of safe practices, inaccessibility to services and cultural and social limitations to negotiate safer sex (Campbell, Reerink, Jenniskens & Pathak, 2003). The social and cultural antecedents may have connection with the risk-taking behaviors of young people (Senderowitz, 2000).

Interestingly, both young male and female have more than one lover. It elucidates that young people are more experimental to sexually unhealthy behaviors. As Caldwell, Gajanayake, Caldwell, & Caldwell (1989) remark that along with the transformation in social values and structure, individual prefer freedom on decisions related to marriage, sexual unions and practices; Nepalese young people carry the message of such behaviors.

Nepalese adolescents and youth also show involvement in some sexual practices that are uncommon and rarely considered as healthy sexual practices in Nepalese society. For example, as NAYS 2010/11 shows that 8 percent young people are involved in oral sex, 5 percent in anal sex, 5 percent in paid sex and 13 percent in pre-marital sex. These behaviors are risky and demand health cautions. Voluntary involvement of young people in such activities indicates the true experimental nature of this group. The NAYS 2010/11 has shown that non-penetrative sexual activities are quiet common within the love union. Despite the limited access to health and restrictive cultural and sexual norms (Mathur, Malhotra & Mehta, 2001), young people are claiming liberation on traditional sexual norms.

Contraceptive Use and Fertility

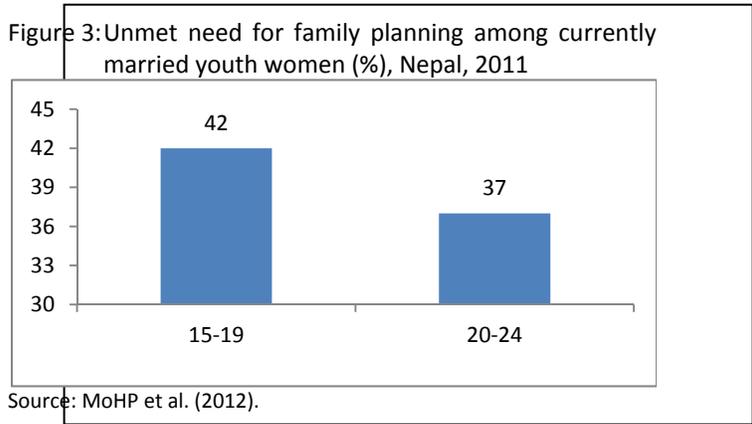
Although the knowledge of contraception is universal among young people, there are some marked gaps in the utilization. The youth females have one of the lowest contraceptive prevalence rates. For example, the NDHS 2011 shows that only 14 percent currently married women aged 15-19 use modern contraception followed by 24 percent women age 20-24. If we further decomposed the contraceptive use at first sexual intercourse, a large proportion do not use. The NAYS 2010/11 shows that 33 percent and 40 percent male aged 15-19 and 20-24 do not use contraceptive at first sexual intercourse. The proportion of females not using

contraception at first sexual intercourse is even higher. The same survey reports that 59 percent and 72 percent female aged 15-19 and 20-24 do not use contraceptive at first sexual intercourse.

The survey shows that young people are at greater risk of health hazards because of inadequate use or non-use of family planning methods and involvement in early unsafe sexual practices. The NDHS 2011 shows that women of 20-24 years have highest fertility rate; 15-19 and 20-24 years women practice shortest birth interval; 17 percent adolescent women aged 15-19 are already mother or pregnant; one quarter give birth by the age 18 and nearly half by the age 20. It resembles with the trend of developing countries in the south Asia region (Acharya, Bhattari, Poobalan, van Teijlingen & Chapman, 2010). These results show that despite the improvements in demographic and reproductive health indicators, young people are at comprehensive need of sexual and reproductive health services.

Unmet Need for Family Planning

Contraceptive prevalence rate in Nepal has faced stalemate in the last half a decade with increasing unmet need. Controversially, despite the expansion of the government and non-government services on family planning, the unmet need is still in rise. This simply indicates gap in service delivery. Figure 3 shows the unmet need among the currently married youth women. It shows that 15-19 years women have the highest unmet need followed by 20-24 years women.



There may be several reasons why young people have high unmet need. UNFPA (2004) points accessibility, choices, client-providers interaction, spousal or community support, follow-up and financial constraints as some reasons for low use of family planning services. Family planning for this group may not only have health benefits, it allows them to enjoy autonomy and opportunity of education, employment, participation and movement (Pokharel, 2008).

There are also some gaps to be addressed by the information and communication programs. For example, 21 percent (15-19) and 23 percent (20-24) women have not heard about family planning from radio, TV, newspaper, poster and street drama. Further, among the non-users 95 percent (15-19) and 85 percent (20-24) women do not discuss about family planning methods with health professionals at their visit to health services (MoHP et al., 2012). These indicators are demanding responsive and accountable service delivery systems to reach the young people.

Maternal Health Care

Early childbearing is still prevalent in Nepal. Women who begin fertility at younger age, particularly before 20 years, suffer from several health risks with increasing risk to newborns. WHO (2008) reports that early pregnancy leads to anaemia, STIs, mental illness, unsafe abortion

complications and obstetric fistulae. The health risks are also compounded to newborns. Besides the endogenous biological health factors, the exogenous socioeconomic and cultural factors increase the health risk of young mothers and babies from them (Conde-Agudelo, Belizan & Lammers, 2005). Besides the health disadvantage, the impacts are extended to education and household wellbeing (Greene & Merrik, 2005). The NDHS 2011 approves these arguments. For example the infant mortality rate (IMR) is about 20 points higher for the babies from less than 20 years mothers. The risk ratio reaches to 1.61 for less than 18 years mothers. If combined with birth interval less than 24 months and mother's age less than 18 years, the relative risk ratio of infant mortality reaches to 2.69.

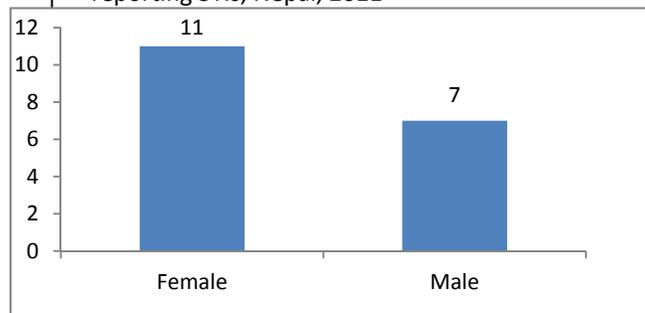
Young mothers in Nepal need comprehensive reproductive health services to prevent them from health hazards associated with early reproductive practices (Suwal, 2008). For example, among the young mothers below 20 years, 10 percent do not receive antenatal care (ANC); 58 percent deliver at home; 58 percent are assisted by non-skilled persons and 50 percent do not receive post-natal care (PNC). Reports also show discouraging health seeking behaviors among young females. As many as three quarters females (15-19 years) having at least one health problem do not access to health services owing to either permission, money, distance and accompany (MoHP et al., 2012).

Sexually Transmitted Infections (STIs) and HIV/AIDS

Preliminary knowledge about STIs and HIV/AIDS is common among Nepali young people with male being better informed. Having knowledge is prerequisite for being safe but not sufficient. The risk taking behaviors, refraining from health seeking behaviors and inaccessibility to health services mount the relative risk of STIs and HIV/AIDS. For females, gender power relations, cultural and social values restrict to negotiate and practice safer sex.

The NDHS 2011 indicates that young people are vulnerable to STIs and HIV/AIDS. There are two major indicators to derive this conclusion- prevalence of STIs and comprehensive knowledge of HIV/AIDS. Figure 4 shows the self-reported prevalence of STIs (STIs, genital discharge, sore or ulcer) among youth (15-24 years). More females than males report of having these problems. The severity increases when the youth have economic, education and cultural disadvantages.

Figure 4: Percentage of youth who ever had sexual intercourse reporting STIs, Nepal, 2011



Source: MoHP et al. (2012).

Despite the massive investment in spreading message, Nepali youth lack comprehensive and correct knowledge of HIV/AIDS. Comprehensive knowledge is important for making HIV/AIDS prevention program successful and promoting healthy sexual behavior. It is also necessary to reduce HIV/AIDS related stigma and discrimination. The NDHS 2011 shows that only 26 percent females and 34 percent males (15-24) have comprehensive knowledge. By comprehensive we

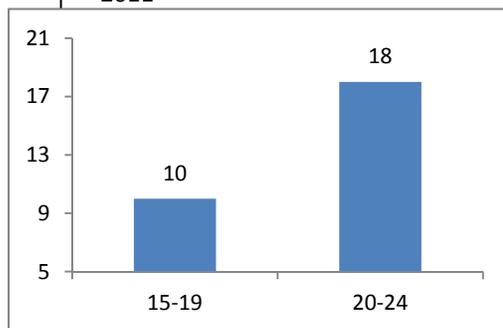
mean knowledge of mode of transmission, ways of prevention and appropriate attitude about HIV/AIDS infected persons.

Domestic Violence

Nepal has included domestic violence against women as one of the components of reproductive health. Two reasons may be behind it. First, domestic violence is cause of poor health of women. Because it restricts women's choices required for attaining good health including fertility choice and decision, use of contraception and health seeking behaviors. Second many cases of domestic violence are related to SRH issues. Women may suffer from domestic violence simply because they are unable to have birth or particularly male birth. Additionally, women are immediate victims of household poverty and shocks. Studies show that in comparison to non-abused women, abused women have 50-70 percent increase in gynaecological, central nervous system and chronic stress related problem (Campbell et al., 2002)

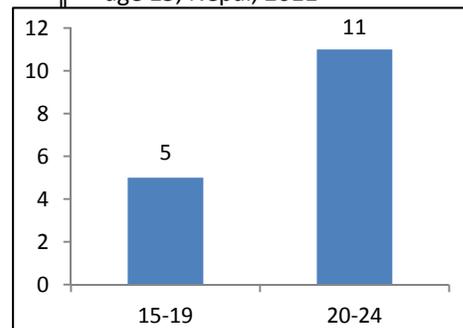
The NDHS 2011 for the first time includes the issues related to domestic violence and finds a significant proportion of young women suffering from domestic violence. Figures 5 and 6 show the proportions of women reporting ever experience of physical and sexual violence respectively. One in 10 women aged 15-19 have experienced physical violence while the proportion reaches nearly 2 in 10 for 20-24 years. Women who suffer from physical violence exhibit far reaching health consequences of women and children (Abbott & Williamson, 1999).

Figure 5: Percentage of women experiencing physical violence since age 15, Nepal, 2011



Source: MoHP et al. (2012)

Figure 6: Percentage of women ever experiencing sexual violence since age 15, Nepal, 2011



Source: MoHP et al. (2012)

Domestic violence against women has substantial consequences of physical injury, psychological and emotional distress, suicide and substance abuse among victims (Stark & Flitcraft, 1991). Some studies also term early and child marriage as violence against women and also a cause of domestic violence (UNICEF, 2005). In fact, domestic violence has far reaching physical and psychological consequences.

Knowledge and Attitude towards Family Planning and Abortion

Although Government of Nepal has legalized abortion under certain legal and medical conditions in 2002, the information has not been well spread to younger women. This has put them at risk of unsafe abortion which is one of the major causes of maternal mortality and morbidity in Nepal. The risk of unsafe abortion may jeopardize health of many adolescents and youth as their participation in premarital sexual activities is alarmingly increasing. The NDHS

2011 shows that 60 percent (15-19) and 42 percent (20-24) women do not know that abortion is legal in Nepal. This calls stakeholders to be more sensitive and focused to increase awareness and access to the safe abortion services.

Despite the improvements in level of education and access to information, young people have some misconceptions about family planning which eventually discourages them to use contraceptives for better health. The NDHS 2011 shows that one in 10 youth (15-24) believe contraceptive is women's business while two in 10 believe using contraception may make women promiscuous. These attitudes prevent women to enjoy sexual and reproductive health rights.

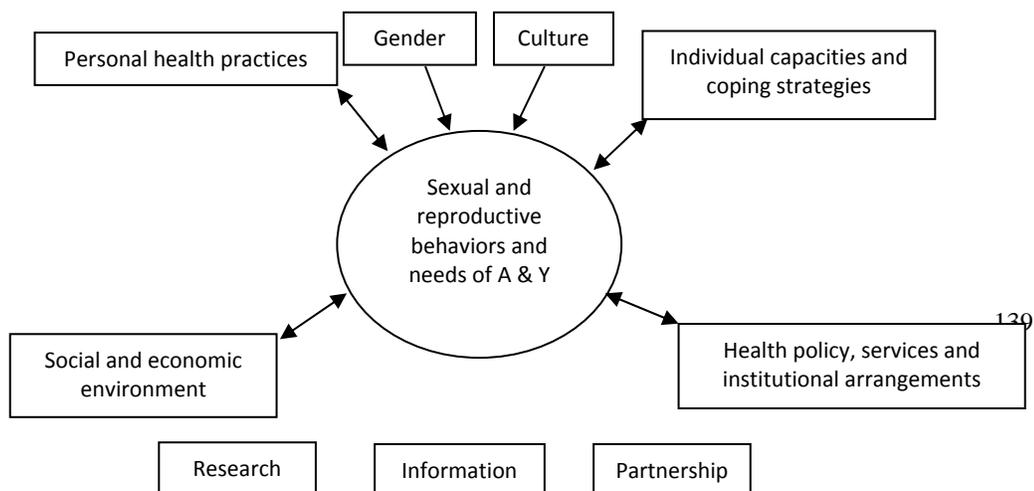
Mental Health: Moving Beyond Physical Health

The NAYS 2010/11 has collected information on mental health of adolescents and youth. It shows that a large proportion of young people have mental health issues. Frustration, hopelessness and attempts to suicide are common type of mental health issues. These issues may have relationship with sexual and reproductive health status. The survey shows that 28 percent (10-14), 46 percent (15-19) and 54 percent (20-24) ever felt hopelessness. Although reasons of feeling hopelessness are not disclosed, it may have critical health consequences. More severe to this 9 percent (10-14), 14 percent (15-19) and 15 percent (20-24) have thought about suicide. Thinking about suicide should have some critical driving factors at the background. In many instances, family and social restriction and pressure related to SRH issues are causes for inducing to suicide. Therefore, health services and programs have to address the mental health issues of young people because mentally healthy young people are physically healthier, demonstrate more socially positive behaviors and engage in fewer risky behaviors (Resnick, 2000).

CONCLUSION

Besides the physiological transition, a natural process, adolescents and youth in Nepal are passing through socio-cultural and ideational transition. They are, on the one hand, contesting the traditional norms, practices and values of sexuality. This has left them at risk of exclusion from family system, social structure and policy and program responses. On the other hand, the individual coping strategies are not sufficiently strong for many young people. As a result they are unable to resist the peer pressures and demonstration effects. The NDHS 2011 and NAYS 2010/11 show some important findings as discussed above that need to be addressed by the policy and programs. Figure 7 shows the mechanism to address the SRH needs of adolescents and youth in Nepal.

Figure 7: Response mechanism for adolescents and youth's SRH needs



The main message of Figure 7 is to illustrate how adolescents and youth SRH needs be ensured. One important step is to explore personal health practices and individual capacities and coping strategies through gender and cultural perspectives. It is equally important to assess the socioeconomic environment in which adolescents and youth survive. Government institutions like policy, services delivery mechanisms and institutional arrangements also play important roles to address the SRH needs. And at outer circumference, research, information and partnership are required to consolidate SRH service delivery by exploring SRH issues and needs, sharing information and building stronger partnership. Therefore, an enduring collaborative and comprehensive approach is recommended to address the SRH needs of young people in Nepal.

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